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	315426	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE PARAMUS, NJ 07652**

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F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 09/25/23 - 09/28/23 Survey Census: 82 Sample Size: 26 Supplemental Residents: 0 No deficiencies were issued related to Intakes: NJ162698, NJ154890, NJ160130, NJ163557, NJ160129, NJ157268, and NJ167334.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		10/16/23

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

Electronically Signed | 10/16/2023

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F 582	Continued From page 1 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy review, the facility failed to ensure each Medicare resident whose Medicare [redacted] were terminated received a notice including the reason the services were ending or what the options were prior to the discontinuation	F 582	Resident 259 was informed of [redacted] documentation. Furthermore, resident was re-evaluated due to change of status on 8/2 and resumed skilled services un Medicare [redacted].	

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F 582	Continued From page 2 of therapy services. This had the potential to affect one of three residents (Resident (R)259) who were reviewed for Skilled Nursing Facility (SNF) *Ex Order 26. 4B1* . Findings include: Review of the electronic medical record (EMR) for R259 revealed she was admitted to the facility on *Ex Order 26. 4B1* . R259 had Medicare *Ex Order 26. 4B1* and when she was discharged from *Ex Order 26. 4B1* on *Ex Order 26. 4B1* , she had not exhausted her Medicare *Ex Order 26. 4B1* . However, the facility failed to notify her representative regarding the expiration of benefits prior to the expiration date. Further review of the EMR failed to reveal any documentation of R259 and/or R259's representative being given written notification of the discontinuation of covered services. Review of the "Nursing Facility Beneficiary Protection Notification Review," provided on paper, revealed *Ex Order* was discharged from Medicare *Ex Order 26. 4B1* on *Ex Order 26. 4B1* and remained in the facility with *Ex Order 26. 4B1* remaining. During an interview on 09/26/23 at 9:45 AM with the Director of Nursing (DON), the DON stated " "R259 was not issued a Skilled Nursing Facility *Ex Order 26. 4B1* . We didn't think *Ex Order* needed it since *Ex Order* stayed in the facility." Review of the facility policy titled, "Medicare Advance Beneficiary and Medicare Non-Coverage Notices," dated 09/2022, documented, "Policy: Residents are informed in advance when changes will occur to their bills.	F 582	All residents under Medicare *Ex Order 26. 4B1* in the facility have the potential to be affected. A weekly audit will be completed by the Director of Social Services which will include all patients that remain in the facility for respite services or long term care. The *Ex Order 26.* report will be reported monthly to the Administrator and a quarterly report of the findings will be submitted to the Administrator during the quarterly QA meeting for further recommendations.	

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F 582	Continued From page 3 Skilled Nursing Facility Advance Beneficiary Notice ...1. If the director of admissions or benefits coordinator believe (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the services(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). 2. The facility issues the Skilled Nursing Facility Advance Beneficiary Notice ...for the following triggering events: ...c. Termination - In the situation in which the facility proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF ABN is issued to the beneficiary before such extended care items or services are terminated. 3. The resident (or representative) is informed that they may choose to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility." NJAC 8:39-5.1(a)	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583		10/16/23

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F 583	Continued From page 4 and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to protect the *Ex Order 26. 4B1* [redacted] for eleven of eleven (R49, R312, R65, R41, R311, R28, R309, R310, R35, R68 and R308) residents reviewed for resident rights out of 22 sampled residents by leaving the resident's personal and medical information exposed on an open and unattended computer screen in an area accessible to the public. Findings included:	F 583	RN7 and RN8 were re-educated on the importance of closing the computer screen when the medication cart is left unattended. All residents have the potential to be affected. 1:1 in service counseling provided to identified nurses who had the deficient practice. All licensed staff were in serviced on HIPAA and the inadvertent	

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F 583	Continued From page 5 Review of a facility's policy titled, "Computer Terminals/Workstations," revision date April 2014, revealed, ". . .3. A user may not leave his/her workstation or terminal unattended unless the terminal screen is cleared and the user is logged off. Each user must log off at the end of his/her work shift ..." Observation of the medication cart on the [redacted] Hall on 09/25/23 at 9:30 AM revealed the medication cart was observed unattended. The computer screen on the cart was open and showed R49's face, name, room number, and medications the resident received. The cart was unattended with the c until 9:33 AM when Registered Nurse (RN) 8 returned. Interview on 09/25/2023 at 9:33 AM with RN8, revealed someone had called them to a resident's room to see something and they walked away from the cart without locking the screen. RN8 stated they had been trained to lock the computer screen when away, but they forgot. Observation of a medication cart on the [redacted] Hall on 09/27/2023 from 8:57 AM to 9:02 AM revealed medication cart on the [redacted] Hall was observed unattended. The computer screen on the cart was open and showed R312, R65, R41, R311, R28, R309, R310, R35, R68 and R308 face, name, room number listed under the medication administration record (MAR) tab. The cart was unattended with the computer screen open to resident's confidential information until 9:02 AM when RN7 returned. Interview on 09/27/2023 at 9:02 AM, RN7 stated they went into a room to wash their hands and was away from the cart for a couple of minutes.	F 583	disclosure of health information. During orientation of new hires, the importance of protecting patient information will be added to the orientation packet. DON or designee will conduct weekly random audit for 5 computer screens for security x 4 weeks. Result of audits will be presented during the quarterly QA meeting and reported by the DON for any recommendations.	

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F 583	Continued From page 6 RN7 stated they normally lock the computer screen leaving them open was not the normal practice. RN7 stated they understood they should keep the computer screen locked forHealth Insurance Portability and Accountability Act (HIPAA) reasons. Interview on 09/27/2023 at 2:44 PM with the Director of Nursing (DON) revealed they have educated staff multiple times on locking the computer screen they are away from them. The DON stated they have a pharmacy consultant who does medication pass with the staff monthly and they go over several things such as ensuring the *Ex Order 26. 4B1* and medication cart is locked. DON stated they anticipate that staff should keep resident information confidential at all times. NJAC 8:39-4.1(a)18 NJAC 8:39-35.2(i)(k)	F 583		
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 observations, interview, record review and policy review, the facility failed to clean the filter of the *Ex Order 26. 4B1* for the use of delivering *Ex Order 26. 4B1* for one of four	F 695	The filter was changed for resident with affected filter. All residents have the potential to be	10/11/23

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F 695	Continued From page 7 residents (Resident (R) 9) reviewed for Ex Order 26. 4B1 of the twenty-six sampled residents Findings include: Review of R9's "Face Sheet" in the Electronic Medical Record (EMR) under the "Profile" tab revealed R9 was admitted to the facility on Ex Order 26. 4B1 with the following diagnosis of Ex Order 26. 4B1 and Ex Order 26. 4B1. Review of the annual "Minimum Data Set (MDS)" in the EMR, with an 'Ex Order 26. 4B1 " of NJ Exec. Order 26:4.b.i coded the resident as having a 'Ex Order 26. 4B1 " score of out of 15. This represented R9 was Ex Order 26. 4B1. On 09/25/23 at 9:49 AM an observation was made at which time the resident was wearing the Ex Order 26. 4B1 at /minute by Ex Order 26. 4B1. The had a white lint like substance on it. On 09/27/23 at 11:20 AM R9's Ex Order 26. 4B1 had a white lint like substance on it. Review of R9's "Orders" under the "Orders" tab in the revealed there was a physician's order for R9 to receive Ex Order 26. 4B1 at /min by Ex Order 26. 4B1 as needed to keep the resident's Ex Order 26. 4B1 above percent. Interview with the Director of Nursing (DON) on 09/27/23 at 11:35 AM revealed, "Maintenance is supposed to clean those. I don't know how often." Follow up interview on 09/27/23 at 2:06 PM, DON stated, "I talked to our Ex Order 26. 4B1, and he showed me the cleaning list that he had done.	F 695	affected. A weekly Filter Cleaning Report will be generated for all Ex Order 26. 4B1 being used in house and given to the Maintenance Director. The Maintenance Director will monitor and report will be submitted to the Safety Meeting. The findings will be reported by the Maintenance Director to the Administrator at the quarterly QA Meeting	

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F 695	Continued From page 8 He admitted that he missed R9 when he cleaned them." Review of the facility's policy titled, "Departmental Respiratory Therapy- Prevention of Infection," with a revision date of 08/28/18, stated, "Check filters once weekly while they are in continuous use ..." NJAC 8:39-19.4(k)	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		10/16/23

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F 761	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, the facility failed to store medication in a locked compartment when left unattended ([redacted] floor medication cart #1), failed to have a medication label that could be read ([redacted] floor medication cart #2) as well as fail to ensure the medication cart was secure when out of the site of the nursing staff. Findings include: 1. Review of the facility's policy titled, "Medication Labeling and Storage" with a revision date of February 2023, stated " ... Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others ... During the Medication Pass Observation on 09/27/23 at 9:28 AM. Registered Nurse (RN)8 was preparing the [redacted] to administer to R63. RN8 stated, "There is no [redacted] in my cart, so I have to go and get it." RN8 left [redacted] on top of the med cart to go into nurses' station. While looking for the [redacted], RN8 turned her back to the cart. This medication cart was on the [redacted] floor, cart #1. On 09/27/23 at 9:55 AM, RN8 stated, "I should have placed them in the top drawer and locked the cart and no I could not see the cart when I turned my back." Review of the cup revealed the following medication was in the cup: [redacted].	F 761	1N and 1S medication carts were immediately closed/locked. RN7, RN8 and LPN3 were educated on importance of locking their medication carts. RN8 was re-educated on ensuring that medications are not left on top of the medication cart unattended. R82's [redacted] and [redacted] zip lock bag with unreadable label was removed from the medication cart and medication was re-ordered from the pharmacy. All residents have the potential to be affected RN7,15 RN8 and LPN 3 who were observed deficient in their practices were given disciplinary counselling. ADON/Facility Educator will provide in service training on locking medication carts and not leaving medication on top of medication carts unattended to all licensed staff. Pharmacy consultant will continue with medication pass observation competency of 2 licensed staff monthly to include locking of the medication cart and storing medication inside locked medication cart. The Medication cart audit form will be revised to include inspection of	

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F 761	Continued From page 10 Review of Resident (R)63's Ex Order 26. 4B1 in the Ex Order 26. 4B1 under the "Profile" tab revealed R64 was admitted to the facility on Ex Order 26. 4B1 with the following diagnosis of Ex Order 26. 4B1 . Review of the quarterly "Minimum Data Set (MDS)" in the EMR, with an 'Ex Order 26. 4B1 " of NJ Exec. Order 26:4.b.1 coded the resident as having a 'Ex Order 26. 4B1 " score of Ex Order out of 15. which indicated the resident was Ex Order 26. 4B1 . Review of R63's EMR, the physician had ordered " Ex Order 26. 4B1 Give 2 [sic] tablets NJ Exec. Order 26:4.b.1 tablets = Ex Order 26. 4B1 ." This order was written on NJ Exec. Order 26:4.b.1 Interview with the Director of Nursing (DON) was interviewed on 09/29/23 at 11:30 AM. DON stated, "We have been reviewing the med (medication) pass with all of our nurses for some time now. We were hoping this would help when the state came to do the med (medication) pass with them." 2. Review of the facility's policy titled, "Medication Labeling and Storage" with a revision date of February 2023, stated " ... Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: a. medication name (generic and /or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name; f. route of administration; and g.	F 761	medication label. The DON/designee will conduct weekly random audits of 5 medication carts with focus on locking, storing meds and medications are properly labelled x 4 weeks. Results of the audits will be reported to the Administrator during the quarterly QA Meeting and reviewed for any recommendations.	

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CAREONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE PARAMUS, NJ 07652**

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F 761	Continued From page 11 appropriate instructions and precautions." Review of R82's "Face Sheet" in the EMR) under the "Profile" tab revealed R82 was readmitted to the facility on [redacted] with the following diagnoses of [redacted]. Review of the admission " MDS)" in the EMR, with an "ARD" of [redacted] coded the R82 as having a "[redacted]" score of [redacted] out of 15 indicating [redacted]. Observation on 09/28/23 at 9:07 AM, of Medication Cart [redacted] located on the [redacted] floor, had R82's [redacted] and [redacted]. The label on the [redacted] bag for R82's, the label for this medication could not be read. The only information on this label that could be read was R82's name. Interview with Unit Manager (UM) 4 at time of observation stated, "You can't read that label. Looks like it got wet or something. The nurses should have called the pharmacy to see if this could be refilled." 3. Review of the facility's policy titled, "Security of Medication Cart" with revision date of April 2007 indicated, "Medication carts must be securely locked at all times when out of the nurse's view." Observation on 09/25/23 at 9:30 AM revealed an unlocked medication cart next to room [redacted] nursing station was unlocked and out the sight of the nurse. The med cart. No medications were on top the cart however, the drawers to the cart were easily accessible to anyone walking down the hall. RN8 came from a resident's room to the unlocked medication cart at 9:33 AM.	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE PARAMUS, NJ 07652**

(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 761	Continued From page 12 Interview on 09/25/23 at 9:33 AM with RN8 revealed someone had called them to a resident's room to see something and they walked away from the cart without locking the medication cart. RN8 stated they had been trained to lock the medication cart when away, but they forgot. 4. Observation on 09/25/23 at 4:28 PM revealed an unlocked medication cart next to [redacted] nursing station. The cart was out the sight of the nurse. No medications were on the cart however, the drawers to the cart were easily accessible to anyone walking down the hall. Interview on 09/25/2023 at 4:38 PM with Licensed Practical Nurse (LPN) 3 revealed they were the nurse on the unit and acknowledged they forgot to lock the medication cart. LPN3 stated they were working with two different medications carts and forgot to lock one prior to walking away. LPN3 stated it was a mistake and they had been trained to lock the cart when away from it. 5. Observation on 09/27/23 at 8:57 AM revealed an unlocked medication cart next to [redacted]. The cart was out the sight of the nurse. No medications were on the cart however, the drawers to the cart were easily accessible to anyone walking down the hall. RN7 came of a resident's room to the unlocked medication cart at 9:02 AM. Interview on 09/27/2023 at 9:02 AM with RN7, revealed they went into a room to wash their hands and was away from the cart for a couple of minutes. RN7 stated they normally lock the medication cart and leaving them open was not the normal practice.	F 761		

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	315426	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE PARAMUS, NJ 07652**

(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 761	Continued From page 13 Interview on 09/27/23 at 2:44 PM with the DON stated they have educated staff multiple times on locking the computer screen they are away from them. DON stated they have a pharmacy consultant who does medication pass with the staff monthly and they go over serval things such as ensuring the electronic health record and medication cart is locked. DON stated they anticipate that staff should keep resident information confidential at all times.	F 761		
F 812 SS=E	NJAC 8:39-29.4(a)(f)(h) Food Procurement,Store/Prepare/Serve-Sanitary 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, record review, and staff interview the facility failed to ensure food stored in	F 812	The 3 items in the Ex Order 26. 4B1 nurses station refrigerator were discarded due to	10/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE PARAMUS, NJ 07652**

(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 14 the unit refrigerators on one of four units was stored in a sanitary manner. This failure had the potential to affect the 15 residents on the [redacted] unit with a census of 82. Findings include: Observation on 09/25/23 at 9:03 AM revealed the [redacted] floor [redacted] resident refrigerator located by the nursing station contained a container of caramel dip that was not labeled with the date it was opened and was not labeled with a resident name; a container of what appeared to be partially eaten pasta dish with Resident (R) 49's name written on it, the container was not dated to indicate when it was placed in the refrigerator. There was one [redacted]-ounce container of "Ready Care mighty shake" on the shelf in the door. The container was not dated to indicate when it was thawed out. The manufacturer's instructions on the container stated to be used within 14 days of thawing. Interview with the Dietary Manager on 09/25/23 at 9:30 AM at the time of the observation revealed the food should have been dated and labeled with the date it was placed in the refrigerator and the shake should have been dated with the date it was thawed out. Review of the "Foods Brought by Family/Visitors" policy with a revised date of October 2017 stated containers of food will be labeled with the resident's name, the item name, and the date. NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)	F 812	not being properly labeled. Any item not labeled correctly will be removed. Patient will be contacted if item container is not disposable for proper return to owner. Items provided by families who ask to have the items stored in the patient refrigerator will be labeled properly before being placed into the refrigerator. All staff will be inserviced to maintain proper handling of patient items. All patient refrigerators will be inspected daily for any undated items located in the refrigerator. Signage on each refrigerator will be prominently displayed for easy identification and to ensure compliance. The policy will be added to the admissions agreement paperwork to ensure patient and family compliance. The Food Service Director will ensure compliance for properly stored patient items. On the days the Food Service Director is not available, this task will be added to the flow sheet by the Dietary Supervisor. The Food Service Director will monitor and add the refrigerator inspections to the daily signature logs for compliance. The daily report will be added to the Sanitation Report and reported to the Quarterly QA meeting by the Administrator.	

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
	060214	A. BUILDING: _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on facility document review it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:	S 560	LNHA and DON has met on an ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified staffing needs. Any resident has the potential to be affected. The facility has implemented a significant above market rate for nurses and certified aides. The facility has implemented an incentive program including sign-on bonus for new hires and referrals bonuses for employees referring staff. The facility continues to conduct ongoing job fairs, internally and externally with	10/16/23

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

Electronically Signed | 10/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060214	A. BUILDING: _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

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S 560	Continued From page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The facility was deficient in CNA staffing for residents day shifts as follows: 1. For the week of Complaint staffing from 02/13/2022 to 02/19/2022, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -02/13/22 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. 2. For the week of Complaint staffing from 04/17/2022 to 04/23/2022, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -04/17/22 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs. -04/23/22 had 9 CNAs for 79 residents on the day shift, required at least 10 CNAs. 3. For the week of Complaint staffing from 05/08/2022 to 05/14/2022, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -05/08/22 had 8 CNAs for 92 residents on the day	S 560	immediate interviews and offers. The DON/designee meets with the staffing coordinator daily to review facility census and callouts, if any and the staffing needs. The DON/designee will monitor callouts and staffing ratios weekly until the requirement is met. The results of the staffing audit will be forwarded to the Administrator and the quarterly QA meeting for further review and recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060214	A. BUILDING: _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

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S 560	Continued From page 2 shift, required at least 11 CNAs. -05/14/22 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. 4. For the 2 weeks of Complaint staffing from 11/06/22 to 11/19/2022, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -11/07/22 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -11/08/22 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -11/09/22 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -11/10/22 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -11/11/22 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -11/12/22 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -11/13/22 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs. -11/14/22 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs. -11/16/22 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -11/17/22 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -11/18/22 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. 5. For the week of Complaint staffing from 01/29/2023 to 02/04/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -01/29/23 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.	S 560		

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	060214	A. BUILDING: _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

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S 560	Continued From page 3 -01/30/23 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -01/31/23 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs. -02/01/23 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. -02/04/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. 6. For the 2 weeks of Complaint staffing from 04/09/2023 to 04/22/2023, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -04/15/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -04/18/23 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs. -04/20/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. 7. For the week of Complaint staffing from 08/27/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -08/27/23 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -08/28/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -08/31/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/02/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. 8. For the 2 weeks of staffing prior to survey from 09/10/2023 to 09/23/2023, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 4 -09/11/23 had 9 CNAs for 94 residents on the day shift, required at least 12 CNAs. -09/12/23 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -09/14/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -09/15/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -09/16/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/17/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/18/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/21/23 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. -09/23/23 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs.	S 560		

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
315426 Y1	A. Building B. Wing Y2	11/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

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 F0582	Correction	ID Prefix F0583	Correction	ID Prefix F0695	Correction
Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed	Reg. # 483.25(i)	Completed
LSC	10/16/2023	LSC	10/16/2023	LSC	10/11/2023
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	10/16/2023	LSC	10/16/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/28/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060214	A. Building B. Wing	11/1/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

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 10/16/2023	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING **01** B. WING _____	**09/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE** **PARAMUS, NJ 07652**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/27/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/27/23 and 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. CareOne at Ridgewood Avenue is a two-story building. The [Ex Order] floor was built in 1971 and the [Ex Order 26. 4B] floor was built in 2001. It is composed of Type II protected construction. The facility is divided into five - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The currently occupied beds are 80 of 110.	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324		10/11/23

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

Electronically Signed | 10/16/2023

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
	315426	A. BUILDING **01** B. WING _____	**09/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE** **PARAMUS, NJ 07652**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 1 toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that penetrations of the hood enclosure were sealed by devices that were listed for such use and whose presence did not distract from the hood's structural integrity in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition) Section 5.1.5. This deficient practice had the potential affect all 80 residents. Findings include: An observation on 09/27/23 at 2:31 PM revealed the kitchen hood enclosure had a one-inch diameter unsealed opening. During an interview at the time of the observation,	K 324	The kitchen head enclosure 1 inch diameter unsealed opening was sealed with a steel cover with secure lock washers. Cooking area will be inspected to ensure no additional openings are visible. Any vendor who completed work to the kitchen area will be reported on the monthly Life Safety Inspection Report to be visibly be checked by the Maintenance Director for workmanship. Life Safety Inspection Report will include kitchen hood to ensure no openings occur monthly.	

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	315426	A. BUILDING **01** B. WING _____	**09/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 324	Continued From page 2 the Regional Maintenance Director confirmed the unsealed opening. NJAC 8:39-31.1(c). 31.2(e) NFPA 96	K 324	Life Safety Rounds Report will be reported monthly by the Maintenance Director and submitted by Administrator to the quarterly QA Meeting.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure automatic smoke detection was provided at the location of the fire alarm control unit in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 10.15. This deficient practice had the potential to affect all 80 residents. Findings include:	K 341	Smoke detector located at the fire alarm panel was installed by the fire alarm company in the area noted. Installation including programming, testing and monitoring will be completed by the fire alarm company. Testing will occur bi-annually to ensure compliance. Daily monitoring will occur	10/16/23

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	315426	A. BUILDING **01** B. WING _____	**09/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE** **PARAMUS, NJ 07652**

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K 341	Continued From page 3 An observation on 09/27/23 at 2:43 PM revealed the fire alarm control unit was located in a hallway that was not continuously occupied and automatic smoke detection was not provided. The nearest smoke detection was located 26 feet away from the fire alarm control unit as measured by the Maintenance Director. During an interview at the time of the observation, the Maintenance Director confirmed the fire alarm control unit was not provided with smoke detection. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 341	through the fire alarm company to ensure the entire system is in working order. Any additions to the facility will be reported on the Life Safety Inspection Report every month completed by the Maintenance Director. Quarterly Report will be submitted to the Maintenance Director and submitted to the Administrator for the quarterly QA meeting for further recommendations.	
K 372 SS=F	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 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 interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke	K 372	The identified penetrations that were unseal are sealed by the Maintenance Director using high performance 3M fire barrier sealant.	10/16/23

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K 372	Continued From page 4 barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) Sections 8.5.6.1 and 8.5.6.2. This deficient practice had the potential to affect all 80 residents. Findings include: An observation on 09/27/23 at 1:16 PM revealed the smoke barrier wall, located on the [redacted] floor and adjacent to the front desk, had a 3-inch by 6-inch unsealed opening above a sprinkler pipe on both sides of the smoke barrier. An observation on 09/27/23 at 1:21 PM revealed the smoke barrier wall, located on the [redacted] floor and adjacent to Recreation, had a bundle of yellow, blue, and white wires penetrating a two-inch diameter unsealed opening on both sides of the smoke barrier. An observation on 09/27/23 at 1:26 PM revealed the smoke barrier wall, located on the [redacted] floor and adjacent to [redacted], had a bundle of yellow, blue, and white wires penetrating a one-inch diameter unsealed opening on both sides of the smoke barrier. During an interview at the time of the observations, the Maintenance Director confirmed the unsealed penetrations. The Maintenance Director stated he checks the smoke barriers every six months and after subcontractors have completed work. NJAC 8:39-31.1(c), 31.2(e)	K 372	The Maintenance Director has inspected all fire barrier areas for any opening requiring attention. All vendors requiring wiring services in the bui8lding will be required to maintain the fire barrier areas. The Maintenance Director will oversee all projects which require ceiling work in order to maintain integrity of the barriers. The Safety Inspection Report will be completed by the Maintenance Director and reported monthly to the Safety Meeting which will then be reported by the Administrator to the quarterly QA Meeting.	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101	K 911		10/16/23

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K 911	Continued From page 5 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure an electrical junction box was provided with a cover compatible with the box and suitable for the condition of use in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 314.28(C). This deficient practice had the potential to affect 21 residents. Findings include: An observation on 09/27/23 at 1:30 PM revealed an open electrical junction box, located above the ceiling tile adjacent to Ex Order 26. 4B1, that contained wiring for a light fixture and did not have a cover. During an interview at the time of the observation, the Regional Maintenance Director confirmed the junction box did not have a cover. NJAC 8:39-31.2(e) NFPA 70	K 911	The existing electrical junction box was replaced by the electrical company. All electrical ceiling junction boxes were inspected for possible wiring issues. All electrical lighting requiring work will be inspected by the Maintenance Director. The building Inspection Report will address any electrical work done in the building and be reported to the monthly Safety Meeting. The report will be presented to the quarterly QA meeting by the Administrator.	

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
315426 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	10/11/2023	LSC K0341	10/16/2023	LSC K0372	10/16/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0911	10/16/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO