STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	**188 HIGHWAY 34 HOLMDEL, NJ 07733**

(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 NJ: #150791, #151552, #153980, #160391, #160888, # 161821, #162204, #164959, #169012, #170229 Survey Date: 3/13/2024 Census: 86 Sample: 28 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		4/8/24

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

Electronically Signed | 04/04/2024

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint # NJ 169012 Based on observation, interviews, review of medical records (MR) and other pertinent facility documentation, it was determined that the facility failed to NJ Exec Order 26.4b1 which resulted NJ Exec Order 26.4b1 to the New Jersey Department of Health (NJ DOH) within 2 hours for 1 of 3 sampled residents, (Resident #20). This deficient practice was evidenced by the following: On 3/04/24 at 11:49 AM, the surveyor observed the resident in their room sitting in chair. The resident was NJ Exec Order 26.4b1 . Resident #20 was NJ Exec Order 26.4b1 . Review of the residents Admission Record (an admission summary) reflected that the resident had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 Review of the residents Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b indicated the resident had a Brief Interview for	F 609	1. Resident #20 received treatment as per doctor orders. Resident #20 had NJ Ex related to this practice. 2. All residents have the potential to be affected by this practice. 3. Staff education was immediately provided on timely reporting of incidents with injuries of unknown origin. Director of Nursing/Designee conducted an audit of incident reports from the last three months to ensure there were no injuries of unknown origin. There were no incidents of unknown origin. 4. Director of Nursing/Designee will audit incident reports daily, especially those involving injury to ascertain origin. Any incident reported to Director of Nursing/Designee that indicates a major injury will be reported to the regulatory agencies within the appropriate reporting timeframe. Audits will be conducted weekly for 4 weeks, monthly for 3 months with results presented at the QAPI meeting monthly for 3 months for compliance.	

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F 609	Continued From page 2	F 609		

Mental Status (BIMS) of [redacted] which indicated the resident had a NJ Exec Order 26.4b1.

Review of the resident's care plan (CP) initiated on [redacted] and revised on [redacted], included: NJ Exec Order 26.4b1 [redacted] " The CP also included NJ Exec Order 26.4b1 [redacted] "

Review of the residents Progress Notes included the following:

On [redacted] at 9:00 PM, "Resident observed NJ Exec Order 26.4b1 [redacted] applied, 911 called. Ambulance arrived at 8:15 PM, taken to [name redacted] hospital."

On [redacted] at 10:27 PM, NJ Exec Order 26.4b1 [redacted] toward the nurse's station with NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. Noted to be NJ Exec Order 26.4b1 ... [redacted] ... 911 called and NJ Exec Order 26.4b1 [redacted]."

On [redacted] at 12:25 AM, "Writer spoke to ER [emergency room] nurse ... who stated that the resident was treated NJ Exec Order 26.4b1 to the [redacted] and NJ Exec Order 26.4b1 in the ER."

Review of a [redacted] care report dated [redacted] included the resident was treated for a NJ Exec Order 26.4b1 [redacted] " which was NJ Exec Order 26.4b1 [redacted] Further review of additional [redacted] care reports indicated that the resident received treatment to the NJ Exec Order 26.4b1

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through NJ Exec Orde.

On 3/6/24 at 10:24 AM, th U.S. FOIA (b) (6) provided the surveyor with a completed NJ Exec Order investigation for Resident #20 who sustained NJ Exec Order 26.4b1 dated NJ Exec Order 2 at 8:14 PM.

On 3/7/24 at 9:27 AM, the U.S. FOIA (b) (6)) provided the surveyor with a "Reportable Event Record / Report" which was sent to the NJDOH dated NJ Exec Order 26. It reflected the incident was called in to the NJDOH on NJ Exec Order 26 at 7:00 PM by the U.S. FOIA (b

On 3/11/24 at 11:23 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who was Resident #20's U.S. FOIA (b) (6) until NJ Exec Order 26. She stated that approximately NJ Exec Orde ago the resident had an incident which NJ Exec Order 26.4b1 . She stated that the resident came out of the room and had already NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1. She stated she was not on duty at that time, but staff reported that they applied NJ Exec Order 26.4b1, but the NJ Exec Order 26.4 was NJ Exec Order 26.4b1, and he/she was sent to the hospital where the resident NJ Exec Order 26.4b1. She stated that the NJ Exec Order 26.4b1 and acknowledged that it required more care than the facility could provide. The U.S. stated that the resident NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b . She also acknowledged that the incident was unwitnessed by any staff members. She further stated that the resident continued to be evaluated and treated by the NJ Exec Order care company and that the NJ Exec Order 2 was NJ Exec Order 26.4b1

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On 3/11/24 at 2:08 PM, the surveyor interviewed the [redacted] about the incident and the reporting process to the NJDOH. She acknowledged that the resident [redacted] to the [redacted], was [redacted] and had to be sent to the hospital. She also acknowledged that the resident [redacted]. The [redacted] stated that she reported the incident to the NJDOH and the Ombudsman's office since it [redacted]." In addition, she stated that she reported the incident in less than 24 hours and was not familiar with requirements for other reporting time frames.

On 3/13/24 at 11:38 AM, the surveyor interviewed the [redacted] and [redacted] in the presence of the survey team. The [redacted] stated after she spoke with the surveyor the other day " I could have reported it a lot sooner," and that "my focus was related to patient care and staff interviews making sure when I did report it, it was accurate." She further stated, "I should have reported it as soon as I was notified." She stated that at that time she was not looking at the incident as a [redacted] in terms of reporting times. The [redacted] stated that she should have reported the incident in a more timely manner. The [redacted] stated it should have been reported "within 2 hours."

Review of the facility policy "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" dated 9/2022, included the following:

- "If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and

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F 609	Continued From page 5 to other officials according to state law." - "The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. the state licensing/certification agency responsible for surveying/licensing the facility ..." - "Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury ..." - NJAC 8:39-13.4(2)(v)	F 609		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint NJ# 164959 Based on observation, interviews, record review and review of pertinent facility documentation, it was determined that the facility failed to (a) document the measurement of a [NJ Exec Order 26.4b1]	F 686	1. Resident #70's orders were reviewed. Appropriate [NJ Exec Order] treatment orders are in place. Resident #70 had [NJ Exec Order 26.4b1] [redacted] related to this practice. 2. All residents have the potential to be affected by this practice.	4/8/24

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F 686	Continued From page 6 NJ Exec Order 26.4b1 and (b) obtain a physician's order for NJ Exec Order 26.4b1 for a resident admitted with a community-acquired NJ Exec Order 26.4b1 in accordance with professional standards of practice. This deficient practice was identified for 1 of 3 resident's (Resident #70) reviewed for NJ Exec Order 26.4b1 This deficient practice was evidenced by the following: On 3/4/24 at 11:33 AM, the surveyor observed Resident #70 lying in bed. The resident was NJ Exec Order 26.4b1 and stated that he/she had a NJ Exec Order 26.4b1 on their NJ Ex Orde but it did not occur at the facility. A review of the resident's medical record revealed the following: The Admission Record (an admission summary) indicated that Resident #70 was admitted to the facility with diagnoses including, but not limited to, NJ Exec Order 26.4b1 Review of the form titled "Resident Evaluation" dated NJ Exec Order 26 section NJ identified that Resident #70 had NJ Exec Order 26.4b1 . However, there were no measurements documented on the resident evaluation form for	F 686	3. Director of Nursing/Designee immediately provided education to all nurses to obtain orders for wound treatments upon admission, after completion of the new admission skin assessment. Director of Nursing/Designee reviewed the last 7 days' new admissions to ensure appropriate wound treatment orders were entered at the time of admission. 4. Director of Nursing/Designee will perform weekly audits of new admission skin assessments to ensure appropriate treatments are initiated. This will be weekly for 4 weeks, then monthly for 3 months. Director of Nursing will present results to the Quality Assurance Process Improvement committee monthly for 1 quarter.	

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F 686	Continued From page 7	F 686		

the [NJ Exec Order 26.4b1] or [NJ Exec Order 26.4b1].

Review of the comprehensive admission Minimum Data Set (MDS), a tool to facilitate the management of care, included a Brief Interview for Mental Status (BIMS) score of [NJ Exec] which indicated an [NJ Exec Order 26.4b1]. It also reflected that the resident was admitted to the facility with [NJ Exec] . Interventions coded as being in place included [NJ Exec Order 26.4b1], as well as [NJ Exec Order 26.4b1] care.

Review of the care plan initiated on [NJ Exec Order 26], included a focus of [NJ Exec Order 26.4b1], with a goal to show [NJ Exec Order 26.4b1]. Interventions included but were not limited to "Administering treatment per physician orders."

Review of the [NJ Exec Order 26.4b1] Order Summary Report revealed a physician's order (PO) dated [NJ Exec Order 26], for [NJ Exec Order 26.4b1] every shift for [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1]. There was no PO for [NJ Ex Order 26] treatment prior to [NJ Exec Order 26].

Review of the [NJ Exec Order 26.4b1] Treatment Administration Record (TAR) reflected that the order for [NJ Exec Order 26.4b1] was being administered effective [NJ Exec Order 26] , on the night shift, as documented by licensed nursing staff.

On 3/12/24 at 8:52 AM, the surveyor interviewed the [NJ Exec Order] care [U.S. FOIA (b) (6)]) regarding the protocol when [NJ Exec Order 26.4b1] are identified on admission. The nurse stated that on admission, a [NJ Exec Order 26.4b] assessment should be

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F 686	Continued From page 8	F 686		

completed, NJ Exec Order 26.4 should be NJ Exec Order 26.4b1 and documented as the NJ Exec Order 26.4b assessment. She further stated that hospital records should be reviewed for NJ Exec Order treatment, the doctor should be notified to obtain PO's, and the treatment should occur immediately. The NJ Exec Order then should be assessed and measured weekly to ensure appropriate treatment and NJ Exec Order 2. The NJ Exec Order 2 care U.S. FOIA reviewed the NJ Exec Order 26.4b1 dated NJ Exec Order 26, in the presence of the surveyor and acknowledged that the resident was admitted with NJ Exec Order 26 from the hospital. She stated that interventions should have been implemented immediately and acknowledged that NJ Exec Order care treatment did not occur until NJ Exec Order 26

On 3/12/24 at 12:07 PM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the protocol when NJ Exec Order 26 are identified on admission. The U.S. FOIA (b) (6) stated that NJ Exec Order 26 should be assessed and measured upon admission, the nurse in charge should notify the physician for treatment orders, and the treatment should occur immediately.

On 3/12/24 at 12:17 PM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the protocol when NJ Exec Order 26 are identified on admission. The U.S. FOIA stated the following should be completed and documented: a NJ Exec O , NJ Exec Order 26.4b1, and treatments initiated. She further stated that admissions were reviewed during clinical meetings, and the nurse/unit manager was responsible to ensure that the treatment was initiated.

Review of the facility policy "Admission Assessment and Follow-Up: Role of the Nurse"

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F 686	Continued From page 9 dated 4/25/22, Under the section titled "Steps in the Procedure," "11. Conduct a physical assessment including, the following systems ... j. the skin." "15. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information, obtaining admission orders based on these findings." Review of the facility policy "Pressure Ulcer/Skin Breakdown-Clinical Protocol" dated 4/2018, included that "in addition, the nurse shall describe and document/report the full assessment of pressure sores, including location, stage, length, width, depth, and presence of exudates or necrotic tissue." N.J.A.C 8:39-27.1 (a)(e)	F 686		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		4/8/24

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F 692	Continued From page 10 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to obtain, record and monitor [NJ Exec Order 26.] on admission, readmission and weekly in accordance with professional standards of practice. This deficient practice was identified for 1 of 6 residents (Resident #82) reviewed for [NJ Exec Order 26.]. The deficient practice was evidenced as follows: On 03/11/24 at 12:30 PM, the surveyor observed Resident #82 in NJ Exec Order 26.4b1. The resident was NJ Exec Order 26.4b1 themselves and had NJ Exec Order 26.4b1. A review of the electronic medical record (EMR) revealed that the resident was admitted to the facility on [NJ Exec Order 26.] discharged on [NJ Exec Orde], and re-admitted back to the facility on [NJ Exec Orde]. A review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but not limited to; NJ Exec Order 26.4b1 [redacted] A review of the comprehensive admission	F 692	1. [NJ Exec Order 2] was obtained for Resident #82. Resident #82 had NJ Exec Order 26.4b1 related to this practice. 2. All residents have the potential to be affected by this practice. 3. Director of Nursing/Designee conducted an audit of all admissions in the last 7 days to ensure an admission weight was obtained. Director of Nursing/Designee immediately provided education to the [US FOIA (b)(6)] nurses and Certified Nursing Assistants on the process to obtain a weight at the time of admission. 4. Dietician or Designee will perform weekly audits of new admissions to ensure weights were obtained at the time of admission. Audits will be conducted weekly for 3 weeks, then monthly for 3 months with the results of the audit presented to the Quality Assurance Performance Improvement committee monthly for 3 months.	

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Minimum Data Set (MDS), a tool which facilitates the management of care, revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which reflected a [redacted]

A review of the Care Plan initiated on [redacted] revealed a focus for NJ Exec Order 26.4b1 [redacted] and interventions included, but were not limited to, "[redacted] ."

A review of the Physician's Order's (PO) for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 did not reflect a PO to obtain [redacted]

A review of a [redacted] Evaluation dated [redacted] included a NJ Exec Order 26.4b1 which was based on a "NJ Exec Order 26.4b1." It further included that the NJ Exec Order 26.4b1 was unable to determine the resident's estimated NJ Exec Order 26.4b1 since a NJ Exec Order 26.4b1 was not available.

A review of the "Resident Evaluation's" dated [redacted] and [redacted] which is completed by nursing on admission did not include documentation of the resident's "[redacted] " (the section was blank).

A review of the resident's [redacted] recorded in the EMR revealed the following:

-"NJ Exec Order 26.4b1)"
NJ Exec Order 26.4b1

On 03/06/24 at 09:17 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] regarding the facility's

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F 692	Continued From page 12	F 692		

protocol for obtaining NJ Exec Order 26 on new admissions and re-admissions. The U.S. FOIA (b) (6) stated that NJ Exec Order 26.4 should be obtained on admission, re-admission, and then weekly for four weeks, and monthly thereafter. She stated that a new admission/re-admission NJ Exec Order should be obtained on the same day of admission/re-admission, and if the NJ Exec Order was not obtained, another attempt should be made on the next day. She stated that it was her and the US FOIA (b responsibility to ensure that the weights are obtained. She stated that if someone refused to be NJ Exec Order 26.4b it should be documented in the assessment or on a separate note.

On 03/06/24 at 12:23 PM, the surveyor interviewed the NJ Exec regarding the facility's protocol of obtaining NJ Exec Order 26.4 and assessing the resident's NJ Exec Order 26.4b1 was not available. The NJ Exec stated that NJ Exec Order 26 should be obtained on admission and re-admission. She further stated that the U.S. FO was responsible for ensuring that NJ Exec Order 26 were obtained on admission or re-admission. She stated that if a NJ Exec Order was not obtained, she made a list of missing NJ Exec Order 26 and emailed the list to the U.S. FO and cc'd (carbon copy) the administrator and U.S. FOIA (b) (6)). She stated that the U.S. FOIA (b) (6)) was responsible for obtaining the resident's NJ Exec Order 2 In the event that a NJ Exec Order was not recorded, she would remind the U.S. FOIA to obtain a NJ Exec Order 2 In addition, she stated if a NJ Exec Order 2 was not available, she would contact the family for a NJ Exec Order history and if need be, she used the hospita NJ Exec Order 2 to assess the resident's NJ Exec Order 26.4b1 .

During this same interview, the surveyor inquired what delayed the staff from obtaining a NJ Exec Order 2 on

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 692	Continued From page 13 admission, re-admission and weekly for Resident #82. The [NJ Exec] stated that the resident was discharged to the hospital on [NJ Exec Order 26.4b1] re-admitted back to the facility on [NJ Exec Order 2]. She stated that the resident refused to be [NJ Exec Order 26.4] because NJ Exec Order 26.4b1. The surveyor also inquired if a resident refused to be [NJ Exec Order 26.4], should it be documented? The [U.S. FO] stated, "it should be" and it (the refusal) would be care planned. The surveyor inquired why weekly [NJ Exec Order 2] were not obtained and documented, and she stated, "they didn't do it." On 03/07/24 at 02:02 PM, the surveyor interviewed the [U.S. FOIA] regarding the protocol for obtaining [NJ Exec Order 26]. The [U.S. FOIA] stated that the practice was that [NJ Exec Order 26] were obtained on admission, re-admission, and weekly for four weeks. She stated that her expectation was that a [NJ Exec Order] should be obtained within 48 hours of admission or re-admission. She also stated that it was a team effort to obtain a [NJ Exec Order]. She acknowledged that if a resident refused to be [NJ Exec Order 26.4], it should be documented, and care planned. A review of the facility policy "Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol" dated 9/2017, reflected under the section "Assessment and Recognition 1. the nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time." N.J.A.C 8:39-27.1(a);27.2(a)	F 692		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h)	F 694		4/8/24

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F 694	Continued From page 14 § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to (a) obtain a physician order to maintain NJ Exec Order 26.4b1 and, (b) discontinue NJ Exec Order 26.4b1 after completion of an NJ E[illegible] in accordance with professional standards of practice. This deficient practice was identified for 1 of 1 resident (Resident #70) reviewed for NJ Exec Order 26.4b1 use. The deficient practice was evidenced by the following: On 03/04/24 at 11:26 AM, Resident #70 was observed lying in bed NJ Exec Order 26.4b1 A NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 On 03/05/24 at 10:28 AM, Resident #70 was observed in NJ Exec Order 26.4b1, after having received morning care from the U.S. FOIA (b) (6)). The surveyor observed a NJ Exec Order 26.4b1) with a NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 A review of the admission record (an admission summary) revealed that Resident #70 was	F 694	1. Physician's orders were received and the NJ Exec Order 26.4b1 was immediately discontinued for Resident #70. Resident #70 had NJ Exec Order 26.4b1 related to this practice. 2. All residents have the potential to be affected by this practice. 3. Director of Nursing/Designee provided education on peripheral intravenous site care to all licensed nurses. Director of Nursing/Designee conducted an audit of all residents with peripheral intravenous orders. There were no untoward findings. 4. Director of Nursing/Designee will perform weekly audits of residents with orders for peripheral Intravenous lines to ensure physician's orders are in place to discontinue the intravenous line upon completion of the treatment. Audits will be conducted weekly for 3 weeks, then monthly for 3 months with report to the Quality Assurance Performance Improvement committee monthly for 3 months.	

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F 694	Continued From page 15	F 694		

admitted to the facility with the following diagnoses, which included but not limited to: NJ Exec Order 26.4b1 .

A review of the comprehensive Minimum Data Set (MDS), a tool used to facilitate the management of care, revealed that the Brief Interview for Mental Status (BIMS) score was NJ Exec which indicated an NJ Exec Order 26.4b1. It also reflected that resident was on NJ Exec Order 26.4b1 while at the facility.

A review of the NJ Exec Order 26.4b1 Order Summary Report (summary of physician orders [PO]) revealed a PO dated NJ Exec Order 26 for the following: "NJ Exec Order 26.4b1 ," and a PO dated NJ Exec Order 26 for NJ Exec Order 26.4b1 ." Further review of the Order Summary Report did not reflect a PO to NJ Exec Order 26.4b1 .

A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed that Resident #70 had received NJ Exec Order 26.4b from NJ Exec Order 2 to NJ Exec Order 26 for an NJ Exec Order 26.4 and NJ Ex from NJ Exec Order 2 to NJ Exec Order 2 for a NJ Exec Order 2

A review of the Care Plan initiated on NJ Exec Order 2 reflected a focus for the potential for

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complications at the NJ Exec Order 26.4b1 and a goal that the NJ Exec Order 26.4b1 and interventions which included but were not limited to NJ Exec Order 26.4b1 per physician orders.

A review of the "Progress Notes" revealed the following:

NJ Exec Order 26.4b1 14:56 Nursing/Clinical "Note Text: Patient NJ Exec O and NJ Exec Order 26. with times of NJ Exec Order 26.4b1 No s/s [signs and symptoms] of NJ Exec Order 26 or NJ Exec O NJ Exec Order 26.4b1 noted. NJ Exec Order 26.4b1 is NJ Exec O and NJ Exec Order 26 NJ Exec Order 26. Due medications given and NJ Exec Order 26.4b1. Call bell within reach."

NJ Exec Order 26.4b1 14:18 Nursing/Clinical "Note Text: Patient NJ Exec O and NJ Exec Order 26.4 NJ Exec Order 2 . am care and NJ Exec Order 26.4b1 provided by staff with NJ Exec Order 26.4b1. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1]. Due medications give and NJ Exec Order 26.4b1. Patient NJ Exec O NJ Exec Order 26.4b1 and NJ Exec Orde . Patient NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Provided NJ Exec Order care treatment. Call bell within reach."

NJ Exec Order 26.4b1 15:13 Nursing/Clinical "Note Text: Patient NJ Exec O and NJ Exec Order 26.4 NJ Exec Order 2 . Am care and NJ Exec O provided by staff with NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 NJ Exec Order 26 . Due medications give and NJ Exec Order 26.4b1. Patient NJ Exec Order 26.4b1 and NJ Exec Orde NJ Exec Order 26.4b1 Called MD to make aware of patient NJ Exec Order 26 treatment during this shift, no at this

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F 694	Continued From page 17 time. Patient [redacted] Call bell within reach." [redacted] 15:59 Nursing/Clinical "Note Text: Patient received in bed. Patient [redacted] and [redacted] NJ Exec Order 26.4b1. No s/s of [redacted] noted. NJ Exec Order 26.4b1. Patient continues on [redacted] wit [redacted] Encouraged [redacted]. [redacted]. NJ Exec Order 26.4b1. Due medications given and [redacted]. [redacted] Call bell within reach." [redacted] 14:32 Nursing/Clinical "Note Text: Patient received in bed. Patient [redacted] NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 AM care and [redacted] provided by staff with [redacted] NJ Exec Order 26.4b1 and [redacted]. Patient continues with NJ Exec Order 26.4b1 of [redacted]. NJ Exec Order 26.4b1. [redacted] Due medications given and [redacted]. [redacted]. Patient had a [redacted] for this shift. [redacted] and [redacted] with [redacted] in the [redacted] Called MD [redacted] and aware of above. NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted]. Call bell withing reach." [redacted] 21:01 Nursing/Clinical "Note Text: Resident NJ Exec Order 26.4b1 [redacted] This was [redacted] after the residents [redacted] On 03/05/24 at 10:31 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the resident's [redacted]. The [redacted] stated that Resident #70 had a [redacted] and was NJ Exec Order 26.4b1. She stated that	F 694		

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the NJ Exec Order 26.4b1 remained in place because sometimes the resident's NJ Exec Order 26.4b1 would NJ Exec Order 26.4b1 and the physician NJ Exec Order 26.4b1. The surveyor inquired how long should a NJ Exec Order 26.4b1 remain in place, and she stated she was unsure. The surveyor also inquired about the maintenance of the NJ Exec Order 26.4b1, and she stated that the NJ Exec Order 26.4b1 every shift. After surveyor inquiry, the US FOIA (stated she would attempt to remove the NJ Exec Order 26.4b1 since the resident's family was present and he/she was NJ Exec Order 2 during visits.

A review of the Progress Note dated NJ Exec Order 26.4b at 11:37 AM, reflected that the NJ Exec Order 26.4b1 was removed.

On 03/06/24 at 09:17 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the protocol for NJ Exec Order 26.4b1. The U.S. FOIA (b) (6) stated that Resident #70 had a NJ Exec Order 2 and was unsure how long the NJ Exec Order 26.4b1 was in place. She further stated that a NJ Exec Order 2 should not remain at the NJ Exec Order 26.4b1 for more than NJ Exec Order 26.4 and stated that if the NJ Exec Order 26.4b1 was not being used, it should be removed immediately. The surveyor inquired as to why Resident #70's NJ Exec Order 26.4b1 remained in place after the NJ Exec Order 26.4b1 treatment. The U.S. FOIA (b) (6) stated that the resident had NJ Exec Order 26.4b1. She acknowledged that if the resident NJ Exec Order 2 to allow the nurse to NJ Exec Order 2 , it should have been documented. The U.S. FOIA (b) (6) reviewed the Order Summary Report for NJ Exec Order 26.4b1 and acknowledged that there was no order to NJ Exec Ord

On 03/11/24 at 11:55 AM, the surveyor

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interviewed the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) in the presence of U.S. FOIA (b) (6) . The surveyor inquired about the protocol for NJ Exec Order 26.4b1 use. The U.S. FOIA stated that a NJ Exec Order 26.4b1 would be inserted once there was a PO. The NJ Exec Order 26.4b1 would then be NJ Exec Order 26.4b1 and the date and time should be noted on the NJ Exec Order 26.4. The U.S. FOIA further stated that after placement, nursing should have documented at least every shift to include assessment NJ Exec Order 26.4b1 The U.S. FOIA stated that the NJ Exec Order 26.4b1 should be removed after NJ Exec Order 26.4b1 were completed and per PO. The U.S. FOIA stated that if NJ Exec Order 26.4b1 were completed on NJ Exec Order 26. that the NJ Exec Order 26.4b1 should have been removed the same day. In addition, she stated that if a resident NJ Exec Order 26 to allow the nurse to remove the NJ Exec Order 26.4b1 the physician should have been notified and this should have been documented. The U.S. FOIA stated that there should have been a PO for NJ Exec Order 26.4b1 before and after NJ Exec Order 26.4b1 administration and every shift "intermittently," when NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1. She also stated that it was important to remove the NJ Exec Order 26.4b1 after NJ Exec Order 26.4b1 were completed to NJ Exec Order 26.4b1 and the NJ Exec Order 2

The U.S. FOIA provided the surveyor with a policy with a review date of NJ Exec Order 26.4b, from their pharmacy [name redacted] and stated that the facility adopted this policy. The policy was titled NJ Exec Orde and did not include protocol for NJ Exec Order 26.4b1 and discontinuation.

N.J.A.C 8:39-25.2(c)5

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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, record review, and review of facility documentation, it was determined that the facility failed to follow a Physician Orders (PO) for the administration of	F 755	1. Resident #25 was assessed by the primary care physician; vital sign history reviewed; and orders for the medication [redacted] were discontinued. Resident	4/8/24

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F 755	Continued From page 21 NJ Exec Order 26.4b1 for 1 of 1 residents (Resident #25) reviewed for NJ Exec Order 26.4b1 management. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a 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." On 03/04/24 at 10:00 AM, the surveyor observed Resident #25 in the room. The resident was in bed watching television. The resident was NJ Exec O but NJ Exec Order 26.4b1 .	F 755	#25 had NJ Ex Order 26.4b1 related to this practice. 2. All residents have the potential to be affected by this practice. 3. Director of Nursing/Designee immediately conducted an audit of all residents with parameters for midodrine medication administration. There were no untoward findings. Director of Nursing/Designee provided education to nurses with regards to following physician's orders for medication administration, especially for those orders with parameters for administration. 4. Director of Nursing/Designee will perform weekly audits of all residents with parameters for midodrine medication administration for 3 weeks, then monthly for 3 months, with results presented to the Quality Assurance Performance Improvement committee monthly for 3 months.	

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The surveyor reviewed Resident #25's medical records.

A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

A review of the Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's NJ Exec Order 26.4b1 for daily NJ Exec Order 26.4b1 score was [redacted] out of 15, which indicated that the resident's NJ Exec Order 26.4b1

A review of the Order Summary Report (OSR) revealed a PO dated NJ Exec Order 26, for NJ Exec Order 26.4b1 give 1 tablet by mouth three times a day for NJ Exec Order 26.4b1. Do not administer after the evening meal or 4 hours from bedtime to NJ Exec Order 26.4b1

A review of the NJ Exec Order 26.4b1 electronic Medication Administration Record (eMAR) revealed a PO dated NJ Exec Order 26, for NJ Exec Order 26.4b1, give 1 tablet by mouth three times a day. Do not administer after the evening meal or 4 hours from bedtime to NJ Exec Order 26.4b1. NJ Exec Order 26.4b1. Further review of eMAR revealed that the NJ Exec Order 26.4NJ was signed as administered (2) two times when the resident's NJ Exec Order 26.4b1 on the following dates:

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NJ Exec Order 26. at 9 AM NJ Exec Order 26.4b1 and NJ Exec Order 26 at 9 AM NJ Exec Order 26.4b1

A review of the NJ Exec Order 26.4b1 eMAR revealed a PO dated NJ Exec Order 26, for NJ Exec Order 26.4b1, give 1 tablet by mouth three times a day. Do not administer after the evening meal or 4 hours from bedtime to NJ Exec Order 26.4b1. Hold for NJ Exec Order 26.4b1. The eMAR revealed that the NJ Exec Order 26.4b1 was signed as administered (2) two times when the resident's NJ Exec Order 26.4b1 on the following dates: NJ Exec Order 2 at 9 AM NJ Exec Order 26.4b1 and NJ Exec Order at 1 PM NJ Exec Order 26.4b1

On 3/06/24 at 11:45 AM, the U.S. FOIA (b) (6) reviewed Resident #25's PO for NJ Exec Order 26.4b1 in the presence of the surveyor. The U.S. FOIA stated that according to the PO that NJ Exec Order 26.4b1 should be NJ Exec Order 26.4b1 The U.S. FOIA reviewed Resident #25's NJ Exec Order 26.4 and NJ Exec Order 26.4b1 eMARs in the presence of the surveyor. The U.S. FOIA acknowledged that on (4) four occasions, Resident #25 was administered NJ Exec Order 26.4b1 when the resident's NJ Exec Order 26.4b1. She stated that on those occasions that NJ Exec Order 26.4b1 should have been NJ Exec O.

On 3/12/24 at 2:00 PM, the surveyor presented the above concerns to the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)

There was no additional information provided.

A review of the facility's policy for "Administering Medications" dated 5/21/19, which was provided by the US FOIA (b) included the following:
"4. Medications are administered in accordance

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F 755	Continued From page 24 with prescriber orders, including any required time frame." "11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary." NJAC 8:39-11.2 (b), 29.2 (d)	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		4/8/24

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but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 880	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to ensure staff wear the appropriate personal protective equipment (PPE) to prevent the potential spread of NJ Exec Order 26.4b1 [redacted] observed on 1 of 2 units observed, ([redacted]). This deficient practice was evidenced as follows: On 03/05/24 at 10:30 AM, the surveyor observed a U.S. FOIA (b) (6) [redacted]) exiting Resident #342's room. The [redacted] was not wearing goggles, or a face shield. She was wearing glasses that did not have protective shields to protect her eyes from exposure to splashes, sprays, splatter, and respiratory secretions. The surveyor observed a [redacted] sign on the outside of the resident's door. The sign read "Everyone Must: including visitors, doctors, and staff; Clean hands: when entering and exiting, gown, N 95 Respirator (a mask that filters out particulates) Eye Protection (face shield or goggles), gloves." A PPE bin was hanging outside of the door which contained the following items: gown, surgical masks and N 95 masks. The surveyor interviewed the [redacted] who stated that the resident was on NJ Exec Order 26.4b1. The surveyor reviewed the sign with the [redacted] The surveyor inquired why she wasn't wearing eye protection, she stated, "I thought my glasses were enough." A review of Resident #342's "Admission Record" revealed the resident had diagnoses that included but were not limited to: [redacted] and	F 880	1. The Certified Nursing Assistant was immediately educated on appropriate Personal Protective Equipment including eyewear such as a face shield or goggles when entering a NJ Exec Order 26.4b1 room of resident #342. Resident #342 had [redacted] related to this practice. 2. All residents have potential to be affected by this practice. 3. Director of Nursing/Designee immediately provided education to all staff, regarding appropriate use of PPE use for residents on droplet precautions, including the use of goggles or a face shield. 4. Director of Nursing/Designee will conduct weekly audits for 3 weeks and monthly for 3 months to ensure staff are wearing the appropriate PPE, including goggles or a face shield to care for residents in rooms with droplet precautions. Director of Nursing/Designee will present results of the audits to the Quality Assurance Performance Improvement committee monthly for 3 months.	

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NJ Exec Order 26.4b1.

A review of Resident #342's "Order Summary Report" revealed a physician's order for [redacted] dated [redacted].

On 03/11/24 at 11:55 AM, the surveyor interviewed the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) in the presence of the U.S. FOIA (b) (6) . The [redacted] stated that [redacted] required an N 95 mask, goggles, gloves, and gown worn upon entry to the room. She stated that the expectation was that staff follow the signage posted on the resident's door. The [redacted] confirmed that eyeglasses were not adequate eye protection to protect the eyes because particles could get around the glasses. The [redacted] confirmed that the [redacted] observed exiting Resident #342's room was wearing regular eyeglasses. The [redacted] stated that the purpose of wearing the appropriate PPE was to protect residents and staff from [redacted].

On 03/12/24 at 1:44 PM, during a meeting with the survey team, the [redacted] and the [redacted] were made aware of the above findings.

A review of the facility's "Personal Protective Equipment (PPE) Competency Validation" revealed the CNA received a check under the column marked Competent, YES, for "Donning (putting on) PPE" 7. Don Goggles or Face Shield: Place over face and eyes; adjust fit and "Standard Precautions & Transmission Based Precautions" 23. Staff correctly identifies the appropriate PPE for the following scenarios: d. NJ Exec Order 26.4b1 on [redacted].

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F 880	Continued From page 28 A review of the facility's "Employee Education Attendance Record" revealed that the CNA received an in-service for "Content-COVID, Infection Control, PPE," dated [NJ Ex Order 2]. A review of the facility's policy, "Isolation-Categories of Transmission-Based Precautions" with a review date of 01/08/2024, revealed "Droplet Precautions"; 1. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 microns in size] that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures suctioning).; 4. Gloves, gown and goggles are worn if there is a risk of spraying respiratory secretions.	F 880		
F 882 SS=D	NJAC 8:39-19.4(a)(1-2)(c) Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification;	F 882		4/8/24

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F 882	Continued From page 29 §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on facility staff interviews and review of pertinent facility documentation, it was determined that the facility failed to provide a designated qualified Infection Prevention and Control Nurse from [NJ Exec Order 2] until [NJ Exec Order 26]. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020, revealed the following: ii. Required Core Practices for Infection Prevention and Control: Facilities are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; or b. A Physician who has completed an infectious disease fellowship; or c. A healthcare professional licensed and in good	F 882	1. The facility's full time Infection Preventionist date of hire was [NJ Exec Order 26.4b]. The facility will ensure there is always a full time Infection Preventionist employed. The Director of Nursing/Designee will obtain certification. 2. All residents have the potential to be affected by this practice. 3. The Infection Preventionist date of hire was [NJ Exec Order 2]. The Infection Preventionist immediately conducted an audit of all residents falling under the following categories (healthcare associated infections; those with other epidemiologically significant infections requiring transmission-based precautions; and review of the facility's outbreak status (as indicated). 4. The Infection Prevention Nurse will conduct audits of residents with active infection and those utilizing transmission-based precautions weekly for 3 weeks, then monthly for 3 months with results of the audits presented to the Quality Assurance Performance Improvement committee monthly for 3 months.	

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standing by the State of New Jersey, with five (5) or more years of Infection Control experience.

iv. Facilities with 100 or more beds or on-site hemodialysis services must:

1. Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than August 10, 2021.

On 03/04/24 at 10:22 AM, during entrance conference with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), the U.S. FOIA stated the facility had a designated full time Infection Preventionist Nurse (IPN #1).

A review of IPN #1's "Center for Disease Control and Prevention (CDC)" certificate revealed that IPN#1 completed the "Nursing Home Infection Preventionist Training Course" on NJ Exec Order 26.4b1

On 03/05/24 at 10:56 AM, during an interview with IPN #1, she stated that she had been in the Infection Preventionist (IP) position fo NJ Exec Order 26.4b. She stated prior to that she was the US FOIA (b)(6) for the NJ Exec Order 26.4b1.

On 03/07/24 at 09:54 AM, the U.S. FOIA (b) provided the surveyor with a timeline for the IPN. A review of the timeline revealed the following: IPN#2 "left the position on NJ Exec Order 26.4b1 IPN#1 "assumed the role on NJ Exec Order 26.4b1 NJ." At that time, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the U.S. FOIA was performing the IPN duties while IPN#1 transitioned (between IPN#2 leaving and IPN#1 assuming the position) to the IPN role. The U.S. FOIA (b) confirmed that the U.S. FOIA was

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performing both the duties of the [redacted] and the duties of the IPN. She then acknowledged that the IPN should be a designated fulltime position.

On 03/07/24 at 10:20 AM, during an interview with the surveyor, the [redacted] confirmed that the [redacted] did not have an Infection Control certification. She stated that IPN #2 was a consultant during the transition but was not working in the building. She then stated that the facility consulted with an Infectious Disease doctor as needed. The [redacted] again confirmed that there was not a designated full time IPN in the building after [redacted] and until [redacted].

On 03/11/24 at 11:55 AM, the surveyor interviewed the [redacted] and IPN#1, in the presence of the [redacted] The [redacted] confirmed she was performing both [redacted] and IPN duties after IPN#2 left the position on [redacted] The [redacted] confirmed she was not certified in IP. She stated she was overseeing the NJ Exec Order 26.4b1 [redacted] when it started on [redacted].

A review of the facility's policy, "Infection Prevention and Control Program" reviewed on 1/8/24, revealed: "Policy Interpretation and Implementation"; 5. Coordination and Oversight: a. The infection prevention control program is coordinated and overseen by an infection prevention specialist (infection preventionist.)

A review of the facility's policy, "Surveillance for Infections" reviewed on 1/8/24, revealed: "Policy Statement": The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that

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F 882	Continued From page 32 have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. 6. If a communicable disease outbreak is suspected, this information will be communicated to the Charge Nurse and Infection Preventionist immediately. 9. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the Infection Preventionist will collect data to help determine the effectiveness of such measures. A review of the facility's job description for the "Infection Preventionist" revealed: "The primary purpose of this position is to plan, organize, develop, coordinate and direct the facility infection prevention and control program and its activities in accordance with current federal, state, and local standards, guidelines and regulations that given such programs and as directed by the Administrator and the Infection Prevention and Control Committee." NJAC 8:39-19.1 (b), 19.4(d) (e)	F 882		
F 922 SS=F	Procedures to Ensure Water Availability CFR(s): 483.90(i)(1) The facility must-- §483.90(i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and pertinent facilty documents it was determined that the facility failed to maintain the designated emergency supply of water needed for residents	F 922	1. The facility immediately ordered and received a delivery of gallons of water to ensure the requirement of one gallon of water per day per resident was met and	4/8/24

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F 922	Continued From page 33 in the event of a loss of normal water supply. This deficient practice was evidenced by the following: On 3/04/24 at 10:22 AM, the surveyor conducted an entrance conference with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)). The facility was licensed for 120 beds and the facility census was 86 (the number of residents who currently resided at the facility). On 3/04/24 at 9:30 AM, the surveyor conducted a kitchen tour with the U.S. FOIA (b) (6)), in the presence of a second surveyor. The U.S. FOIA showed the emergency water supply located in the salon separate from the kitchen. The U.S. FOIA counted the cases in the surveyors' presence and stated there were 22 cases, each had six one-gallon bottles (132 gallons). He further stated that it was enough emergency water for three days and that the requirement was one gallon per person per day for three days (258 gallons). On 3/07/24 at 9:00 AM, the surveyor observed the emergency food supply which was in a closet in the staff break room with the U.S. FOIA and a second surveyor. At that time, the surveyors did not observe cases of water in the closet or the break room. On 3/11/24 at 2:32 PM, the surveyor interviewed the U.S. FOIA (b) in the presence of a second surveyor. At that time, she acknowledged that 22 cases of water were "not enough." On 3/12/24 at 11:36 AM, the U.S. FOIA (b) informed the surveyor that there were additional cases of water in the staff breakroom.	F 922	exceeded the requirement. No residents were negatively impacted by this practice. 2. All residents have the potential to be affected by this practice. 3. Administrator provided education to the US FOIA (b)(6) on how to calculate the designated emergency supply of water needed for residents in the event of a loss of normal water supply. Food service director immediately ordered and received water for the emergency supply. 4. Food Service Director/Designee will perform weekly audits of the emergency water supply on an on-going basis. The Food Service Director will present the results of the audits to the Administrator weekly for 4 weeks and to the Quality Assurance Performance Improvement committee monthly for 3 months.	

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On 3/12/24 at 11:46 AM, the surveyor observed the water in the staff breakroom with the U.S. FOIA and the U.S. FOIA (b) (The U.S. FOIA stated there was 10 cases of water, and there were 6 gallons of water per case which totaled 60 gallons.

On 3/12/24 at 1:12 PM, the U.S. FOIA informed the surveyor that he miscounted the number of cases of water that was stored in the salon during the initial tour.

On 3/13/24 at 10:06 AM, the surveyor interviewed the U.S. FOIA in the presence of a second surveyor. He stated that on the initial tour he miscounted the number of cases of emergency water in stock. He stated initially he counted 22 cases but rather it was approximately 36 cases (216 gallons). The U.S. FOIA stated that water was ordered the second day of survey which now equaled 82 cases. This included the emergency water now stored in the staff breakroom. He acknowledged that the water in the staff breakroom was not there on the initial tour and that the additional water was ordered by the U.S. FOIA (b) (6)

On 3/13/24 at 10:47 AM, the surveyor interviewed the U.S. FO in the presence of the survey team. He stated that he had not ordered emergency water and that it was the U.S. FOIA (b) responsibility. He did state that the local water company dropped off water to the facility on 3/7/24 or 3/8/24 due to a possible local water interruption, which did not occur. He stated he did not have any documentation as to the amount of water that the water company had provided but estimated the amount to have been "probably a few hundred gallons."

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Review of the facility's undated "Emergency Supply Quantity Converter," included a three-day supply of water for the facility to include census and staff should be 70 cases, each of which had six - one-gallon bottles per case.

Review of the facility' undated policy "Disaster Feeding Plan," included "If uncontaminated water ... not available ... the Food Service Department will use its three to seven day ...fluid supply."

Review of the facility policy "Dietary Considerations for Residents" dated 1/2011, included that the facility has planned for the dietary needs of the residents in the case of an emergency situation. It included emergency water which should be located in a specific location and the amount based on the number of residents, employees and visitors during a crisis or disaster situation to last for "seven day's." It also included to take into consideration minimal resource availability.

The facility provided a contract with a food service vendor dated 1/2/23, which included "With proper notification, [name redacted] will maintain an inventory of bottled water in a variety of pack sizes to sufficiently address this potential emergency need." It also included "We will do our best to meet your needs on a timely basis." In addition, the contract included that the facility should maintain an estimated need of 64 ounces of water per day for each resident, employee and/or visitors. "A three-day supply is recommended should such a need arise." It also included, "Depending on the severity of the storm and impacts to our fleet, buildings and potentially employees, we will do our best to recover as

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(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 922	Continued From page 36 quickly as possible following any weather event." NJAC 8:39-31.6 (n)	F 922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061312	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility 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 interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the State of New Jersey for 13 of 14-day shifts reviewed. This deficient practice was evidenced by the following: 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	S 560	1. The facility leadership team met, along with corporate input, to identify staffing challenges and opportunities to fulfill a robust staffing pattern. This is on an ongoing basis. Recruitment efforts include: monthly recruitment and retention meetings, staff appreciation programs, Certified Nursing Assistant training facility at another sister facility, Refer a Friend bonus, sign on bonus, online advertisements, weekend and offsite interviews and use of agency staff to supplement. The facility also uses nurse management and occupational therapists to assist with direct care as directed by the Director of Nursing. 2. All residents have the potential to be	4/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/04/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061312	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" completed by the facility for the 2 weeks from 02/18/2024 to 03/02/2024 revealed that the facility was deficient in CNA staffing for residents on 13 of 14-day shifts as follows: -02/18/24 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -02/19/24 had 7 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/21/24 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/22/24 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/23/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -02/24/24 had 7 CNAs for 95 residents on the day shift, required at least 12 CNAs. -02/25/24 had 7 CNAs for 88 residents on the day shift, required at least 11 CNAs.	S 560	affected by this practice. 3. The facility reviewed rates and is competitive, often exceeding competitors for licensed and certified staff. The facility continues to use online recruitment and job fairs with immediate interviews and on the spot offers pending criminal background checks and other requirements. The facility will use agency staff as needed to meet staffing needs. 4. The Director of Nursing/Designee meets with the Staffing Coordinator daily to review facility census, needs and call outs, if any. The DON/Designee will monitor call outs and staffing ratios weekly until the requirement is met. The results of the audit will be forwarded to the Administrator. The results will be presented at the Quality Assurance Performance Improvement committee meeting monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061312	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 -02/26/24 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs. -02/27/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -02/28/24 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs. -02/29/24 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. -03/01/24 had 8 CNAs for 87 residents on the day shift, required at least 11 CNAs. -03/02/24 had 8 CNAs for 85 residents on the day shift, required at least 11 CNAs. During an interview with the surveyor on 03/11/24 at 01:12 PM, the Staffing Coordinator (SC) expressed knowledge regarding the New Jersey state mandated Certified Nursing Assistant (CNA) to resident ratios. At this time, she stated that they (the facility) were not always meeting them.	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
315092 Y1	A. Building B. Wing Y2	6/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 04/08/2024	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 04/08/2024	ID Prefix F0882 Reg. # 483.80(b)(1)-(4) LSC	Correction Completed 04/08/2024
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	
3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315092 Y1	A. Building B. Wing Y2	6/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0609	Correction	ID Prefix	F0686	Correction	ID Prefix	F0692	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.25(b)(1)(i)(ii)	Completed	Reg. #	483.25(g)(1)-(3)	Completed
LSC		04/08/2024	LSC		04/08/2024	LSC		04/08/2024
ID Prefix	F0694	Correction	ID Prefix	F0755	Correction	ID Prefix	F0880	Correction
Reg. #	483.25(h)	Completed	Reg. #	483.45(a)(b)(1)-(3)	Completed	Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed
LSC		04/08/2024	LSC		04/08/2024	LSC		04/08/2024
ID Prefix	F0882	Correction	ID Prefix	F0922	Correction	ID Prefix		Correction
Reg. #	483.80(b)(1)-(4)	Completed	Reg. #	483.90(i)(1)	Completed	Reg. #		Completed
LSC		04/08/2024	LSC		04/08/2024	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	
3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061312 (Y1)	A. Building B. Wing (Y2)	6/12/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/08/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO	

 EVENT ID: 6SEN12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	**188 HIGHWAY 34** **HOLMDEL, NJ 07733**

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E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015		4/8/24

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

Electronically Signed | 04/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 015	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based upon observations, staff interviews and review of pertinent facility documents, it was determined that the facility failed to a.) have an emergency menu readily available and b.) have all of the menu items in stock, in accordance with facility policy and the emergency preparedness plan. The deficient practice was evidenced by the following: On 3/04/24 at 10:22 AM, the surveyor conducted an entrance conference with the U.S. FOIA (b) (6) [redacted]) and the U.S. FOIA (b) (6)). The facility was	E 015	1. In accordance with the "Emergency Supply Quantity Converter" form for NJ, the facility immediately ordered and stocked the emergency food storage area to ensure three days food is on hand. The correct emergency supply menu is now in use. No residents were adversely affected by this practice. 2. All residents have the potential to be affected by this practice. 3. Administrator educated the US FOIA (b) ([redacted] on the correct menu to be used for emergency supply. The Food Service Director ordered and stocked the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	**188 HIGHWAY 34** **HOLMDEL, NJ 07733**

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E 015	Continued From page 2 licensed for 120 beds and the facility census was 86 (the number of residents who currently resided at the facility). On 3/04/24 at 9:30 AM, the surveyor conducted a kitchen tour with the U.S. FOIA (b) (6)) in the presence of a second surveyor. The surveyor observed emergency food stored in a closet in the staff breakroom. The U.S. FOIA stated that the food supply should be enough for three days. He stated, "We use whatever is here [emergency food supply] and what is in the kitchen." The surveyor observed an "Emergency Supply Quantity Converter" form posted on the closet door which included the food items and quantities that should be available in an emergency. It also included that the facility "Must have 3 days food on hand." On 3/07/24 at 9:00 AM, the surveyor reviewed the emergency food storage verse the items and quantities listed on the "Emergency Supply Quantity Converter," in the presence of the U.S. FOIA and a second surveyor. There was no evidence of canned Beef Stew, Mayonnaise or Non-Fat Skim Milk Powder. On 3/07/24 at 9:50AM, the surveyor interviewed the U.S. FOIA in the presence of a second surveyor. He stated that he was responsible to ensure the emergency food supply was intact. On 3/07/24 at 1:20 PM, the surveyor interviewed the (b) (9) in the presence of a second surveyor. He stated that the "Emergency Supply Quantity Converter" form included the food items and quantities that should be available in an emergency, in addition to what they have "on hand." He stated that the emergency food supply	E 015	emergency food storage area to ensure three days food on hand. 4. Food Service Director/Designee will per form weekly audits of the emergency food supply x 4 weeks then monthly x 3 months with the results of the audits presented to the Administrator and the QAPI committee monthly x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING **01** B. WING _____	**03/13/2024**

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E 015	Continued From page 3 should sustain residents and staff. The [U.S. FOIA] stated that he would find out each day of an emergency how many staff were in the building and approximated it would be 100 staff. He stated that he had never seen an emergency menu and that he would create a menu if there was an emergency. He reviewed the emergency menu that was in the facility's Emergency Preparedness book provided to the surveyor by the [U.S. FOIA (b)(] The [U.S. FOIA] acknowledged that he was unaware of that menu, and that the items on the menu were inconsistent with the items on the "Emergency Supply Quantity Converter" list. He stated that he was unaware of the Emergency Preparedness Program, was not involved in the process and had no knowledge of how to access the information. The [U.S. FOIA] stated that their vendor would prioritize the facility to provide emergency food if needed but could not speak to how that was guaranteed. The [U.S. FOIA] stated that the purpose of the emergency menu and food supply was to ensure that the facility could feed and sustain the residents during an emergency. On 3/11/24 at 2:32 PM, the surveyor interviewed the [U.S. FOIA (b)] in the presence of a second surveyor. She stated that there should have been a three-day food supply, a minimum of three days of canned food stored in a separate location from the regular menu items. She also stated that the FSD should have been part of the Emergency Preparedness Plan. Review of the undated "Emergency Supply Quantity Converter," form included that NJ "Must have 3 days food on hand." It also included that the facility should have had a case of Beef Stew, a half case of Mayonnaise and a half case of Nonfat skim milk powder.	E 015		

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E 015	Continued From page 4 Review of the undated facility policy "Disaster Feeding Plan," included "If ... gas is not available, the Food Service Department will use its three day ... food and fluid supply for regular and therapeutic diets. The food will include canned items and dry goods ..." Review of the facility policy "Dietary Considerations for Residents" dated 1/2011, included the following: - "This facility has planned for the dietary needs of its residents in the case of an emergency situation." - "Emergency dietary planning for residents and staff includes the consideration of such situations as ... long-term sheltering in place without the support of outside resources (food, water and food service supplies)." - "A disaster menu shall be developed, and this emergency menu shall be updated regularly based on the needs of the residents." - "The menu shall be created based on the following considerations: a. Vulnerabilities that may exist if the crisis or disaster situation occurs near the end of a delivery cycle: and b. Identification of minimal resources needed to provide food and water service (gas, electricity, refrigeration, lighting in kitchen, etc ...). - "A minimum amount of food and water ... shall be maintained at the facility in a specific location. This minimal amount of food and water should be determined based on the number of residents, employees and visitors during a crisis	E 015		

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(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 015	Continued From page 5 or disaster situation." The facility provided a contract with a food service vendor dated 1/2/23, which included "With proper notification, [name redacted] will maintain an inventory of bottled water in a variety of pack sizes to sufficiently address this potential emergency need." It also included "We will do our best to meet your needs on a timely basis." In addition, the contract included that "We suggest storing a minimum of a 3-day supply of non-perishable food on site." It also included, "Depending on the severity of the storm and impacts to our fleet, buildings and potentially employees, we will do our best to recover as quickly as possible following any weather event." NJAC 8:39-31.6(n)	E 015		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by CertiSurv, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/05/2024 and CareOne At Holmdel 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 Occupancies. CareOne At Holmdel is a one-story Type III Protected building that was built in 1967. The facility is divided in to seven smoke zones.	K 000		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101	K 363		4/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	**188 HIGHWAY 34** **HOLMDEL, NJ 07733**

(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 363	Continued From page 6 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	**188 HIGHWAY 34** **HOLMDEL, NJ 07733**

(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 363	Continued From page 7 Based on observation and interview, the facility failed to maintain rated smoke doors to resist the passage of smoke and/or fire as required by the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, section 19.3.6.3. The deficient practice had the potential to affect 1 of 7 smoke compartments. Findings included: An observation on 03/05/2024 at 10:50 AM revealed the corridor door to the janitor's closet in the service corridor was damaged to the core, negating the assembly's ability to resist the passage of smoke. In an interview at the time, the U.S. FOIA (b) (6) [redacted] confirmed the observation and stated the facility had an inspection program to inspect smoke doors in the facility, but the inspections did not include the janitor's closet in the service corridor.	K 363	1. The facility replaced the door to the janitor closet immediately. 2. All residents have the potential to be affected by this practice. 3. The door was immediately purchased and replaced on 3/5/24. The Maintenance Director performed an audit of all doors and all others were in good repair. The janitor closets are now included in the door inspections. 4. Maintenance Director/Designee will perform weekly audits of the doors to ensure they are in good repair for four weeks, then monthly x 3 months.	
K 372 SS=E	New Jersey Administrative Code § 8:39-31.2 (e) Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour 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.	K 372		4/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	**188 HIGHWAY 34** **HOLMDEL, NJ 07733**

(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 372	Continued From page 8 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 maintain rated smoke barriers to resist the passage of smoke and/or fire for a minimum of 30-minutes as required by the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, section 8.35. This deficient practice had the potential to affect 5 of 7 smoke compartments. Findings included: 1. An observation on 03/05/2024 at 11:10 AM revealed the wall surfaces within the janitor's closet in the service corridor were missing pieces of drywall, negating the assembly's ability to resist the passage of smoke. The condition observed affected one smoke compartment. 2. An observation on 03/05/2024 at 11:20 AM revealed the smoke barrier above a suspended ceiling assembly located in the North Wing near the U.S. FOIA (b) (6)) office had unsealed penetrations to permit the installation of communication cables and electrical wiring, negating the assembly's ability to resist the passage of smoke. The condition observed affected two smoke compartments. 3. An observation on 03/05/2024 at 11:38 AM revealed the smoke barrier above a suspended ceiling assembly located in the South Wing, near Room NJ EX had unsealed penetrations to permit the installation of communication cables and electrical wiring, negating the assembly's ability to	K 372	1. The holes in the closet were repaired on 3/5/24 with endothermic sealant. No residents were affected. 2. All residents have the potential to be affected by this practice. 3. The Maintenance Director had all supplies including endothermic sealant and corrected the penetrations on 3/5/24. An audit was conducted and no other findings were located. A formal inspection of of smoke barriers is now in place and will be documented. 4.The Maintenance Director/Designee will audit the facility for penetrations weekly x 4 weeks, monthly x 3 months with results presented at the QAPI meeting monthly x 3 month for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING **01** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	**188 HIGHWAY 34** **HOLMDEL, NJ 07733**

(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 372	Continued From page 9 resist the passage of smoke. The condition observed affected two smoke compartments. In interviews at the times of observations, the [redacted] confirmed the observations and stated the facility did not have a formal inspection program to inspect smoke barriers in the facility, but asserted they were checked periodically. However, he stated he did not document the periodic inspections. New Jersey Administrative Code § 8:39-31.2 (e)	K 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING **01** B. WING _____	R **05/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	**188 HIGHWAY 34** **HOLMDEL, NJ 07733**

(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	{E 000}		
	Corrected			
{K 000}	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted and CareOne At Holmdel 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 Occupancies, specifically K372. CareOne At Holmdel is a one-story Type III Protected building that was built in 1967. The facility is divided in to seven smoke zones.	{K 000}		
{K 372} SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour 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 review of the facility's Plan of Correction on 05/16/2024, the facility failed to	{K 372}	1. The unsealed penetrations of the wall were repaired on 3/5/24. The product	5/17/24

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

Electronically Signed | 05/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING **01** B. WING _____	R **05/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	**188 HIGHWAY 34** **HOLMDEL, NJ 07733**

(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 372}	Continued From page 1 maintain rated smoke barriers to resist the passage of smoke and/or fire for a minimum of 30-minutes as required by the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, section 8.35. This deficient practice had the potential to affect 5 of 7 smoke compartments. The facility failed to provide evidence of the correction of the following concerns that were cited during the 03/13/2024 Recertification survey: 1. The wall surfaces within the janitor's closet in the service corridor were missing pieces of drywall, negating the assembly's ability to resist the passage of smoke. The condition observed affected one smoke compartment. 2. The smoke barrier above a suspended ceiling assembly located in the North Wing near the U.S. FOIA (b) (6)) office had unsealed penetrations to permit the installation of communication cables and electrical wiring, negating the assembly's ability to resist the passage of smoke. The condition observed affected two smoke compartments. 3. The smoke barrier above a suspended ceiling assembly located in the South Wing, near Room 41, had unsealed penetrations to permit the installation of communication cables and electrical wiring, negating the assembly's ability to resist the passage of smoke. The condition observed affected two smoke compartments.	{K 372}	used to seal the penetrations had endothermic properties. No residents were affected. 2. All residents have the potential to be affected by this practice. 3. The Maintenance Director corrected the penetrations on 3/5/24. An audit was conducted and no other findings were located. 4. The Maintenance Director/Designee will audit the facility for penetrations weekly x 4 weeks, monthly x 3 months with results presented at the Quality Assurance Performance Improvement meeting monthly x 3 months for compliance. Completion Date: 5/17/24	

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)
315092	A. Building B. Wing	5/16/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

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 E0015 Reg. # 483.73(b)(1) LSC	Correction Completed 04/08/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315092	A. Building 01 - MAIN BUILDING 01 B. Wing	5/16/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

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 K0363	Correction Completed 04/08/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315092	A. Building 01 - MAIN BUILDING 01 B. Wing	7/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

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 K0372	Correction Completed 05/17/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO