STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING ______ B. WING ______	C 10/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Survey Date: 10/13/2023 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ00160759, NJ00162265, NJ00164205, NJ00164636, NJ00166506, NJ00167387, NJ00162689, NJ00166908, NJ00167793 Survey Date: 10/13/2023 Census: 92 Sample: 27 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		11/2/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/03/2023

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

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F 609	Continued From page 1 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint # NJ00166908, NJ00162689 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) within 24 hours for an allegation of a NJ Ex Order 26. 4B1 . The deficient practice was identified for 2 of 3 investigations of reportable incidents reviewed (Resident #62, #195, #55). This deficient practice was evidenced by the following: 1. On 10/3/23 at 10:40 AM, the surveyor observed Resident #62 ambulating in the hallway of the 2nd floor. The surveyor interviewed the resident who was NJ Exec Order 26.4b1	F 609	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. It is the policy at Care One at Wellington to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are reported within a timely manner; if serious injury 2 hours, or no later than 24 hours, or no later then 24 hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury to the administrator of the facility and to other officials.	

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F 609	Continued From page 2 The surveyor reviewed Resident #62's hybrid medical records. The resident's Admission Record (an admission summary) indicated Resident #62 was admitted to the facility with diagnoses that included but was not limited to NJ Ex Order 26. 4B1. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26. 4B reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15 which indicated that the resident had NJ Ex Order 26. 4B1 . A review of Resident #62's interdisciplinary care plan with a revision date of NJ Exec Order 26. included a care plan titled, "[Resident #62] has NJ Exec. Order 26:4.1 symptoms removing NJ Exec Order 26.4b1 related to NJ Ex Order 26. 4B1..." On 10/10/23 at 12:25 PM, the surveyor reviewed #195's medical records. The resident was admitted to the facility with diagnosis that included but not limited to NJ Ex Order 26. 4B1 . A review of the Admission MDS, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26. 4B reflected that the resident had a BIMS score of NJ Ex out of 15 which indicated that the resident was NJ Ex Order 26. 4B1. On 10/11/23 at 12:21 PM, the surveyor reviewed a "Reportable Event Record/Report Form" provided by the facility. The form was dated	F 609	How the Facility will identify other residents having the potential to be affected by the same deficient practice. Any residents have the potential to be affected. Resident #62 had no adverse effect related to incident. Resident #195 had no adverse effect related to incident. Resident #55 had no adverse effect related to incident. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not reocurr. Director of Nursing conducted an audit for reportable events within the last three months to ensure proper reporting. Director of Nursing/ Assistant Director of Nursing provided re education to nursing staff on reportable events ands the importance of timely reporting. Audit tool, which will track all reportable events, will be initiated including incident, incident date, and time of incident and name of designee providing the reporting. Audit tool to also include time of reporting to the Department of health and way in which event was reorted ie. email, fax or phone. How the facility will monitor its corrective actions to ensure that the deficient practice is being correted and will not	

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F 609	Continued From page 3 NJ Ex Order 26. 4B1 and documented an event that occurred on NJ Ex Order 26. 4B1 at 10:56 AM involving Resident #195 and Resident #62. The report documented Resident #195 reported to the nursing staff that Resident #62 NJ Exec Order 26.4b1 . The report concluded, "NJ Ex Order 26. 4B1 " and Resident #195 was moved to a different unit. On 10/12/23 at 11:31 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed the details of the incident that took place on, Saturday, NJ Ex Order 26. 4B1. The DON stated the incident "happened on a weekend" and the "Reportable Event Record/Report Form" was not submitted to the NJDOH until Monday, NJ Ex Order 26. 4B1. The DON could not provide any documentation of the NJ Ex Order 26. 4B1 being reported within 24 hours to the NJDOH. A review of the provided facility policy titled, "Unusual Occurrence Reporting" which documented under Policy Interpretation and Implementation: "2. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations." On 10/12/23 at 1:52 PM, the surveyor informed the facility's Licensed Nursing Home Administrator (LNHA), the DON, and the Assistant Director of Nursing of the above	F 609	reoccur i.e. what QA program will be put in place to monitor the continued effectiveness of the systemic change. Director of Nursing or designee will complete an audit of all reportable incidents twice weekly x 1 month then weekly ongoing to verify that all reportables were reported within appropriate time frame in accoradance with state law. Reports will be submitted to Quality assurance performance improvement monthly.	

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F 609	Continued From page 4	F 609		

concerns. The DON and the LNHA acknowledged the reportable event was not reported to the NJDOH in a timely manner according to federal and state regulations. There was no further information provided by the facility.

2.) On 10/3/23 at 10:43 AM, the surveyor observed Resident #55 in the room with eyes closed. The surveyor further observed a NJ Ex Order 26. 4B1 at the bed side.

The surveyor reviewed Resident #55's Admission Record. The resident was admitted to facility with diagnoses that included but were not limited to, NJ Ex Order 26. 4B1

A review of the Quarterly MDS dated NJ Ex Order 26. reflected that the resident had a BIMS score of NJ out of 15 which indicated that the resident had NJ Ex Order 26. 4B1.

A review of Resident #55's interdisciplinary care plan with a revision date of NJ Exec Order 26. documented a care plan titled, "[Resident #55] has episodes of NJ Exec Order 26.4b1 related to NJ Ex Order 26. 4B1, NJ Exec Order 26.4b1. [Resident #55] has episodes of NJ Exec Order 26.4b1 on the unit and laying on unoccupied beds. On NJ Ex Order 26. 4B1 [Resident #55] was NJ Exec Order 26.4b1 going into peers' room at risk for NJ Ex Order 26. 4B1 with peers."

The surveyor reviewed Resident #62's Admission Record. The resident was admitted to facility with diagnoses that included but were not limited to NJ Ex Order 26. 4B1

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F 609	Continued From page 5 NJ Ex Order 26. 4B1 A review of the Quarterly Minimum Data Set (MDS) dated NJ Ex Order 26. 4B1 reflected that the resident had a BIMS score of NJ out of 15 which indicated that the resident had NJ Ex Order 26. 4B1 . A review of Resident #62's interdisciplinary care plan with a revision date of NJ Exec Order 2 documented a care plan titled, "[Resident #62] is at risk for NJ Ex Order 26. 4B1 with [Resident #55] on NJ Ex Order 26. 4B1 and other wandering peers." The surveyor reviewed a document provided by the facility titled "Reportable Event Record/Report Form", which was dated NJ Ex Order 26. 4B1. It documented an incident that occurred on NJ Ex Order 26. 4B1 at 1:00 AM between Resident #62 and Resident #55. The report read, "around 1:00am, staff heard a loud inaudible talking coming from the hallway. Upon seeing what the sounds were, noted two residents by the doorway of room NJ Exec. O. Resident #55's NJ Ex Order 26. was flailing around. Resident #62 noted to NJ Exec Orde Resident #55's NJ Ex Order 26. 4B1 to get his attention. Staff separated both resident immediately. Resident #55 was brought to his room. Body assessment done on both residents. NJ Exec Order 26.4b1 was noted." The report forms further documented, "In conclusion, the interaction between the two resident was not anticipated and NJ Exec Order 26.4b resulted from interaction. Care plans were updated for both residents." On 10/12/23 at 11:31 AM, the surveyor interviewed the DON who confirmed that the above incident took place on NJ Ex Order 26. 4B1 and the "Reportable Event Record/Report Form" was not submitted to the NJ DOH until NJ Ex Order 26. 4B1 because "it	F 609		

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F 609	Continued From page 6 happened on a weekend". The DON could not provide any documentation of the NJ Ex Order 26. 4B1 being reported within 24 hours to the NJDOH. A review of the provided facility policy titled, "Unusual Occurrence Reporting" which documented under Policy Interpretation and Implementation: "2. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations." On 10/12/23 at 01:52 PM, the surveyor discussed the above concerns with the facility's LNHA, DON and Assistant Director of Nursing who agreed that the above reportable event was not reported to the NJDOH in a timely manner according to the federal and state regulations. There was no further information provided by the facility. N.J.A.C. 8:39-5.1(a)	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		11/2/23

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F 656	Continued From page 7 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop a comprehensive, person-centered care	F 656	How the corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 656	Continued From page 8 plan for 2 of 27 residents reviewed for comprehensive care plans (Resident #14 and #72). This deficient practice was evidenced by the following: 1. On 10/3/23 at 10:57 AM, the surveyor observed Resident #14, resting in bed in their room. Resident #14 was receiving NJ Ex Order 26. 4B via a NJ Ex Order 26. 4B1 that was attached to a NJ Ex Order 26. 4B1 . The NJ Ex Order 26. 4B1 was set a NJ Ex Order 26. 4B1 . On 10/4/23 at 10:45 AM, the surveyor observed Resident #14 resting in bed. The resident was receiving NJ Ex Order 26. 4B via NJ Ex Or that was attached to a NJ Ex Order 26. 4B1 set at NJ Ex Order 26. 4 . The surveyor reviewed the electronic health record (EHR) of Resident #14 which revealed the following: The resident's Admission Record documented that Resident #14 was admitted with diagnoses that included, but were not limited to, NJ Ex Order 26. 4B1 . The Admission Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26. , indicated that the facility assessed the resident's NJ Exec Order 26.4b1 status using a Brief Interview for Mental Status (BIMS). The resident scored a NJ out of 15 which indicated that the resident had NJ Ex Order 26. 4B1 . Under section NJ E of the MDS, it was documented that the resident had received	F 656	practice. Resident #14 and #72 care plan updated to include NJ Ex Order 26. 4B use as per physicians orders. How the faciltiy will identify other residents having the potential to be affected by the same deficient practice. All residents on oxygen have the poetential to be affected. What measures will be put into place or systemic changes will be made to ensure tat the deficient practice will not reoccur. Director of Nursing/Assistant Director of Nursing conducted and audit of residents using oxygen to ensure respiratory careplans are in place. Education provided to staff regarding care plan interventions for oxygen use. How the Facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not reocur, ie. what QA program will be put into place to monitor the continued effectiveness of systemic change. DON/ADON or designee will conduct 5 oxygen audits weekly x 1 month then monthly x 3 months. Findings to be reported to the administrator as well as QAPI monthly x 3 months. QAPI team to determine if further action is	

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F 656	Continued From page 9	F 656		

NJ Ex Order 26. 4B1 while a resident in the facility.

A review of the resident's care plan (CP) revealed there was no CP for NJ Ex Order 26. 4B1.

On 10/4/23 at 10:48 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to care for the resident. The LPN stated the resident received NJ Ex Order 26. 4B continuously and had been using NJ Ex Order 26. 4B since NJ Ex Order 26. 4B1 for NJ Exec. Order 26:4.b.1.

On 10/4/23 at 10:54 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM), who reviewed the resident's EHR with the surveyor and confirmed there was no care plan related to NJ Ex Order 26. 4B1 for Resident #14. He stated the supervisors, including unit managers, and the MDS coordinator were responsible for initiating and updating resident care plans. The LPN/UM acknowledged there should have been a care plan for the resident's NJ Ex Order 26. 4B1.

On 10/4/23 at 12:53 PM, the surveyor interviewed the Director of Nursing (DON) about the above concerns. The DON acknowledged there should have been a care plan for Resident #14 as the resident was receiving NJ Ex Order 26. 4B1 and she could not explain why there was not one.

2. On 10/3/23 at 11:44 AM, the surveyor observed Resident #72 resting in bed, NJ Exec. Order 26:4.b The resident was receiving NJ Ex Order 26. 4B via NJ Ex Or that was attached to a concentrator set at NJ .

On 10/4/23 at 11:48 AM, the surveyor observed Resident #72 resting in bed. The resident was

Provider's plan of correction (continued): required.

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F 656	Continued From page 10 receiving NJ Ex Order 26. 4B via NJ Ex O that was attached to a NJ Ex Order 26. 4B1 set a NJ Ex Order 26. Resident #72 stated that their NJ Exec Order 26 setting was NJ Ex Order 26. The surveyor reviewed the EHR of Resident #72, which revealed the following: The resident's Admission Record documented Resident #72's diagnoses included but were not limited to, NJ Ex Order 26. 4B1 . A Quarterly MDS, dated NJ Ex Order 26. 4B1, documented that the resident had a BIMS score of NJ Ex out of 15, which indicated the resident had NJ Ex Order 26. 4B1 . A physician's order (PO) dated NJ Ex Order 26. 4B1 read, "NJ Ex Order 26. 4B1 ". A review of the resident's CP revealed there was no CP for NJ Ex Order 26. 4B1. On 10/4/23 at 11:54 AM, the surveyor interviewed the LPN/UM about Resident #72's NJ Ex Order 26. 4B . The LPN/UM reviewed with the surveyor, the resident's PO for NJ Ex Order 26. 4B and the resident's care plans. The LPN/UM stated the resident had a PO for NJ Ex Order 26. 4B1 at NJ Ex Order 26. continuously via NJ Ex O and there was no care plan for the resident's NJ Ex Order 26. 4B1. The LPN/UM acknowledged the resident should have a care plan for NJ Ex Order 26. 4B and that it was expected for residents who required NJ Ex Order 26. 4B1. On 10/4/23 at 12:53 PM, the surveyor interviewed the DON, who acknowledged Resident #72	F 656		

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F 656	Continued From page 11 should have had a care plan for NJ Ex Order 26. 4B1 in place. A review of the facility's policy titled, "Oxygen administration" with a revised date of 04/02/2019, under Preparation read, " ...2. Review the resident's care plan to assess for any special needs of the resident." On 10/6/23 at 10:18 AM, the surveyor informed the Licensed Nursing Home Administrator, the DON, and the Assistant DON about the concern that there were no NJ Ex Order 26. 4B1 care plans for Resident #14 and Resident #72. No further information was provided by the facility. NJAC 8:39- 11.2 (d), (e)(2); 27.1 (a)	F 656		
F 686 SS=D	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, and record review, it was determined that the facility failed to	F 686	How the corrective action will be accomplished for those residents found to	11/2/23

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	315152	A. BUILDING ______ B. WING ______	C 10/13/2023

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CAREONE AT WELLINGTON	301 UNION STREET HACKENSACK, NJ 07601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12 obtain a physician's order (PO) for the NJ Ex Order 26. 4B1 of four NJ Ex Order 26. 4B1. This deficient practice was observed for 1 of 3 residents (Resident #22) reviewed for NJ Ex Order 26. 4B1. This deficient practice was evidenced by the following: On 10/3/23 at 10:55 AM, the surveyor observed Resident #22 resting in bed on a NJ Ex Order 26. 4B1. The resident was NJ Exec. Order 26:4.b.1, and NJ Exec. Order 26:4.b.1. Resident #22 stated they had NJ Ex Order 26. 4B1 on their NJ Ex Order that were being treated. The surveyor reviewed the electronic health record (EHR) for Resident #22 which revealed the following: The resident's Admission Record (an admission summary) documented Resident #22 had diagnoses that included but were not limited to NJ Ex Order 26. 4B1. The Admission Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated NJ Ex Order 26. 4B1, revealed the facility assessed the resident's cognition using the Brief Interview for Mental Status (BIMS) test. Resident #22 scored a NJ Ex Order out of 15, which indicated the resident was NJ Ex Order 26. 4B1. A NJ Ex Order 26. 4B1 note dated NJ Ex Order 26. 4B1, indicated the resident had a NJ Ex Order 26. 4B1	F 686	have been affected by the deficient practice. The treatment orders for resident #22 was separated according to site. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with multiple wounds have potental to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not re ocur. DON and ADON conducted and audit with all residents with multiple wounds to ensure that all patients have individual treatments orders by individual sites. How the facility will monitor its corretive 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 conducted effectiveness of the systemic change. Director of Nursing or designee will review all patients with muliple wounds to ensure all indivdualized orders are in place and separated by site. Director of Nursing or designee will audit weekly x 4 weeks, monthly x 3 months and with results reported QAPI monthly x 3 months.	

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F 686	Continued From page 13 NJ Ex Order 26. 4B1 . The NJ Ex Order 26. 4B1 recommended NJ Ex Order 26. 4B1 orders as follows: For the NJ Ex Order 26. 4B1 to NJ Exec Order 26.4b1 ". A review of the resident's care plan indicated a care plan dated NJ Ex Order 26. 4B1 with a focus that read, "actual NJ Exec Order 26.4b1 related to NJ Ex Order 26. 4B1 , NJ Ex Order 26. 4B1 ". The care plan included an intervention which read, "Administer treatment per physician orders". A review of the Order Summary Report for NJ Ex Order 26. 4B1 revealed a PO, initiated NJ Ex Order 26. 4B1, that read "wash NJ Ex Order 26. 4B1 with NJ Ex Order 26. 4B1, apply NJ Exec Order 26.4b1 NJ Ex Order 26. 4B1, apply NJ Ex Order 26. 4B1 every day shift for NJ Ex Order 26. 4B1". There were no PO wound treatment orders documented for the NJ Ex Order 26. 4B1 . The surveyor reviewed the NJ Ex Order 26. 4B1 Treatment Administration Record (TAR) which revealed a treatment order dated NJ Ex Order 26. 4B1 that read, "wash NJ Ex Order 26. 4B1 with NJ Ex Order 26. 4B1, apply NJ Exec Order 26.4b1 NJ Ex Order 26. 4B1 apply NJ Ex Order 26. 4B1 every day shift for NJ Ex Order 26. 4B1". The treatment order entry was signed by the nurses on the 7am-3pm shift to document the treatment was provided.	F 686		

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F 686	Continued From page 14 There were no NJ Ex Order 26. 4B1 entries on the NJ Ex Order 26. 4B1 TAR for the NJ Ex Order 26. 4B1 On 10/10/23 at 10:43 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to care for Resident #22 who stated, the resident had NJ Ex Order 26. 4B1 in the NJ Ex Order 26. 4B1 and the treatments were done daily in the morning on the 7am-3pm shift. On 10/10/23 at 10:46 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM) who stated the resident had five NJ Ex Order 26. 4B1 . The surveyor reviewed with the LPN/UM the EHR of Resident #22. The LPN/UM confirmed there was a NJ Ex Order 26. 4B1 order for the NJ Ex Order 26. 4B1 only. The LPN/UM stated for the other NJ Ex Order 26. 4B1 the treatment order was the same and separate orders were not needed for the NJ Ex Order 26. 4B1. There was no additional information provided by the LPN/UM. On 10/10/23 at 11:45 AM, the surveyor interviewed the Director of Nursing (DON) about Resident #22 not having NJ Ex Order 26. 4B1 orders for four of the five NJ Ex Order 26. 4B1. The DON could not speak to why there was only one NJ Exec. Order 26:4.b.1 order for the NJ Ex Order 26. 4B1 and stated there should have been a treatment order for each NJ Ex Order 26. 4B1. A review of the facility's policy provided titled, "Clean Dressing Changes" with a revised date of 4/29/19, under Process read, "1. Review physician order for wound cleansing and treatment." The policy did not further address the procedure for the documentation of a wound	F 686		

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F 686	Continued From page 15 treatment order. On 10/10/23 at 12:07 PM, the DON stated there were no other policies related to wound treatment orders. On 10/12/23 at 01:52 PM, the surveyor informed the DON and Licensed Nursing Home Administrator about the above concerns. There was no further information provided by the facility. NJAC 8:39-27.1(a)	F 686		
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 by: Based on observation, interview, and record review, it was determined that the facility failed to: a) obtain a physician's order (PO) for a resident receiving NJ Ex Order 26. 4B1, and b) ensure a resident received NJ Ex Order 26. 4B1 as ordered by the physician. This deficient practice was identified in 2 of 2 residents (Resident #14, and #72), who were reviewed for NJ Ex Order 26. 4B1. The deficient practice was evidenced by the following:	F 695	How the corrective action will be accomplished for those residents found to have been effected by the deficient practice. Resident #14 careplan updated to include NJ Ex Order 26. 4B1 and/or NJ Ex Order 26. 4B1. Resident #14 physicians orders updated to reflect NJ Ex Order 26. 4B1. Resident #72 NJ Ex Order 26. 4B orders clarified with physician and order updated accordingly. Resident #72 careplan updated to include	11/2/23

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F 695	Continued From page 16 1. On 10/3/23 at 10:57 AM, the surveyor observed Resident #14, resting in bed in their room. Resident #14 was receiving NJ Ex Order 26. 4B via a NJ Ex Order 26. 4B1 that was attached to a NJ Ex Order 26. 4B1. The NJ Ex Order 26. 4B1 was set a NJ Ex Order 26. 4B1. On 10/4/23 at 10:45 AM, the surveyor observed Resident #14 resting in bed. The resident was receiving NJ Ex Order 26. 4B via NJ Ex Or that was attached to a concentrator set at NJ Ex Order 26. 4. The surveyor reviewed the electronic health record (EHR) of Resident #14 which revealed the following: The resident's Admission Record documented that Resident #14 was admitted with diagnoses that included, but were not limited to, NJ Ex Order 26. 4B1. The Admission Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26., indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a NJ out of 15 which indicated that the resident had NJ Ex Order 26. 4B1. Under section NJ E of the MDS, it was documented that the resident had received NJ Ex Order 26. 4B1 while a resident in the facility. A review of the Order Summary Report for the resident revealed there was no PO for NJ Ex Order 26. 4B. A review of the NJ Ex Order 26. 4B1 and NJ Ex Order 26. 4B1	F 695	NJ Ex Order 26. 4B1 and/or NJ Ex Order 26. 4B1. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with oxygen orders have potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Director of Nursing/ Assistant Director of Nursing conducted an audit of residents with oxygen therapy to ensure oxygen delivery coincided with physician order. Director of Nursing/ Assistant Director of Nursing conducted an audit of residents on oxygen therapy to ensure careplan for residents on oxygen therapy/ respiratory care plan in place. All nurses were educated to ensure oxygen administration according to physician orders. All nurses were educated on ensuring residents oxygen therapy have appropriate care plans. How Facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not reocur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systtemic change.	

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F 695	Continued From page 17 NJ Ex Order Treatment Administration Record (TAR) revealed there were no entries for NJ Ex Order 26. 4B1 documented. A review of the resident's care plan (CP) revealed there was no CP for NJ Ex Order 26. 4B1 or NJ Ex Order 26. 4B1 . On 10/4/23 at 10:48 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to care for the resident. The LPN stated the resident received NJ Ex Order 26. 4B continuously and had been using NJ Ex Order 26. 4B since NJ Ex Order 26. 4B1 for NJ Exec Order 26.4b1. The LPN reviewed the EHR with the surveyor and confirmed there was no PO for NJ Ex Order 26. 4B1. The LPN did not know why there was no NJ Ex Order 26. 4B order for the resident and stated it was expected for there to be a PO for a resident receiving NJ Ex Order 26. 4B1. On 10/4/23 at 10:54 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM), who reviewed the resident's EHR and confirmed there was no NJ Ex Order 26. 4B order for Resident #14. The LPN/UM stated there should be a PO for NJ Ex Order 26. 4B1 in the resident's EHR and could not explain why there was not a PO. On 10/4/23 at 12:53 PM, the surveyor interviewed the Director of Nursing (DON) regarding the above concerns. The DON acknowledged there should have been a PO for Resident #14's NJ Ex Order 26. 4B1. 2. On 10/3/23 at 11:44 AM, the surveyor observed Resident #72 resting in bed, NJ Exec O and NJ Exec Order 26.4b1 The resident was receiving NJ Ex Order 26. 4B via NJ Ex O that was attached to a NJ Ex Order 26. 4B1 set at NJ	F 695	Director of Nursing/Assistant Director of Nursing will conduct audits for 100% of residents on oxygen therapy to ensure oxygen administration is according to physician orders weekly x 4 weeks then monthly x 3 months with results reported monthly to QAPI x 3 months. Director of Nursing/Assistant Director of Nursing or designee will conduct audits for 100% of residents on oxygen therapy to ensure respiratory/oxygen therapy care plans in place weekly x 4 weeks then monthly x 3 months with results reported monthly to QAPI x 3 months.	

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F 695	Continued From page 18 NJ Ex Order. On 10/4/23 at 11:48 AM, the surveyor observed Resident #72 resting in bed. The resident was receiving NJ Ex Order 26. 4B via NJ Ex Or that was attached to a NJ Ex Order 26. 4B1 set a NJ Ex Order 26. Resident #72 stated that their NJ Ex Order 26. 4B setting was NJ Ex Order 26. The surveyor reviewed the EHR of Resident #72, which revealed the following: The resident's Admission Record documented Resident #72's diagnoses included but were not limited to, NJ Ex Order 26. 4B1 . A Quarterly MDS, dated NJ Ex Order 26. 4B1, documented that the resident had a BIMS score of NJ Ex out of 15, which indicated the resident had NJ Ex Order 26. 4B1 . A physician's order (PO) dated NJ Ex Order 26. 4B1 read, 'NJ Ex Order 26. 4B1 ". A review of the resident's CP revealed there was no CP for NJ Ex Order 26. 4B1 or NJ Ex Order 26. 4B1. On 10/4/23 at 11:54 AM, the surveyor interviewed the LPN/UM about Resident #72's NJ Ex Order 26. 4B . The LPN/UM reviewed with the surveyor the resident's PO for NJ Ex Order 26. 4B in the EHR. The LPN/UM confirmed the PO was for the resident to receive NJ Ex Order 26. 4B at NJ Ex Order 26 continuously by NJ Ex Or. The LPN/UM accompanied the surveyor to Resident #72's room and confirmed the NJ Ex O setting on the resident's NJ Ex Order 26. 4B1 was at NJ Ex Order 26. The LPN/UM acknowledged the physician's order was	F 695		

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F 695	Continued From page 19 not being followed and the NJ Ex Order 26. 4B setting should have been at NJ Ex Order 26. On 10/4/23 at 12:53 PM, the surveyor interviewed the DON about the above concerns for Resident #72's NJ Ex Order 26. 4B1. The DON stated it was expected for the nurses to follow the physician's order, and for the nurses to check a resident's NJ Ex Order 26. 4B setting every shift and as needed. A review of the facility's policy titled, "Oxygen administration" with a revised date of 04/02/2019, under Preparation read, "1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration ..." Further review of the policy under Steps in the Procedure read, " ...9. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. " On 10/6/23 at 10:18 AM, the surveyor informed the Licensed Nursing Home Administrator, the DON, and the Assistant DON about the concerns for Resident #14 not having a PO for NJ Ex Order 26. 4B and Resident #72's NJ Ex Order 26. 4B1 not being administered as ordered. No further information was provided by the facility. NJAC 8:39-27.1 (a)	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and	F 698		11/3/23

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F 698	Continued From page 20 the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to monitor a resident's NJ Ex Order 26. 4B1 . This deficient practice was identified for 1 of 2 residents (Resident #343) reviewed for NJ Ex Order 26. 4B. This deficient practice was evidenced by the following: On 10/4/23 at 11:16 AM, the surveyor observed Resident #343 sitting on their bed eating breakfast. Resident #343 was NJ Exec Order 26.4b1 A review of the electronic health record (EHR) of Resident #343 revealed the following: The Admission Record (an admission summary) for the resident documented Resident #343 had diagnoses that included, but were not limited to, NJ Ex Order 26. 4B1 . A review of a Brief Interview for Mental Status (BIMS) assessment dated NJ Ex Order 26. 4B1, indicated the facility assessed the resident's NJ Exec Order 26.4b1 using the BIMS test. Resident #343 scored a NJ Ex out of 15, which indicated the resident was NJ Ex Order 26. 4B1 . A review of a physician progress note dated NJ Exec Order 26.4 documented, "Patient has a NJ Ex Order 26. 4B1 to NJ Ex Order 26. 4B1 for	F 698	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #343 physician orders updated to reflect monitoring of NJ Ex Order 26. 4B1 . How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents on hemodialysis have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Don/ADON conducted an audit of residents on hemodialysis to ensure physician orders for monitoring the dialysis access site in place. 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. DON/ADON or designee will conduct audits for 100% of residents on hemodialysis to ensure physician orders for monitoring the dialysis access site are	

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F 698	Continued From page 21 NJ Ex Order 26. 4B1." A review of a physician order (PO) dated NJ Ex Order 26. 4B1, indicated the resident was scheduled for NJ Ex Order 26. 4B1 on Monday, Wednesday, and Friday. The Order Summary Report for NJ Ex Order 26. 4B1 revealed there was no PO to monitor the resident's NJ Ex Order 26. 4B1. A review of the Treatment Administration Record (TAR) for NJ Ex Order 26. 4B1 indicated there was no documentation for the monitoring and assessment of Resident #343's NJ Ex Order 26. 4B1. A review of the Medication Administration Record (MAR) indicated there was no documentation for the monitoring and assessment of Resident #343's NJ Ex Order 26. 4B1. A review of progress notes dated NJ Ex Order 26. 4B1 found there was no documentation of Resident #343's NJ Ex Order 26. 4B being assessed. On 10/5/23 at 10:56 AM, the surveyor interviewed the Licensed Practical Nursing (LPN) who was assigned to care for Resident #343. The LPN stated Resident #343 had NJ Ex Order 26. 4B every Monday, Wednesday, and Friday and the NJ Ex Order 26. 4B1 was checked before the resident went to NJ Ex Order 26. 4B and upon their return. The LPN stated the NJ Ex Order 26. 4B was to be checked on every shift and documented in the progress notes. On 10/5/23 at 11:02 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM), who stated	F 698	in place weekly x 4 weeks then monthly x 3 months with results reported monthly to QAPI x 3 months.	

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F 698	Continued From page 22 NJ Ex Order 26. 4B1 should be checked by nurses before and after a NJ Ex Order 26. 4B1. The LPN/UM stated a PO should be in the resident's EHR for checking the NJ Ex Order 26. 4B1 and documented in the TAR. The LPN/UM reviewed the EHR of Resident #343 and confirmed there was no PO for the monitoring the NJ Ex Order 26. 4B1 of the resident and there was no documentation in the TAR. On 10/5/23 at 11:08 AM, the surveyor interviewed the Director of Nursing (DON) about the above concerns. The DON stated for residents on NJ Exec. Order 26 it was expected for the nurses to assess their NJ Exec. Order 26:4.b.1 every shift. The DON further stated a PO would be obtained to monitor the NJ Exec. Order 26:4.b.1 every shift and it was expected for the nurses to document the monitoring of the NJ Exec. Order 26:4.b.1 in the TAR. A review of the facility's policy titled, "Hemodialysis Pre and Post Care" with a revised date of 3/2022 under General Information read, " ...Treatment sites are to be assessed regularly; including upon admission to the center and each shift, upon complaint of pain, pre and post hemodialysis treatment and more frequently if complications arise ..." On 10/6/23 at 10:18 AM, the surveyor informed the Licensed Nursing Home Administrator, the DON, and the Assistant DON about the concerns for the monitoring of Resident #343's NJ Ex Order 26. 4B. No further information was provided by the facility. NJAC 8:39-27.1(a)	F 698		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		11/3/23

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F 812

Continued From page 23

CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of facility policies, it was determined that the facility failed to properly store, label, and discard potentially hazardous foods in a manner to prevent food borne illness.

This deficient practice was evidenced by the following:

On 10/3/23 at 9:20 AM, the surveyor in the presence of the Culinary Director (CD) observed the following during the kitchen tour:

1. Under the Chef's Prep table, the surveyor observed an opened 1-gallon container of liquid butter alternative, which had no opened or

F 812

How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

It is the policy of CareOne at Wellington to ensure all food items are properly stored, labeled and dated and potentially hazards foods are discarded in a manner to prevent foodborne illness. All open non-dated items were discarded

How the facility will identify other residents having the potential to be affected by the same deficient practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING ______ B. WING ______	C 10/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 812 Continued From page 24

discard date. The CD stated the container should have been labeled with an opened and discard date.

2. On a shelf above the Chef's Prep table, the surveyor observed two opened 16-ounce(oz.) spice containers of ground cloves and chili pepper. The two spice containers had no opened or discard date. The CD stated all spices should be labeled with an opened date and discard date.

3. In the dry storage area, the surveyor observed the following:
- Two, 48oz. containers of oatmeal, with no labeled delivery dates.
- Twelve, 16oz. boxes of orzo, with no labeled delivery dates.

The CD stated everything in the dry storage area should have a delivery date label, to follow the First In-First Out (FIFO) protocol for food items.

4. In the walk-in refrigerator, the surveyor observed the following:
- One package of sliced deli ham wrapped in plastic wrap, with a use by date of 10/2/23.
- One package of sliced salami wrapped in plastic wrap, with a use by date of 10/2/23.
- Two packages of sliced deli turkey wrapped in plastic wrap, with a use by date of 10/2/23.

The CD stated the evening chef was responsible for removing food items when they were set to expire and that the morning chef should have also seen the expired items.

On 10/5/23 at 10:14 AM, the CD provided the surveyor with two facility policies for food storage

F 812

All residents have the potential to be affected.

What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.

1.
Food Service Director conducted an audit of all liquid containers to ensure opened and discard date were properly labeled.
2.
Food Service Director conducted an audit of all oatmeal containers and orzo box to ensure a receiving date was on container.
3.
Food Service Director conducted an audit of all spices to ensure an opened on and expire date was on containers.
4.
Food Director conducted an audit of all deli meat to ensure a prepared on and expire on date was on all deli meat.

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.

1.
Food Service Director/Designee will conduct an audit to ensure proper labeling and dating is done on all potentially hazards and non- potentially hazards food items.
2.
A weekly audit will be conducted weekly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING ______ B. WING ______	C 10/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 25 and labeling. A review of the facility's policy titled "CareOne Labeling and Dating Policy", with a revised date of 1/3/18 read, "It's the policy that all food items have a receiving label placed on all products.....We use a day mark labeling gun to date and label all products. Once the product is opened an opened on label will be used on that product. All products will be wrapped tight and sealed with an open on date. Once any product is opened a prepared and use by label will be placed on the product ad used when in 3 days. After 3 days all product wil be discarded". A review of the facility's Food Receiving and Storage policy, with a revised date of November 2022 revealed under the section titled, Refrigerated/Frozen Storage, "7. Refrigerated foods are labeled, dated and monitored so they are used by their "use-by" date, frozen, or discarded." On 10/06/23 at 10:14 AM, the surveyor informed the Licensed Nursing Home Administrator, the Director of Nursing, and the Assistant Director of Nursing of the above concerns during the kitchen tour. No further information was provided by the facility. NJAC 8:39-17.2(g)	F 812	for 4 weeks and monthly for 3 months. Results will be reported to QAPI monthly for 3 months. 3. An opening and closing checklist were put into place for our cooks/designee to check food items in refrigerator, freezer and dry storeroom to ensure proper labeling and dating.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060205	A. BUILDING: ___ B. WING ___	C 10/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing	S 560	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Nursing leadership met and continues to meet on an on-going basis and continues to identify staffing challenges and areas of improvement and recruitment for certified nursing assistants necessary to maintain the required minimum direct care to ratio as required. How the facility will identify other residents having the potential to be affected by the same deficient practice.	11/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/03/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060205	A. BUILDING: ______ B. WING ______	C 10/13/2023

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

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S 560	Continued From page 1 requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to	S 560	All residents have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. To ensure that problem of staffing does not recur: CNA class approved in Bergen County. The goal to offer classes any candidates free Certified Nursing Assistant courses in preparation to sit for the PSI Certified Nursing Assistant examination. The 5-week course will be offered every6 weeks on an on-going basis. Nursing agency usage as needed to assist in filling open positions The facility has implemented a significant above-market rate increase for nurses and certified nursing assistants. Incentives are offered which include tuition, reimbursement, sign-on bonus, employee referral program. The facility continues to offer job fairs with on-the-spot interviews as well as walk-in applicants that could expedite contingency offers at the time of interview. Staffing plan developed to meet the professional, technical, and administrative needs of the center. The plan is based on historical experience and projected changes. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060205	A. BUILDING: ___ B. WING ___	C 10/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 9/17/23 to 9/23/23 and ending 9/24/23 to 9/30/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total residents on 7 of 14 day shifts. The facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -9/17/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -9/19/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -9/21/23 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs. -9/23/23 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. -9/24/23 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs. -9/29/23 had 4 CNAs for 91 residents on the day shift, required at least 11 CNAs. -9/30/23 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. On 10/12/23 at 9:47 AM, the facility's Licensed Nursing Home Administrator, Director of Nursing, and Regional Administrator were informed of their deficient practice. No further information was provided.	S 560	recur, i.e., what QA program will be put into place to monitor the continued effectiveness of the systemic change. Director of Nursing (or designee) and Administrator (or designee) will review staffing ratios daily and document a weekly review of the daily staffing x 4 weeks, then twice monthly x 3 months. Staffing audits will be presented to Administrator for review at QAPI monthly on an on-going basis	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060205	A. BUILDING: ______ B. WING ______	C 10/13/2023

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

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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)
315152	A. Building B. Wing	11/17/2023

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

This report is completed by a 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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 11/02/2023	ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 11/02/2023	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 11/02/2023
ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 11/02/2023	ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 11/03/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 11/03/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
10/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315152 Y1	A. Building B. Wing Y2	11/17/2023 Y3

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

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 11/02/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
10/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060205 Y1	A. Building B. Wing Y2	11/17/2023 Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/03/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
10/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: ZUYG12

STATE FORM: REVISIT REPORT (11/06)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING **02** B. WING ______	10/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/10/2023 and 10/11/2023 and Careone at Wellington was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 3-story building that was built in 70's, It is composed of Type I fire resistant construction. The facility is divided into 6- smoke zones. The generator does 100% of the facility. The facility has 128 certified beds.	K 000		
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 10/10/2023 and 10/11/2023, in the presence of facility Management it was determined that the facility failed to ensure that 1	K 311	What corrective action will be accomplished for those residents affected by the deficient practice?	11/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/04/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING **02** B. WING ______	**10/13/2023**

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

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K 311	Continued From page 1 of 7 exit access stairwell doors tested, were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 10/10/2023 during the survey entrance at approximately 09:34 AM, a request was made to the Administrator and Director of Environmental Service (DEVS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story building with a basement. There are two (2) interior stairwells that Residents, Visitors and Staff could use in the event of an emergency. There are Resident sleeping rooms on the second (2nd.) and third (3rd.) floors. Starting at approximately 09:50 AM on 10/10/2023 and continued on 10/11/2023 in the presence of the facility's Regional Director of Maintenance (RDM) and DEVS during a tour of the building the surveyor inspected and conducted closure test of a seven (7) exit access doors leading into exit stairways with the following results, 1) At approximately 11:00 AM, during a closure test of the third (3rd.) floor stairway "1" (across from Resident room #314) corridor exit access door, when the door was opened to a 90 degree opening to the door frame and allowed to self-close, the door did not positive latch into its frame. This test was performed two additional times with the same results. The surveyor observed the door latching device	K 311	No residents were affected by this practice. Third floor stairway 1, across from room 314 corridor exit access door was repaired to ensure the door has a positive latch into its frame. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Environmental Services Director or designee will routinely test Exit access stairwell doors to ensure they demonstrate a positive latch into the frame. Exit stairwell doors discovered not to latch appropriately will be immediately repaired and/or replaced by the Environmental Services Director or designee. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Environmental Director and/or Designee will conduct the routine tests on 7 of 7 exit access stairwell doors to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING 02 B. WING ______	10/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 311	Continued From page 2 stopped short of the door frames keeper and did not positive latch into its frame. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. The stairwell doors would need to positive latch into its frame to maintain the 1-1/2 hour fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The RDM and DEVS confirmed the finding at the time of observations. On 10/11/2023 during the survey exit at approximately 12:10 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311	ensure the requirement is met, weekly x 3 weeks; then monthly x 3 months; and quarterly on an on-going basis. The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 10/10/2023 and 10/11/2023, in the presence of the facility management, it was determined that	K 345	What corrective action will be accomplished for those residents affected by the deficient practice?	11/3/23

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	315152	A. BUILDING 02 B. WING	10/13/2023

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K 345	Continued From page 3 the facility failed to: 1) Inspect the fire alarm system on a semi-annual (every 6 months) basis as required by code. 2) Ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: On 10/10/2023 during the survey entrance at approximately 09:34 AM, a request was made to the Administrator and Director of Environmental Service (DEVS) to provide all to provide all mandatory inspections from the last Re-Certification survey of 08/03/2022 through 10/09/2023 for review later. The surveyor also requested the facility to provide a copy of the last smoke detectors sensitivity testing. Later at approximately 12:07 PM a review of the facility provided mandatory inspections for the previous 14 months identified was performed. The surveyor reviewed the following Fire Alarm and Detection system inspections, - 03/27/2023 semi-annual inspection. - 09/28/2023 semi-annual inspection. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. At approximately 12:50 PM on 10/10/2023, the surveyor asked the facility Regional Director of Maintenance (RDM) and DEVS to provide the	K 345	No residents were affected by this deficient practice. CareOne at Wellington maintains the practice of conducting semi-annual inspections of the Fire Alarm and Detection System. Inspections were conducted on 3/27/23 and 9/28/23. The Smoke Detector and Sensitivity Testing was immediately conducted on 11/2/23 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Semi-annual inspection of the Fire Alarm and Detection System will be conducted by the Environmental Services Director and/or designee and reviewed for completion by the Regional Director of Maintenance or designee. Smoke Detector Sensitivity Tests will be conducted every 24 months by the Environmental Services Director and/or designee and reviewed for completion by the Regional Director of Maintenance or designee.	

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K 345	Continued From page 4 latest smoke detector sensitivity testing and any additional fire alarm and detection semi-annual inspections that had been performed between 03/27/2023 and 10/09/2023. At this time the RDM told the surveyor that the smoke detector sensitivity testing and the semi-annual inspection of the fire alarm and detection system had not been done. The RDM and DEVS confirmed the finding at the time of observations. On 10/11/2023 during the survey exit at approximately 12:10 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Environmental Services Director and/or Designee will conduct the routine semi-annual inspection of the Fire Alarm and Detection System, every 6 months, on an on-going basis. The Environmental Services Director and/or Designee will conduct the Smoke Detector Sensitivity Testing on a routine basis, every 24 months, on an on-going basis The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 10/10/2023 and 10/11/2023 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 2 of 19 portable fire extinguishers,	K 355	What corrective action will be accomplished for those residents affected by the deficient practice? No residents were affected by this deficient practice.	11/3/23

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K 355	Continued From page 5 2) Install portable fire extinguishers with-in the required height for 1 of 19 fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference #2 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more	K 355	Immediate corrective action was taken to remedy the deficient practice for 1 of 19 portable Fire Extinguishers: The ABC-Type Fire Extinguisher, in the employee dining room was replaced at the proper height of not more than 5 feet above the floor; and a base of not less than 4 inches from the floor. The ABC-Type Fire Extinguisher located in the basement level Elevator Mechanical Room was immediately inspected and documented by the Environmental Services Director. The ABC-Type Fire Extinguisher located in the Basement Level Maintenance Shop was immediately inspected and documented by the Environmental Services Director. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Monthly inspections will be conducted on every portable Fire Extinguisher within the facility to ensure they are selected, installed, inspected and maintained in	

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K 355	Continued From page 6 than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. The findings include the following, On 10/10/2023 during the survey entrance at approximately 09:34 AM, a request was made to the Administrator and Director of Environmental Service (DEVS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story building with a basement. Starting at approximately 09:50 AM on 10/10/2023 and continued on 10/11/2023 in the presence of the facility's Regional Director of Maintenance (RDM) and DEVS during a tour of the building was conducted. Along the two (2) day tour the surveyor observed and inspected nineteen (19) fire extinguishers in various locations that were last annually inspected December 2022 with the following issues that were identified: On 10/10/2023. 1) At approximately 09:55 AM, One (1) "ABC-Type" fire extinguisher inside the Basement level Elevator Mechanical room was last annually inspected December 2022. There was no evidence of monthly visual examination performed and documented for January 2023. 2) At approximately 10"07 AM, One (1) ABC-Type fire extinguisher inside the Basement	K 355	accordance with regulations. Portable Fire Extinguishers found to not be in compliance, will be immediately replaced. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Environmental Services Director and/or Designee will conduct routine inspection of all portable Fire Extinguishers within the center, on an on-going monthly basis. The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.	

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K 355	Continued From page 7 level Maintenance Shop was last annually inspected December 2022. There was no evidence of monthly visual examination performed and documented for January 2023. On 10/11/2023, 3) At approximately 10:47 AM, the surveyor observed inside the Employee Dining room One (1) ABC-Type fire extinguisher. This extinguisher appeared to be mounted too high. At this time the surveyor measured and recorded the distance from the floor to the center of the pressure indicating gauge. The fire extinguisher was mounted five feet seven inches (5'-7") to the center of the gauge. At this time a request was made to the MD to replace the fire extinguisher. The MD complied with the request. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 8" to the center of the pressure indicating needle. The RDM and DEVS confirmed the finding at the time of observations. On 10/11/2023 during the survey exit at approximately 12:10 PM, the surveyor informed the Administrator of the deficiency. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K 363		11/3/23

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K 363	Continued From page 8 required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 10/10/2023 and	K 363	What corrective action will be accomplished for those residents affected	

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K 363	Continued From page 9 10/11/2023, in the presence of facility management it was determined that the facility failed to ensure that 1 of 26 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following, On 10/10/2023 (day one of survey) during the survey entrance at approximately 09:34 AM, a request was made to the Administrator and Director of Environmental Service (DEVS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked how many Resident sleeping rooms are in the facility. The DEVS told the surveyor that there are 64 Resident sleeping rooms. A review of the facility provided lay-out identified the facility is a three-story building with a basement. There are thirty-three (33) Resident sleeping rooms and common areas on the 3rd. floor There are thirty-one (31) Resident sleeping rooms on the 2nd. and common areas on the second floor. The first floor had the Physical Therapy, Resident Dining room, Main Kitchen, Offices and Common areas. Starting at approximately 09:50 AM on 10/10/2023 and continued on 10/11/2023 in the presence of the facility's Regional Director of Maintenance (RDM) and DEVS during a tour of the building the surveyor inspected and conducted closure test of twenty-six corridor	K 363	by the deficient practice? No residents were affected by this deficient practice. The second-floor resident shower room door was replaced to ensure the undercut of a corridor door is not greater than 1 inch. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Environmental Services Director or designee will inspect and test 6 corridor doors per week to ensure corridor doors meet the code. Doors that are found to not meet code of having an undercut of greater than 1 inch, will be replaced. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Environmental Services Director and/or Designee will inspect and test 6 corridor doors per week x 4 weeks; then	

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K 363	Continued From page 10 doors on all levels of the building with the following results, 1) At approximately 11:12 AM, the surveyor observed the second (2nd.) floor Resident Shower room door appeared to have a large gap along the bottom edge of the doors. At this time the surveyor measured and recorded 1-3/8 of an inch gap along the bottom of the door. The code requires the under cut of a corridor door no greater than one (1) inch. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of facility emergency evacuation diagrams posted in the corridors identify that you would need to pass the Resident Shower room door as the primary and/ or secondary exit access route to reach an exit. The RDM and DEVS confirmed the finding at the time of observations. On 10/11/2023 during the survey exit at approximately 12:10 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	on a monthly basis, on-going. The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour	K 372		11/3/23

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K 372	Continued From page 11 fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 10/10/2023 and 10/11/2023 in the presence of facility management, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for two (2) of two (2) smoke barrier walls as evidenced by the following: On 10/10/2023 (day one of survey) during the survey entrance at approximately 09:34 AM, a request was made to the Administrator and Director of Environmental Service (DEVS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story building with a basement. The Third (3rd.) floor has two (2) sets of corridor double smoke doors with-in the one (1) smoke barrier wall. There are thirty-three (33) Resident sleeping rooms, one (1) Resident shower room and common areas on the 3rd. floor The Second (2nd.) floor has two (2) sets of	K 372	What corrective action will be accomplished for those residents affected by the deficient practice? No residents were affected by this deficient practice. The corridor double smoke door ceiling tiles on the 3rd floor next to elevator #2 (1.5x1" penetration with 2 white Romex wires) and (4" penetration with wires 4 blue and 3 black wires running through the smoke barrier wall) wear immediately sealed closed. The corridor double smoke door ceiling tiles on the 2nd floor next to elevator #2 with (approximately 1x1" penetration with 3 blue wires and an approx. 4" penetration with 4 BX cables and 2 red wires running through the smoke barrier wall) were immediately sealed closed. How will the facility identify other residents having the potential to be affected by the same deficient practice?	

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K 372	Continued From page 12 corridor double smoke doors with-in the one (1) smoke barrier wall. There are thirty-one (31) Resident sleeping rooms, one (1) Resident shower room and common areas on the 3rd. floor The first (1st.) floor has the Physical Therapy, Resident Dining room, Main Kitchen, Starting at approximately 09:50 AM on 10/10/2023 and continued on 10/11/2023 in the presence of the facility's Regional Director of Maintenance (RDM) and DEVS a tour of the building was conducted. Along the two day tour the surveyor observed the following smoke barrier walls that failed to maintain the 1/2 hour fire rated construction as required by code in the following location: On 10/10/2023. 1) At approximately 10:35 AM, the surveyor observed above the corridor double smoke doors ceiling tiles on the third (3rd.) floor next to elevator #2, one approximately 1-1/2" by 1" penetration with 2 white Romex wires and an approximately 4" penetration with wires 4 blue and 3 black wires running through the smoke barrier wall. 2) At approximately 11:10 AM, the surveyor observed above the corridor double smoke doors ceiling tiles on the second floor next to elevator #2, one approximately 1" by 1" penetration with 3 blue wires wires and an approximately 4" penetration with 4 BX cables and 2 red wires running through the smoke barrier wall. These penetrations was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes	K 372	All residents have the potential to be affected. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Environmental Services Director or designee will round and visually inspect smoke barrier partitions for signs of penetration. Any/all found penetrations will be immediately sealed closed. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Environmental Services Director and/or Designee will round and visually inspect smoke barrier partitions weekly x 3 weeks, then monthly on an on-going basis. The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.	

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K 372	Continued From page 13 and fire from passing through to the other smoke compartment. The RDM and DEVS confirmed the finding at the time of observations. On 10/11/2023 during the survey exit at approximately 12:10 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 10/10/2023 and 10/11/2023 in the presence of facility management, it was determined that the facility failed to : 1) Ensure that the facility's ventilation systems were being properly maintained for 4 of 10 Resident bathroom exhaust systems. 2) Provide an exhaust system for 1 of 10 Resident bathrooms, as per the National Fire Protection Association (NFPA) 90A.	K 521	What corrective action will be accomplished for those residents affected by the deficient practice? No residents were affected by this deficient practice. Requisition submitted with quotes to install a ventilation system in the 3rd floor resident shower room. Requisition submitted with quotes to	11/3/23

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	315152	A. BUILDING 02 B. WING	10/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

K 521

Continued From page 14

This deficient practice was evidenced by the following:

On 10/10/2023 (day one of survey) during the survey entrance at approximately 09:34 AM, a request was made to the Administrator and Director of Environmental Service (DEVS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.
The surveyor also asked how many Resident sleeping rooms are in the facility.
The DEVS told the surveyor that there are 64 Resident sleeping rooms.

A review of the facility provided lay-out identified the facility is a three-story building with a basement.
There are thirty-three (33) Resident sleeping rooms, one (1) Resident shower room and common areas on the 3rd. floor
There are thirty-one (31) Resident sleeping rooms, one (1) Resident shower room and common areas on the 2nd. floor.
The first floor had the Physical Therapy, Resident Dining room, Main Kitchen, Offices and Common areas.

Starting at approximately 09:50 AM on 10/10/2023 and continued on 10/11/2023 in the presence of the facility's Regional Director of Maintenance (RDM) and DEVS
a tour of the building was conducted.
During the two (2) day building tour the surveyor inspected inside eight (8) Resident sleeping rooms and two (2) Resident shower bathrooms.
This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to

K 521

repair exhaust system in resident bathrooms for room numbers including: 329; 323; 306; 221.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents who have bathrooms with no windows have the potential to be affected.

What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?

The Environmental Services Director or designee will inspect the ventilation in all resident bathrooms and shower rooms.

Bathrooms found to have exhaust systems not functioning properly will have the vent repaired.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?

The Environmental Services Director and/or Designee will round and visually inspect all resident bathrooms to ensure function of the exhaust system

Inspections will include 10 resident bathrooms weekly x 3 weeks, then monthly x 3 months.

The results of the audits will be forwarded

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	315152	A. BUILDING **02** B. WING ______	**10/13/2023**

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K 521	Continued From page 15 confirm ventilation is present), the exhaust did not function properly in 5 of 10 resident bathrooms in the following locations: On 10/10/2023: 1. At approximately 10:30 AM, inside the third (3rd.) floor Residents shower bathroom, the surveyor observed no evidence of an exhaust system. At this time the surveyor asked the RDM, do you see an exhaust system in the bathroom. The RDM looked up and around and said, No. The RDM also told the surveyor that when the shower room was renovate the contractor probable never re-connected the exhaust system in the drop ceiling. The surveyor asked when was the shower room renovated. The RDM said about 6 months ago. 2. At approximately 10:36 AM, inside Resident room #329 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 10:49 AM, inside Resident room #323 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 4. At approximately 10:56 AM, inside Resident room #306 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation.	K 521	to the facility Administrator and QAA Committee for further review and recommendations as needed.	

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	315152	A. BUILDING 02 B. WING	10/13/2023

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K 521	Continued From page 16 5. At approximately 11:24 AM, inside Resident room #221 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The RDM and DEVS confirmed the finding at the time of observations. On 10/11/2023 during the survey exit at approximately 12:10 PM, the surveyor informed the Administrator of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918		11/3/23

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K 918	Continued From page 17 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview, document review on 10/10/2023 and 10/11/2023, it was determined the facility failed to: - Exercise the emergency generator 12 times each year for at least 30 minutes in 20- to 40-day intervals, in accordance National Fire Protection Association (NFPA) 99 and 110. This deficient practice is evidenced by the following, Findings included: On 10/10/2023 during the survey entrance at approximately 09:34 AM, a request was made to the Administrator and Director of Environmental Service (DEVS) to provide all to provide all mandatory inspections from the last Re-Certification survey of 08/03/2022 through 10/09/2023 for review later. The surveyor also made a request to the DEVS if the facility had an emergency generator, and how	K 918	What corrective action will be accomplished for those residents affected by the deficient practice? No residents were affected by this deficient practice. CareOne at Wellington maintains a policy of exercising the emergency generator 12 times per year for at least 30 minutes in 20-40-day intervals. The generator was exercised via a load run on September 28th, 2023 from 08:11 am to 08:46pm with no untoward issues. On October 20th,2023 from 08:46 am to 13:16 the 36 month load bank test was conducted with no untoward issues. How will the facility identify other residents having the potential to be affected by the same deficient practice?	

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K 918	Continued From page 18 often does the facility run the generator under load and document the load dates. The DEVS told the surveyor, yes we have an emergency generator that we run weekly, run the generator under load monthly for 30 minutes and we have a log. Later at approximately 12:07 PM, a review of the Emergency Generator Test for the previous 14 months identified the Emergency generator ran under load on the following dates, 09/28/2023, 07/31/2023, 06/30/2023, 05/25/2023, 04/23/2023, 03/31/2023, 02/28/2023, 01/31/2023 and 09/20/2022. The facility had not run the emergency generator under a load for 133 days between 09/20/2022 through 01/31/2023. The generator log book indicated there was no documented certification that the generator would start and transfer power to the building within ten seconds, since no load test was conducted for August, October, November and December 2022. A request was made to the facility DEVS to provide any additional documentation for the generator monthly load test. The DEVS could not provide any additional documentation. The DEVS confirmed the finding at the time of observations. On 10/11/2023 during the survey exit at approximately 12:10 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	All residents have the potential to be affected. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Environmental Services Director was re-educated on the practice of exercising the emergency generator 12 times per year; with appropriate documentation of the load run. The Environmental Services Director or designee will exercise the emergency generator monthly, at least 12 times per year for at least 30 minutes in 20□40-day intervals. The Regional Director of Maintenance will review the log of generator load runs on a quarterly basis. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Environmental Services Director and/or Designee will exercise the emergency generator 12 times per year for at least 30 minutes in 20□40-day intervals, with report provided to the Administrator monthly, on an on-going basis. The Regional Director of Maintenance will review the log of generator load runs, quarterly for completion.	

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K 918	Continued From page 19	K 918	The log of the generator load runs will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.	

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)
315152	A. Building 02 - WELLINGTON HALL B. Wing	11/17/2023

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

This report is completed by a 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 K0311	Correction Completed 11/03/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 11/03/2023	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 11/03/2023
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 11/03/2023	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 11/03/2023	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 11/03/2023
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 11/03/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
10/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO