STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. BUILDING _____ B. WING _____	C 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

(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 000	INITIAL COMMENTS Complaint #: NJ173161, NJ173099, NJ169020 Survey Date: 6/4/24 through 6/10/24 Census: 88 Sample: 18 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 1 of 21 residents, Resident #69 reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: Reference: According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) on Chapter 2-page 39 ...	F 641	ID Prefix Tag F Tag 641 SS=D 1. How the corrective action will be accomplished for those residents found to have been affected by the practice. Resident #69 was discharged to [redacted] on 3/6/24. The discharge MDS for resident #69 was immediately modified to correct the inaccurate coding. Resident #69 had [redacted] related to the coding on the discharge MDS.	6/25/24

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

Electronically Signed | 06/24/2024

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F 641	Continued From page 1 "According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023). This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board, and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly. Code 04, Short-Term General Hospital (acute hospital/IPPS): if the resident was discharged to a hospital that is contracted with Medicare to provide acute, inpatient care and accepts a predetermined rate as payment in full. Code 99, Not Listed" 1. On 6/06/24 at 9:36 AM, the surveyor reviewed the closed medical record for Resident #69 whose discharge MDS was coded for discharge to an acute hospital. The surveyor reviewed the NJ Ex Order 26.4 progress notes which indicated that Resident #69 was discharged NJ Ex Order 2 Review of Resident #69's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included but were not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . Review of the "A section" of the Discharge MDS	F 641	2. How the facility will identify other residents having the potential to be affected by same deficient practice. All residents have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Regional Director of Clinical Reimbursement provided re-education to the MDS staff with regard to acccurate coding on the discharge MDS. An audit was conducted by the Director of Clinical Reimbursement on residents discharged in the last 30 days to ensure accuracy of coding on the discharge MDS. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Clinical Reimbursement or designee will conduct random audits using the Comprehensive assessment audit tool on 5 discharged residents weekly for 4 weeks, then monthly X 3 months. Results of the Comprehensive assessment audit will be reported at the	

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F 641	Continued From page 2 for Resident #69 revealed that section "A2105 Discharge Status" documented, "NJ Exec Order 26.4b1 [redacted] On 6/06/24 at 11:10 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted]) regarding where Resident #69 was discharged to. The U.S. FOIA (b) [redacted] stated that she believed that Resident #69 "went NJ Exec Order [redacted]. The surveyor asked the U.S. FOIA (b) [redacted] about Resident #69's Discharge MDS which was coded for discharge to the hospital. The U.S. FOIA (b) [redacted] stated that she thought it was an error in the coding and that she was going to check the medical record. The U.S. FOIA (b) [redacted] then confirmed that the Discharge MDS was coded incorrectly and that Resident #69 was discharged to NJ Exec Ord[redacted] and not to a hospital. On 6/06/24 at 01:43 PM, in the presence of the survey team, the surveyor told the U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6), NJ Ex Order 26.4(b)(1), U.S. FOIA (b) (6) [redacted] and the Clinical Reimbursement Coordinator (CRC #2) the concern that Resident #69's Discharge MDS was coded incorrectly. CRC #2 confirmed that Resident #69's Discharge MDS was coded incorrectly and added that the facility modified the MDS. The facility did not provide any additional information. A review of the facility provided policy titled, "Comprehensive Assessments" with a revised date of March 2022 included the following: Policy Interpretation and Implementation 1. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment	F 641	monthly Quality Assurance Performance Improvement (QAPI) committee meetings for 3 months for review. The QAPI committee will review and determine the need for further follow up.	

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F 641	Continued From page 3 Instrument (RAI) User Manual. N.J.A.C. 8:39-11.1, 11.2	F 641		
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 review of pertinent medical records, it was determined that the facility failed to follow physician orders related to the use of NJ Ex Order 26.4(b)(1)) for 1 of 1 resident, Resident #3. This deficient practice was evidenced by the following: On 6/4/24 at 10:45 AM, the surveyor observed Resident #3, who was laying in bed in their room. Resident #3 was receiving NJ Ex delivered through a NJ Ex Order 26.4(b)(1)) utilizing a NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) at NJ Ex Order 26.4(b)(1)). Resident #3 stated their NJ Ex should be running at NJ Ex Order 26. The surveyor reviewed the resident's medical chart which included a review of a paper as well	F 695	ID Prefix Tag F Tag 695 SS=D 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 was immediately assessed and the physician's orders for the delivery of NJ Ex Order 26.4 via NJ Ex Order 26.4(b)(1) were clarified. The NJ Exec Order 2 delivery was adjusted as per the physician's orders. Resident #3 had NJ Exec Order 26.4b1 related to this practice. 2. How the facility will identify other residents having the potential to be affected by same deficient practice.	6/21/24

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F 695	Continued From page 4 as computerized medical chart. A review of the Admission Record (a summary of important information about the resident) documented the resident was admitted to the facility on [redacted] with diagnoses included but were not limited to [redacted], and [redacted]. A review of an Annual Minimum Data Set (AMDS, an assessment tool to facilitate care), dated [redacted], documented the resident had a Brief Interview for Mental Status (BIMS) and scored a [redacted] out of 15, indicating that Resident #3 was [redacted]. The AMDS further revealed Resident #3 is receiving [redacted] A review of the Physician's Orders (PO) and electronic treatment administration record (eTAR) documented a physician's order for, "[redacted] with [redacted] VIA: [redacted] every shift for [redacted] " with a start date of [redacted] A review of Resident #3's Care Plan (CP) with a revision date of [redacted] read, " ...At risk for [redacted] related to [redacted], [redacted] An intervention for the CP read, "Administer [redacted] per physician order." On 6/5/24 at 9:42 AM, the surveyor observed Resident #3's [redacted], set at [redacted], second observation of [redacted]. On 6/5/24 at 9:45 AM, the surveyor interviewed U.S. FOIA (b) (6)) caring for Resident #3. The [redacted] reviewed with the	F 695	All residents have the potential to be affected by deficient practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The [redacted] was immediately educated by the Director of Nursing regarding the policy on Oxygen Administration. Nursing staff on all shifts were provided re-education by Director of Nursing and designee on the policy for Oxygen Administration. An audit was conducted by the Director of Nursing and designee on all residents with active physicians orders for oxygen administration to ensure oxygen delivery rate was in accordance with the physician's order. 4. How the facility will monitor its corrective action to ensure that deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing or designee will conduct random audits of 100% of residents with oxygen administration orders to ensure the delivery of oxygen is in accordance with the physician's order. Audits will be conducted weekly X 4 weeks, then monthly X 3 months. Results of the oxygen administration audit will be reported at the Monthly Quality	

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F 695	Continued From page 5 surveyor the PO for the resident's [NJ Ex Order 26.4(b)(1)]. The surveyor informed the [U.S. FOIA] of the two observations on 6/4/24 and 6/5/24 in which the resident's [NJ Ex Order 26.4(b)(1)] was at [NJ Ex Order 26.4(b)(1)]. The surveyor accompanied the [U.S. FOIA] to Resident #3's room to check the [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] acknowledged the [NJ Ex] was not set at [NJ Ex Order 26] as ordered by the physician. The [U.S. FOIA] could not explain why the resident's [NJ Ex Order 26.4(b)(1)] was at [NJ Ex Orde] and adjusted the resident's [NJ Ex] setting to [NJ] On 6/5/24 at 11:00 AM, the [U.S. FOIA (b) (6)] provided the surveyor with a facility policy titled, "Oxygen Administration", which had a revised date of October 2010. Under the Preparation portion of the policy it read, "1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." Under the Documentation section of the policy it read, "After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record ...3. The rate of oxygen flow, route, and rationale." On 6/6/24 at 1:42 PM, the survey team met with the [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)]) The surveyor informed the facility about the concerns of the [NJ Ex] setting for Resident #3. The [U.S. FOIA] stated the [NJ Ex] should be administered according to physicians' orders. There was no further information provided.	F 695	Assurance Performance Improvement (QAPI) committee meetings for 3 months for review. The QAPI committee will review and determine the need for follow up.	

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F 695	Continued From page 6 NJAC 8:39-27.1(a)	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 755	ID Prefix Tag	6/24/24

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F 755	Continued From page 7 review, it was determined that the facility failed to properly store a controlled and noncontrolled medications in a secure manner. This deficient practice was identified for one (1) of 3 units inspected and involved two Residents, Resident #123 and #122. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice was evidenced by the following: On 6/4/24 at 11:55 AM, the surveyor inspected the medication cart located on Unit 2 of the facility	F 755	F Tag 755 SS=D 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #123 orders were reviewed by the US FOIA (b)(6)). US FOIA (b) confirmed the bingo card for NJ Ex Order 26.4(b)(1) capsules was in the medication cart. The pharmacy wrapped unit dose of NJ Ex Order 26.4(b)(1) capsule was returned to the NJ Exec Order 26.4 by the US FOIA (b)(6) and the pharmacy issued a credit to resident #123 for the returned medication. Resident #123 had NJ Ex Order 26.4(b)(1) related to this practice. Resident #122 physician orders were reviewed by the US FOIA (b)(6) confirmed the bingo cards for the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) tablets were in the medication cart. The pharmacy wrapped unit does of NJ Ex Order 26.4(b)(1) tablet was returned to the NJ Exec Order 26.4 by the US FOIA (b)(6) and pharmacy issued a credit to resident #122 for the returned medication. 2. How the facility will identify other residents having the potential to be affected by same deficient practice. All residents have the potential to be affected by deficient practice.	

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F 755	Continued From page 8 in the presence of the U.S. FOIA (b) (6). The surveyor opened the top drawer of the medication cart and noted that there was a medication cup that contained 2 pharmacy wrapped unit dose medications. The surveyor inspected the 2 medications which were found to be NJ Ex Order 26.4(b)(1) Capsule (an NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) tablet (NJ Ex Order 26.4(b)(1)). The surveyor discussed the storage of the two medications, NJ Ex Order 26.4(b)(1) Capsule and NJ Ex Order 26.4(b)(1) tablet in the medication cup with the NJ Ex Orde who stated that he was not made aware by the previous shift that the unit dose NJ Ex Order 26.4(b)(1) Capsule and NJ Ex Order 26.4(b)(1) tablet were in his cart. The U.S. FOIA stated that he did not know which resident this belonged to. The U.S. FOIA explained that if he was aware he would have questioned why they were there because the U.S. FOIA (b) (6) should be stored in the locked NJ Ex Order 26.4(box of the medication cart. On 6/4/24 at 12:00 PM, the U.S. FOIA (b) (6)) joined the surveyor in investigating the NJ Ex Order 26.4(b)(1) Capsule and NJ Ex Order 26.4(b)(1) tablet found in a medication cup in the top drawer of the medication cart. The U.S. FOIA (b) could not identify which resident the medications belonged to and The U.S. FOIA (b) stated that she was not aware of the medication left in the top drawer. The U.S. FOIA (b) added that she needed to investigate how and why these medications were left not properly secured in the medication cart, especially a NJ Ex Order 26.4(b)(1) substance. On 6/4/24 at 12:09 PM, the surveyor and U.S. FOIA (b) reviewed the medication back up System	F 755	3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The U.S. FOIA on the NJ Exec Orde medication cart was immediately re-educated by the Director of Nursing with regards to the policy of medication storage including proper storage Schedule II medications. The Pharmacy Consultant provided re-education to all nurses on the policy of medication storage including proper storage of all medications including Schedule II medications. The Pharmacy Consultant conducted a medication cart on 6/24/24 to ensure proper storage of all medications including Schedule II medications. Facility implementing the use of Electronic Prescribing Services for all practitioners to facilitate the immediacy of prescription writing for Schedule II medications at time of a resident's admission. Two nurses on the shift will witness and sign off for the removal of medications removed from the Omnicell as well as the immediate administration of the medication to the resident(s). 4. How the facility will monitor its corrective action to ensure that deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued	

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F 755	Continued From page 9 (NJ Exec Order 26.4b printout for history of NJ Ex Order 26.4(b)(1) Capsule and NJ Ex Order 26.4(b)(1) tablet activity. The NJ Exec Order 26.4b printout showed that on NJ Ex Order 2 at 16:11 (4:11 PM), 1 capsule of NJ Ex Order 26.4(b)(1) was removed for the Resident #123 as well as on NJ Ex Order 2 at 17:21 (5:21 PM), the printout showed that 2 tablets of NJ Ex Order 26.4(b)(1) tablets were removed for Resident #122. The physical count for the NJ Ex Order was shown to be correct in the Omnicell. On 6/4/24 at 12:15 PM, the surveyor interviewed the U.S. FOIA (b) who stated that when a medication is not administered, it needs to be destroyed, relating to the NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1). She added that a control substance (NJ Ex Order 26.4(b)(1)) should be stored separated in a double locked area and that the destruction of a NJ Ex Order 26.4(b)(1) should be carried out by two nurses. The surveyor reviewed the medical record for Resident #123. A review of the Admission Record for Resident #123 reveals that the resident was admitted with diagnosis that include but are not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26 , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) Review of the NJ Ex Order 26.4(b)(1) electronic medication administration record (eMAR) documents a physician's order dated NJ Ex Order 26 for NJ Ex Order 26.4(b)(1) to be administered twice daily for NJ Ex Order 26.4(b)(1) for 10 days. The NJ Ex Orde eMAR documents the administration of the	F 755	effectiveness of the systemic change. The Director of Nursing or designee will conduct random audits of medication carts twice weekly X3 weeks, then weekly X3 months to ensure proper storage of medications including Schedule II medications. The Director of Nursing or designee will conduct random audits of the nurses sign off sheet of Omnicell medication twice weekly X3 weeks, then monthly X3 thereafter. Results of the medication cart audits will be reported at the Monthly Quality Assurance Performance Improvement (QAPI) meetings for 3 months for review. Results of the Omnicell sign off sheet audits will be reported at the Monthly Quality Assurance Performance Improvement (QAPI) meetings for 3 months for review. The QAPI committee will review and determine the need for further follow up.	

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F 755		F 755		

Continued From page 10

NJ Ex Order 26.4(b)(1) twice daily with no missed doses.

Review of the Admission Record for Resident #122 reveals that the resident was admitted with diagnosis that include but are not limited to NJ Ex Order 2 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

Review of the NJ Ex Order 26.4(b)(1) eMAR documents a physician's order dated NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1) every 6 hours as needed for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) every 6 hours as needed for NJ Ex Order 26.4(b)(1)). Documentation for administration for the NJ Ex Order 26.4(b)(1) reveals that it was administered as (1) tablet on NJ Ex Order 2 at 17:35 (5:35 PM) even though (2) tablets were removed from the NJ Exec Order 26.4b at 17:21 (5:21 PM).

The US FOIA (b)(6) presented an interview with LPN#2 who administered the NJ Ex Order 26.4(b)(1) to Resident #122 on NJ Ex Order 2. This interview revealed that Resident #123 was going to NJ Ex Order 26.4 and requested NJ Ex Order 26.4(b)(1). LPN#2 continued that the nursing supervisor went to the NJ Exec Order 26.4b and removed 2 tablets of NJ Ex Order 26.4(b)(1) (logged into the NJ Exec Order 26.4b but that Resident #122 only requested 1 tablet of NJ Ex Order 26.4(b)(1). LPN#2 stated that she forgot to destroy the extra NJ Ex Order 26.4(b)(1) that was not administered.

On 6/6/24 at 1:30 PM, the surveyor telephoned the Provider Pharmacy and spoke to a U.S. FOIA (b) (6) who revealed that #30 tablets of NJ Ex Order 26.4(b)(1) and #30 tablets of NJ Ex Order 26.4(b)(1) were delivered to the facility for Resident #123 on NJ Ex Order 2 at 3:50 PM. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. BUILDING _____ B. WING _____	C 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

(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 755	Continued From page 11	F 755		

U.S. FOIA (b) (6) explained that a NJ Ex Order 26.4 substance does not automatically get transmitted, the pharmacy needs a physician's written and signed order. The U.S. FOIA (b) (6) continued by stating that this is the reason that the facility has a back up medication unit, NJ Exec Order 26.4 so that there is no delay in treatment if medication is needed prior to the pharmacy delivery. The U.S. FOIA (b) (6) stated that the order was received from the facility on NJ Ex Order 26 at 7:00 AM.

The U.S. FOIA (b) (6) stated that the NJ Ex Order 26.4(b)(1) was ordered and delivered on NJ Ex Order 2.

Review of the Controlled Substances policy section Storing Controlled Substances, "1. Controlled substances are separately locked in permanently affixed compartments,". Documented under Dispensing and Reconciling Controlled Substances, "3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count." And "4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services."

On 6/6/24 at 1:51 PM, the surveyor met with facility staff U.S. FOIA (b) (6), U.S. FOIA (b) (6), and U.S. FOIA (b) (6) who did not provide any further information.

NJAC 8:39-11.2(b), 29.2 (a)(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60218	A. BUILDING: _____ B. WING _____	C 06/10/2024

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ#173161 Complaint NJ#169020 Complaint NJ#173099 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	S 560	ID Prefix Tag F Tag 0560 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Administrator and the Director of Nursing immediately reviewed the daily staffing to ensure the 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	6/21/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

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S 560	Continued From page 1 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 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.	S 560	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. No residents were adversely affected by this practice. 2. How the facility will identify other residents having the potential to be affected by same deficient practice. All residents have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Administrator and Director of Nursing provided re-education to the staffing coordinator with regards to the minimum direct care staff-to-resident ratios. The facility has scheduled a job fair for 7/16/24. This fair will have a focus on hiring both Certified Nursing Assistants as well as non-certified staff sho will be immediately enrolled in the July Certified Nursing Assistant certification class the Company provides. There will be no cost to the employee to attend this certification course. The facility has re-assessed wages for	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

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S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for 7 segment dates that related to the standard survey and complaints revealing the following: 1. For the 2 weeks of Complaint staffing from 11/05/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -11/05/23 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs. -11/07/23 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. -11/08/23 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. -11/16/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. -11/18/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. 2. For the 2 weeks of Complaint staffing from 04/14/2024 to 04/27/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -04/15/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.	S 560	Certified Nursing Assistants to maintain a competitive edge in the industry. The facility has implemented incentives such as a sign-on bonus and employee referral bonus for Certified Nursing Assistants. The facility has a contract with an employment agency to be utilized as needed to meet the minimum direct care staff-to-resident ratios. The Administrator will monitor admissions to the facility based upon the ability to maintain the direct care staff-to-resident ratios. The Administrator and Director of Nursing will reduce census by limiting admissions if the minimum staffing is not met or available. 4. How the facility will monitor its corrective actions to ensure that deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing or Designee will review staffing daily to ensure Certified Nursing Assistant staffing meets the minimum staff-to-resident ratios daily on an on-going basis. The Director of Nursing or designee will report the findings of staff-to-resident ratios to the Quality Assurance Performance Improvement committee (QAPI) at the monthly meeting on an on-going basis. The QAPI committee will review and determine the need for further follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60218	A. BUILDING: _____ B. WING _____	C 06/10/2024

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S 560	Continued From page 3 -04/16/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. -04/20/24 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. 3. For the 2 weeks of staffing prior to survey from 05/19/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -05/19/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -05/21/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -05/28/24 had 9 CNAs for 81 residents on the day shift, required at least 10 CNAs. On 6/10/24 at 11:25 AM, the surveyor discussed the staffing ratio concerns with the Licensed Nursing Home Administrator (LNHA), and Director of Quality Assurance. The LNHA replied, "we're trying very hard to meet the daily facility staffing needs required." The LNHA added, "we're continuously working on improving the staffing issue."	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315369	A. Building B. Wing	7/29/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 06/25/2024	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 06/21/2024	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 06/24/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
60218		7/29/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

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 06/21/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
6/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. BUILDING **01** B. WING _____	**06/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	**300 OLD HOOK ROAD** **WESTWOOD, NJ 07675**

(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 (NJDOH) on 06/10/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 06/10/24 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 Valley is a one-story building that was built in the 1960's and is composed of Type II construction. The facility is divided into five - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 82 of 93.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator enclosure; and failed	K 291	ID Prefix Tag F Tag 291 SS=F	6/26/24

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

Electronically Signed | 06/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. BUILDING **01** B. WING _____	**06/10/2024**

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CAREONE AT VALLEY	**300 OLD HOOK ROAD** **WESTWOOD, NJ 07675**

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K 291	Continued From page 1 to ensure the emergency light at the transfer switch was hardwired into the load side of the transfer switch in accordance with NFPA 110, Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3.1 and 7.3.2. This deficient practice had the potential to affect all 82 residents who resided at the facility. Findings include: An observation on 06/10/24 at 12:24 PM revealed emergency lighting was not present at the emergency generator enclosure located behind the facility. An observation on 06/10/24 at 12:35 PM revealed emergency lighting was plugged into an electrical outlet and was not wired directly into the load side of the transfer switch. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the emergency lighting was not present at the emergency generator enclosure and the emergency light was plugged into a wall outlet in the emergency transfer room. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Director of Environmental Services immediately ensured that emergency light was installed and provided at the emergency generator enclosure and hardwired into the load side of the transfer switch in accordance with NFPA 110. 2. How the facility will identify other residents having the potential to be affected by same deficient practice. All residents have the potential to be affected by practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Regional Director of Environmental Services re-educated the U.S. FOIA (b) (6) [redacted] on the Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3.1 and 7.3.2. The Regional Director of Environmental Services conducted an audit to confirm that the emergency lighting was installed at the emergency generator enclosure and that the emergency light at the transfer switch was hardwired into the load side of the transfer switch in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 291	Continued From page 2	K 291	accordance with NFPA 110, Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3.1. 4. How the facility will monitor its corrective action to ensure that deficient practice is being corrected and will will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Environmental Services or Designee will conduct audits using the Emergency Lighting audit tool weekly X3 months and then monthly X3 months. Results of the Emergency Lighting audit tool will be reported at the monthly Quality Assurance Performance Improvement committee (QAPI) meetings for 3 months for review. The QAPI committee will review and to determine the need for further follow up.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,	K 324		6/25/24

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K 324	Continued From page 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 document review, observation, and interview, the facility failed to ensure the fusible links for the kitchen's fire-extinguishing system was replaced at least semi-annually in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 edition) section 11.2.4. This deficient practice had the potential to affect all 82 residents who resided at the facility. Findings include: A review of the facility's "Kitchen Automatic Fire System Reports," provided by the facility, revealed the fire-extinguishing system was inspected on 03/29/24 and 09/21/23. The reports did not indicate the replacement of the fusible links. An observation on 06/10/24 at 12:54 PM of the automatic extinguishing system revealed the inspection tag that was placed on the pull station near the automatic extinguishing system did not	K 324	ID Prefix Tag K Tag 324 SS=F 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Director of Environmental Services ensured that fusible links for the kitchen's fire-extinguishing system were immediately replaced in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 edition- section 11.2.4. 2. How the facility will identify other residents having the potential to be affected by same deficient practice. All residents have the potential to be	

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
CAREONE AT VALLEY	**300 OLD HOOK ROAD** **WESTWOOD, NJ 07675**

(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 4 have the old fusible links. During an interview at the time of observation, the U.S. FOIA (b) (6) confirmed the kitchen's automatic fire-extinguishing system fusible links were not replaced semi-annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K 324	affected by deficient practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Regional Director of Environmental Services re-educated the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted] on NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 edition- section 11.2.4. An audit was conducted by the Regional Director of Environmental Services to ensure that the kitchen's automatic fire-extinguishing system fusible links were replaced. 4. How the facility will monitor its corrective action to ensure that 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. Director of Environmental Services or Designee will conduct audits using Cooking Facility audit tool weekly for 3 months and then monthly thereafter. Results of the Cooking Facility audit tool will be reported at the monthly Quality Assurance Performance Improvement committee (QAPI) meetings for 3 months for review. The QAPI committee will review and determine the need for further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. BUILDING **01** B. WING _____	**06/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	**300 OLD HOOK ROAD** **WESTWOOD, NJ 07675**

(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 5	K 324	follow up.	

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)
315369	A. Building 01 - MAIN BUILDING 01 B. Wing	7/29/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

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 K0291	Correction Completed 06/26/2024	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 06/25/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
6/10/2024	