STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315087	A. BUILDING _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MIDDLETOWN	**1040 STATE ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716**

(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 #: NJ168416 & NJ181485 Survey Dates: 12/24/24 Census: 79 Sample Size: 6 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 #: 168416	F 610	1) How the corrective action will be	1/24/25

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

Electronically Signed | 01/23/2025

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F 610	Continued From page 1 Based on interview and review of facility documents it was determined that the facility failed to conduct a thorough investigation to address an allegation of [NJ Ex Order 2] according to their Reporting and Investigating Policy. This deficient practice was identified for 1 of 6 residents (Resident #2), and was evidenced by the following: Resident #2 [NJ Ex Order 26.4(b)(1)] at facility, on 12/23/24, a closed record review of Resident #2's medical record was completed. The surveyor reviewed Resident #2's clinical record. The "Admission Record" indicated that Resident #2 was admitted to the facility with diagnoses which included but not limited to: [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)] ([NJ Ex Order 26.4(b)(1)]), [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)(1)]. The Minimum Data Set (MDS) an assessment tool dated [NJ Ex Order 26.4(b)(1)], revealed that Resident #2 required [NJ Ex Order 26.4(b)(1)] with ADLs and [NJ Ex Order 26.4(b)(1)] Resident #2 scored [NJ] on the Brief Interview for Mental Status (BIMS) which indicated that Resident #2 had [NJ Ex Order 26.4(b)(1)] On 12/23/24, the [U.S. FOIA (b) (6)] provided a copy of the Reportable Event Record dated [NJ Ex Order 26.4(b)], and a copy of the incident report for [NJ Ex Orde] that occurred on [NJ Ex Order 26.4(b)]	F 610	accomplished for those residents found to have been affected by the deficient practice. 1) Resident #2 [NJ Ex Order 26.4(b)(1)] at the facility. The Administrator immediately conducted an audit of all reportable events in 2024 involving allegations of [NJ Ex Order 2] to ensure the allegation was thoroughly investigated. There were no untoward 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. 2)All residents who report an allegation of abuse have the potential to be affected by this practice. 3)What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 3) On 12/26/2024 the facility Administrator (LNHA) conducted in-service education with the [U.S. FOIA (b) (6)], the [U.S. FOIA (b) (6)] and Unit Managers (UM) on the policy titled, Abuse, Neglect, Exploitation or Misappropriation □ Reporting and Investigating. Education included but was not limited to all reports of resident abuse (including injuries of unknown origin), neglect, exploitation or theft / misappropriation of resident property are reported to local, state and federal agencies& and thoroughly investigated by	

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F 610	Continued From page 2 A review of the progress note dated NJ Ex Order 26.4(b at 12:37 revealed Resident #2 was NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26.4(b)(1) with their NJ Ex Order 26.4(b)(1) their wheelchair. The progress note stated that, Resident #2 told staff that they were trying NJ Ex Order 2 wheelchair and NJ Ex Order 26.4(b)(1). According to a progress note dated NJ Ex Order 26.4(b)(at 10:45, the resident had a NJ Exec Order 26.4b1 related to complaints of NJ Ex Order 26.4 after NJ Ex Order 26.4(b)(1) The nurse notified the doctor, and the resident was sent out to NJ Exec Order 26.4b1 using non-emergent transfer. A review of the progress note dated NJ Ex Order 26.4(b at 21:19 revealed that when Resident #2's nurse called hospital for an update on the resident's status, the NJ Ex Order 26.4 staff stated that resident informed them that they NJ Ex Order 26.4(b)(1), an investigation was completed by NJ Ex Order 26.4(b)(1) Social Workers, and the NJ Exec Order 26.4b1 was NJ Exec Order by Resident #2's family member. The resident was then discharged from NJ Ex Order 26.4(b)(1) and sent back to the facility. No further documentation for the investigation was provided. During an interview with Surveyors on 12/24/24 at 10:14 a.m., the U.S. FOIA (b) (6)), stated that NJ Exec Order 26.4b1 of NJ Ex Order 2 were handled in collaboration with the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)). She stated that she would talk with the resident that made that NJ Exec Order 26.4b1 of NJ Ex Order 2 and collect their statement. She stated that she does not speak with other residents. She stated she was not hired during the time of Resident #2's NJ Ex Order 2 NJ Exec Order 26.4b1	F 610	facility management. On 12/26/2024 the FE/ADON conducted in-service education to line staff on the procedure for reporting allegations of abuse. On 12/26/2024 the Director Of Social Services conducted an audit of all grievances from 2024 to ensure all grievances were investigated and there were no allegations of abuse or mistreatment. There were no untoward findings. The LNHA is the designated individual at the Facility to investigate all allegations of Abuse, Neglect, Exploitation or Misappropriation. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. 4) The Director of Social Services or designee will conduct audits of all reported resident concerns or grievances to ensure allegations are immediately reported to the Administrator for a full and thorough investigation. Audits will be conducted daily x 5 days, then weekly x 4 weeks, then monthly x 3 months. The results of the audits will be provided	

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F 610	Continued From page 3 During an interview with Surveyors on 12/24/24 at 2:52 p.m., the U.S. FOIA (b) (6) stated that after an NJ Exec Order 26.4b of NJ Ex Order 26 it is their policy to separate the NJ Exec Order and the staff member. The staff member would be suspended pending investigation, NJ Ex Order 2 would be called, NJ Ex Or assessments would be completed, witness statements would be collected from other alert and oriented residents. U.S. FOIA (b) (6) stated he became aware of the allegation of NJ Ex Order 26 after he gathered the documentation for Resident #2. The administrator stated he was aware that the provided investigation was not complete. A review of the facility's policy presented by the Administrator, titled, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating," with a revision date of September 2022, included but was not limited to the following: under the heading for "Policy Statement," it states, "All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported." Under the heading for "Investigating Allegations," the policy states," 7. The individual conducting the investigation as a minimum: ...d. interviews the person(s) reporting the incident; e. interview any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative ...h. interviews staff members (on all shifts) who have contact with the resident during the period of the alleged incident ...l. documents the investigation completely and thoroughly."	F 610	monthly x 3 months, then quarterly x 3 quarters to the facility□s Administrator and the Quality Assurance Performance Improvement (QAPI) Committee for review and comment. The QAPI committee meets on a monthly basis. The QAPI Committee will review and determine the need for further audits.	

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F 610	Continued From page 4 N.J.A.C: 8:39-4.1 (a) 5	F 610		
F 655 SS=G	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655		1/24/25

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F 655	Continued From page 5 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00181485 Based on observation, interview, and record review and review of other facility documentation on 12/23/24 and 12/24/24, it was determined that the facility failed to develop and implement baseline care plan (BCP) within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident. This practice was identified for 1 out of 6 residents (Resident #1) reviewed. This deficient practice was evidenced by the following: Resident #1 was not in the facility at the time of the survey. A closed medical record review was conducted. The surveyor reviewed the Admission Record which revealed that Resident #1 was admitted with the diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1). Review of the Admission Minimum Data Set (MDS) an assessment tool used to facilitate the	F 655	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1)Resident #1 NJ Ex Order 26.4(b)(1) at the facility. On 1/22/2024 the Assistant Director of Nursing /FE (ADON/FE) completed an audit of all new admissions in the last 30 days to ensure a baseline care plan was initiated within 48 hours of admission and included person-centered care planning. There were no untoward findings. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. 2) All residents have the potential to be affected by this practice. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 3) On 12/27/2024 the Assistant Director of Nursing/Facility Educator (ADON/FE)	

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F 655	Continued From page 6 management of care, dated [redacted], indicated that Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 indicating an [redacted]. Further review of the MDS dated [redacted] revealed that the resident scored a [redacted] on the [redacted] Interview which indicated [redacted]. A closed record review on [redacted] indicated no [redacted] was initiated for [redacted] On 12/23/24, at 12:50 P.M., during an interview with the [redacted]), the [redacted] stated that it was her responsibility to assess section [redacted] also known as [redacted], of the MDS which reflected the [redacted] score of the resident. The [redacted] stated that she referred the resident for [redacted] services. The [redacted] was unable to provide documentation of the referral or that services were provided. The [redacted] did not provide a [redacted] that reflected an intervention for mood. On 12/24/24, at 10:14 A.M., during a follow-up interview with the [redacted] she stated that a [redacted] score of [redacted] was [redacted] She stated, "A score of [redacted] notes signs and symptoms of [redacted] The [redacted] stated that she became aware that no documentation existed that the [redacted] made any attempts to see the resident after surveyor interview. The [redacted] further stated a [redacted] care plan should have been initiated to address the [redacted] score of [redacted] On 12/24/24, at 2:52 P.M., during an interview with the [redacted] and [redacted], the [redacted] stated, "If a screening is completed and a concern is identified then the resident is followed up with a referral and a care plan." He also stated that "There should be a formal record	F 655	immediately provided in-service education to all nurses including shift supervisors and unit managers on the procedure for developing a baseline care plan within 48 hours of admission. The baseline care plan must include the minimum healthcare information necessary to properly care for a resident including, but not limited to a) initial goals based on the physician orders; b) physicians orders; c) dietary orders; d) therapy orders; e)social services; f) PASARR recommendation, if applicable. On 1/22/2025 The ADON/FE provided in-service education to the [redacted] and [redacted] regarding the process of developing a baseline careplan within 48 hours of admission. The baseline careplan must include the minimum healthcare information necessary to properly care for a resident. The Unit Manager or designee will review all new admission records daily to ensure a baseline care plan has been initiated within 48 hours of admission. This review will continue an on-going basis. On 1/22/2025 the ADON/FE provided in-service education to the [redacted] the [redacted] and [redacted] on the importance of a personalized care plan for depression as well as psychology consult for any resident with a PHQ9 over the score of 10, which notes □signs and symptoms of depression.□	

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F 655	Continued From page 7 of all referrals made to the U.S. FOIA (b) (6) and that all attempts by the U.S. FOIA (b) (6) be documented." Review of the facility's "Director of Social Services" job description, revised in November 2010, revealed that the DSS, " ...Develop a written plan of care for each resident that identifies the social problems/needs of the resident and the goals to be accomplished for each problem/need identified ..." Review of the facility's "Care Plans-Baseline" policy, revised in March 2022, reflected that a "Baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission." The policy further revealed under the "Policy Interpretation and Implementation" section that a baseline care plan, " ...must include the minimum healthcare information necessary to properly care for the resident, including but not limited to the following ...d. therapy services; e. Social Services ..." NJAC 8:39-11.2(d)	F 655	The Director of Social Services and ADON/FE have created a formal record for tracking all referrals made to a psychologist. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. 4) The Director of Nursing or designee will conduct audits of 100% of newly admitted residents to ensure a baseline care plan has been implemented within 48 hours of admission. The audits will continue daily on an on-going basis to ensure compliance. The results of the audits will be reported to the Administrator and the Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 months, then quarterly x 3 quarters. The Director of Social Services or designee will conduct audits of all residents who have referrals for psychology consults. The audits will be conducted weekly x 3 weeks, then monthly x 3 months, then quarterly x 3 quarters. The results of the audits will be provided to the Administrator and QAPI Committee monthly x 3 months then quarterly x 3	

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F 655	Continued From page 8	F 655	quarters. The QAPI Committee will review and determine need for further audits. The QAPI Committee meets on a monthly basis.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00181485 Based on observation, interview, and review of medical records and other pertinent facility documentation on 12/23/24 and 12/24/24, it was determined that the facility failed to maintain a safe enviornment, keep a resident free from hazards, and provide the necessary monitoring and supervision for a resident who was found to have NJ Ex Order 26.4(b)(1) . This deficient practice was identified for 1 of 6 residents (Resident #1) reviewed and was evidenced by the following: Resident #1 was NJ Ex Order 26.4(b)(1) the facility at the time of the survey. A closed record review was conducted.	F 689	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1) Resident #1 NJ Ex Order 26.4(b)(1) at the facility. The Assistant Director of Nursing/Facility Educator (ADON/FE) immediately conducted an audit of all residents who had physician□s orders for a referral for psychology assessment to ensure the consult was completed. There were no untoward findings 2) How the facility will identify other residents having the potential to be	1/24/25

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F 689	Continued From page 9 A review of the Admission Record revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) . Review of the Admission Minimum Data Set (MDS) an assessment tool used to facilitate the management of care dated NJ Ex Order 26.4(b) indicated that Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 indicating an NJ Ex Order 26.4(b)(1) . Further review of the MDS revealed that Resident #1 scored a NJ Ex on the NJ Ex Order 26.4(b)(1) Interview (NJ Ex Order indicating that the resident was NJ Ex Order 26.4(b)(1) . Further review of the medical record did not indicate that a NJ Ex Order 26.4(b)(1) assessment was completed. The surveyor reviewed the Incident Report, dated NJ Ex Order 26.4 , which revealed that the NJ Ex Order 26.4(b)(1) had been NJ Ex Order 26.4(b)(1) and was NJ Ex Order 26.4(b)(1) . The report further revealed that the resident stated that, " ... [his/her] efforts of NJ Ex Order 26.4(b)(were NJ Ex Order 26.4(b)(1) ..." A note under the " NJ Ex Order 26 Status" section revealed, NJ Ex Order 26.4(b)(1) ." On 12/30/24, at 11:06 A.M., the surveyor interviewed the U.S. FOIA (b) (6)) who responded to the incident via telephone. The	F 689	affected by the same deficient practice 2) All residents with referrals for psychology consults have the potential to be affected by this practice. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 3) On 12/27/2024 The Assistant Director of Nursing/Facility Educator (ADON/FE) and the facility Administrator conducted in-service education to the psychology provider on the process for psychology consults. The practitioner has been advised of the implementation of a tracking form for all psych referrals to ensure compliance. The ADON/FE educated the psychology provider on the process of documenting refusal of referrals in the electronic medical record. The ADON/FE provided in-service education to all nurses on the implementation of a tracking form for all psychology referrals to ensure compliance. The ADON/FE provided in-service education to all staff on the process of keeping residents free from hazards and providing the necessary monitoring and supervision for those individuals who may have signs or symptoms of depression. 4) How the facility will monitor its	

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F 689	Continued From page 10 U.S. FOIA stated that she was regularly assigned to the resident and that on the morning of the incident she reported to the floor and noted that the resident's call bell was ringing. She stated that she could not recall how long it had been ringing. The U.S. FOIA stated that she responded to the room and called out the resident's name. She further stated that the resident did not respond, and she saw that the resident was lying in bed underneath the blanket. The U.S. FOIA stated she NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) when she saw that the NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and was NJ Ex Order 26.4(b)(1) . The U.S. FOIA stated that she NJ Ex Order 26.4(b)(1) as she began to NJ Ex Order 26.4(b)(1). She further stated that the resident was NJ Ex Order 26.4(b)(1) but that once the nurse arrived, they NJ Ex Order 26.4(b)(1) resident who then, NJ Ex Order 26.4(b)(1) The U.S. FOIA stated that once NJ Ex Order 26.4(was NJ Ex Order 26.4(b)(1) from the resident's NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4("[He/She] had NJ Ex Order 26.4 ." On 12/30/24, at 11:25 A.M., the surveyor reached the U.S. FOIA (b) (6) via telephone. The U.S. FOIA (b) (6) stated that he was contacted on the morning of the incident by the U.S. FOIA (b) (6)). He stated that he and the U.S. FOIA collaborated to ensure that all aspects of the investigation were initiated and completed. The U.S. FOIA (b) (6) stated that the NJ Ex Order 26.4(had been NJ Ex Order 26.4(b)(1) from the wall and that this can sometimes happen inadvertently by the raising or lowering of the bed. The U.S. FOIA (b) (6) further stated that the NJ Ex Order 26.4(b)(1) involved in the incident did not require NJ Ex Order 2 it was NJ Ex Order 26.4(The U.S. FOIA (b) (6) stated he could not recall if the resident NJ Ex Order 26.4(b)(1)	F 689	corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. 4)The Director of Nursing or designee will conduct audits of the psychology referral book to ensure all referrals for psychology or psychiatry consults are competed timely and documented. Audits will be conducted daily x 5 days, then weekly x 4 weeks then monthly x 3 months. The results of all audits will be provided monthly x 3 months to the facility□s Administrator and the Quality Assurance Performance Improvement (QAPI) Committee for review and comment. The QAPI committee meets on a monthly basis. The QAPI Committee will review and determine the need for further audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315087	A. BUILDING _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MIDDLETOWN	1040 STATE ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716

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F 689	Continued From page 11 NJ Ex Order 26. as a result of the incident, however, if there were any, "It would be noted on the incident report." N.J.A.C. 8:39-27.1(a)	F 689		
F 745 SS=G	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00181485 Based on interviews, review of the medical records, as well as review of other pertinent facility documentation on 12/23/24 and 12/24/24, it was determined that the U.S. FOIA (b) (6) [redacted] failed to develop and implement policies and procedures for the identification of medically related NJ Ex Order and NJ Ex Order 26.4(b)(1) needs for a resident and assist a resident in obtaining needed services from outside entities, as required by the facility's job description for the "Director of Social Services." This deficient practice was identified for 1 of 6 residents (Resident #1) reviewed and was evidenced by the following: Resident #1 was NJ Ex Order 26.4(b)(1) the facility at the time of the survey. A closed record review was conducted. A review of the Admission Record revealed that	F 745	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1) Resident #1 NJ Ex Order 26.4(b)(1) at the facility. The Director of Social Services immediately conducted an audit of 100% of all residents to determine if their NJ Ex Order 26.4(b)(1) interview (NJ Ex Ord indicated a score of NJ Ex or greater, indicating the resident was NJ Ex Order 26.4(b)(1). The Director of Social services identified 13 residents who had a score of NJ Ex or greater in section NJ of the MDS and made a referral to the NJ Ex Order 26.4(b)(1) provider to ensure a NJ Ex Order 26.4(b)(1) assessment was conducted. 2) How the facility will identify other	1/24/25

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F 745	Continued From page 12 Resident #1 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). Review of the Admission Minimum Data Set (MDS) an assessment tool used to facilitate the management of care dated NJ Ex Order 26.4(b) indicated that Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 indicating an NJ Ex Order 26.4(b)(1). Further review of the MDS revealed that Resident #1 scored a NJ Ex on the NJ Ex Order 26.4(b)(1) Interview (NJ Ex Order indicating that the resident was NJ Ex Order 26.4(b)(1). Further review of the resident's record did not indicate if Resident #1 was referred for a NJ Ex Order 26.4(b)(1) assessment nor if an assessment was completed. The surveyor reviewed the facility's "Service Agreement" with the U.S. FOIA (b) (6) dated 06/14/2019, which revealed under the "II. Functions and Responsibilities of the Facility" section that "The facility shall provide a designated staff person to act as a primary contact and coordinator for [name of contracted provider]." On 12/23/24, at 10:14 A.M., during an interview with the surveyor, the U.S. FOIA (b) (6)) stated that it was her responsibility to assess section NJ of the MDS which reflected the NJ Ex Order score of the resident. She further stated that Resident #1 scored a NJ Ex on the NJ Ex Or and that she referred the resident for NJ Ex Order 26.4(b)(1) services. The facility did not provide documentation of the referral or that services	F 745	residents having the potential to be affected by the same deficient practice. 2) All residents with a Resident Mood Interview (RMI) of 10 or greater have the potential to be affected by this practice 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 3) On 12/27/2024 the Administrator provided in-service education to the U.S. FOIA (b) (6) with regards to the Director□s responsibility which includes but is not limited to procedures for the identification of medically related social and emotional needs for residents and assisting residents in obtaining needed services from outside entities as needed. The Director of Social Services is the designated staff person who acts as the primary contact and coordinator for the contracted providers for psychiatry and psychology services. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change 4)The Director of Social Services or designee will conduct audits of 5 residents weekly to review the score of the Resident Mood Interview (RMI). Residents with a	

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F 745	Continued From page 13 were provided. On 12/23/24, at 1:17 P.M., during an interview with the surveyor, the U.S. FOIA (b) (6) stated that she recalled attempting to see the resident several times but was not successful. On 12/23/24, at 2:26 P.M., during an interview with the resident's U.S. FOIA (b) (6)), the surveyor asked the U.S. FO if a resident that scored a NJ Ex on the NJ Ex Or should have had a NJ Ex Order 26.4(b)(1) assessment, the U.S. FO stated, "If there was a NJ Ex O on his assessment, NJ Ex definitely should have been monitored." On 12/24/24, at 10:05 A.M., during an interview with the surveyor, the U.S. FOIA (b) (6) stated that the U.S. FOIA was the primary contact with the contracted psychologist. On 12/24/24 at 10:14 A.M., during a follow-up interview with the surveyor, the NJ Ex Ord stated that a NJ Ex Order score of NJ Ex was " NJ Ex Order She stated, "A score of NJ Ex notes signs and symptoms of NJ Ex Order 26.4(b)(1) The U.S. FOIA stated that she referred Resident #1 to the U.S. FOIA (b) (6) verbally. She further added that if she had not seen the resident, she would have sent an email. The U.S. FOIA also stated that she was the facility's primary contact for the U.S. FOIA (b) (6) She stated that all meetings between her and the U.S. FOIA (b) (6) were verbal and that they would discuss who the U.S. FOIA (b) (6) saw and who she had not seen. She further added that occasional emails were sent, but that nothing was in writing as they would discuss multiple residents at a time. On 12/24/24, at 2:34 P.M., during a follow-up interview with the surveyor, the U.S. FOIA stated, "At	F 745	RMI equal to or greater than 10 will be referred by the Director of Social Services to the contracted psychology provider for consult. The audits will be conducted weekly x 3 weeks, then monthly x 3 months. The results of the audits will be provided monthly x 3 months to the facility□s Quality Assurance Performance Improvement (QAPI) Committee for review and comment. The QAPI committee meets on a monthly basis. The QAPI Committee will review and determine the need for further audits.	

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F 745	Continued From page 14	F 745		

this time, there is no formal tracking of resident's identified as needing a NJ Ex Order 26.4(b)(1) assessment/evaluation, and whether or not those are being completed, and/or if they are effective."

On 12/24/24, at 2:52 P.M., during an interview with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), the U.S. FOIA (b) (6) stated that it is the expectation that if a screening identified a concern, the resident would be followed up by a referral. They further stated that all referrals made to the contracted U.S. FOIA (b) (6) should be documented. The surveyor asked the U.S. FOIA (b) (6) about the U.S. FOIA above statement regarding the lack of formal tracking of resident's NJ Ex Order 26.4(b)(1) referrals, completion of those referrals, and their efficacy, to which the U.S. FOIA (b) (6) stated that he was just made aware of this and that, "There should be a formal record of all referrals made to the contracted NJ Ex Order 26.4(b)(1) that includes follow-up as to whether or not the NJ Ex Order 26.4(b)(1) evaluated the resident and if the provided services were effective."

The surveyor reviewed the Job Description for "Director of Social Services," revised November 2010, under "Administrative Functions: ...Develop and implement policies and procedures for the identification of medically related social and emotional needs of the resident... Provide consultation to members of our staff, community agencies, etc., in efforts to solve the needs and problems of the resident through the development of social service programs ... Work with the facility's consultant as necessary and implement recommended changes as required ... Make written and oral reports to the Administrator concerning the operation of the social service department..."

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F 745	Continued From page 15	F 745		
F 842 SS=D	NJAC 8:39-27.1(a), 39.4(e)(h)(i) Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		1/24/25

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F 842	Continued From page 16 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00181485 Based on observation, interview and review of medical records and other pertinent facility documents it was determined that the facility failed to maintain accurately documented and	F 842	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1) Resident #1 NJ Ex Order 26.4(b)(1) at the	

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F 842	Continued From page 17 complete medical records in accordance with acceptable standards and practice by a.) not documenting attempts to complete NJ Ex Order 26.4(b)(1) assessment and b.) not documenting NJ Ex Order 26.4 for a new admission. This deficient practice was identified for 1 of 6 residents (Resident #1) as evidenced by the following: Resident #1 was not at the facility at the time of the survey. A closed medical record review was conducted. The surveyor reviewed the Admission Record which revealed that Resident #1 was admitted with the diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 2 Review of the Admission Minimum Data Set (MDS) an assessment tool used to facilitate the management of care dated NJ Ex Order 26.4(b) indicated that Resident# 1 had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 indicating an NJ Ex Order 26.4(b)(1). Further review of the MDS revealed that the resident scored a NJ Ex on the NJ Ex Order 26.4(b)(1) interview which indicated NJ Ex Order 26.4(b)(1) The surveyor reviewed the resident record progress notes which revealed the following: -There were no admission weekly NJ Ex Order 26.4 for the weeks of NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b), and there was no documentation indicating why they were not obtained. -There was no documentation that the	F 842	facility. The Assistant Director of Nursing/Facility Educator (ADON/FE) immediately conducted an audit of all residents with referrals for NJ Ex Order 26.4(b)(1) assessment to ensure the assessment was completed timely. There were no untoward findings. The Dietician conducted an audit of all residents residing in the facility to ensure NJ Ex Order 26.4(b)(1) were obtained and entered in the electronic medical record for all new admissions. No residents had untoward effects related to this practice. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. 2) All residents have the potential to be affected by this practice. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 3)On 12/27/2024 The Assistant Director of Nursing /Facility Educator (ADON/FE) provided in-service education to all nurses on the importance of ensuring the contracted vendor for psychology services documented attempts for psychological assessments on residents. On 12/27/2024 The Assistant Director of	

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F 842	Continued From page 18 NJ Ex Order 26.4(b)(1) attempted to assess the resident. On 12/23/24, at 1:17 P.M., an interview was conducted with the U.S. FOIA (b) (6) who stated she attempted to see the resident several times but was not successful. She stated that every time she went to NJ Ex room NJ Ex was sleeping. No documentation was provided to the surveyor indicating that the U.S. FOIA (b) (6) attempted to see the resident. On 12/24/24, at 10:51 A.M., an interview was conducted with the U.S. FOIA (b) (6)) who stated, that "New admissions are to be NJ Ex Order 26.4(b) weekly for four weeks." The U.S. FO stated that she "typically" followed up with weekly NJ Ex Order 26.4(b) If the NJ Exec Order 2 were not obtained, the U.S. FO stated she would have followed up to see the reason why they were not obtained. In the presence of the surveyor, she reviewed the NJ Ex Order 2 record for Resident# 1 and stated that two NJ Ex Order 26.4 were missing. On 12/24/24, at 2:52 P.M., during an interview with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) , the U.S. FOIA (b) (6) stated, "NJ Ex Order 26.4(b) should be done at admission and then weekly." When the surveyor asked what the expectation of the facility is regarding documenting referrals for the U.S. FOIA (b) (6) he stated, "The expectation is that all recommendations to U.S. FOIA (b) (6) should be documented, and all the attempts made by the U.S. FOIA (b) (6) should be documented. Both the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) stated that, "All documentation should be in the system." When the surveyor asked why this is important the U.S. FOIA (b) (6) stated, "It is important to make sure it was documented, if it wasn't documented it wasn't done."	F 842	Nursing /Facility Educator (ADON/FE) provided in-service education to all nurses, Certified Nursing Assistants (CNAs) and the U.S. FOIA (b) (6) on the procedure for documenting weights for new admissions. Weights will be obtained for all new admissions, on the date of admission to the facility. The Dietician or designee will review the admission weight the day after admission, to ensure it is documented in the electronic medical record. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change 4) The Unit Manager or designee will conduct audits of residents with psychology/psychiatry referrals to ensure the provider documents attempts to complete the psychological assessment. The audits will be conducted on 5 residents per week x 3 weeks, then 5 residents per month x 3 months, then 5 residents per quarter x 3 quarters to ensure compliance. The dietitian or designee will conduct audits of residents admission weights to ensure proper completion. These results	

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F 842	Continued From page 19 The surveyor reviewed the facility's "Weight Assessment and Intervention" policy, revised March 2022, which revealed under the weight assessment section that, "Residents are weighed upon admission and at intervals established by the interdisciplinary team such as weekly for four weeks and then monthly unless otherwise indicated." The surveyor reviewed the facility's "Service Agreement" with the U.S. FOIA (b) (6) dated 06/14/2019, under the "Functions and Responsibilities" section revealed that " ...all respective medical record documentation including assessment and progress notes..." would be maintained according to facility policy. The surveyor reviewed the facility's "Charting and Documentation" policy, revised July 2017, revealed under the Policy Statement section that, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical record, physical, functional or psychosocial shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." NJAC 8:39-35.2(d)(f)	F 842	will be monitored weekly. The results of the audits will be provided monthly x 3 months, then quarterly x 3 quarters to the facility's Administrator and the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI committee meets on a monthly basis. The QAPI Committee will review and determine the need for further audits.	

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S 000	Initial Comments Complaint #: NJ00168416 and NJ00181485 Census: 79 Sample size: 6 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00168416 and NJ00181485 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 9 of 21 day shifts. The deficient practice was evidenced by the following:	S 560	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice 1) The facility leadership team has met on an ongoing basis and continued to identify staffing challenges and areas of improvement for licenses and certified staffing needs.	1/24/25

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

Electronically Signed | 01/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061315	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MIDDLETOWN	1040 STATE ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716

(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 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 as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 3 weeks of staffing prior to survey from 12/01/2024 to 12/21/2024, the facility was deficient in CNA staffing for residents on 9 of 21 day shifts as follows: -12/01/24 had 7 CNAs for 79 residents on the day shift, required at least 10 CNAs. -12/04/24 had 8 CNAs for 79 residents on the day shift, required at least 10 CNAs. -12/08/24 had 8 CNAs for 82 residents on the day shift, required at least 10 CNAs. -12/09/24 had 8 CNAs for 80 residents on the day shift, required at least 10 CNAs. -12/13/24 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs. -12/14/24 had 8 CNAs for 83 residents on the day	S 560	2) How the facility will identify other residents having the potential to be affected by the same deficient practice. 2) All residents have the potential to be affected by this practice. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 3) The DON conducted an audit of staffing schedules with the current facility census to ensure fulfillment of staffing requirements per shift. The facility has implemented an incentive program including referral bonuses for employees referring staff where appropriate, conducted job fairs, immediate interviews with contingency offers and expedited the onboarding process of new hires. The facility has contracted a vendor with agency staff as needed to meet staffing needs. The Director of Nursing and Director of Rehabilitation continue to partner in addressing staffing challenges. Where appropriate, the occupational therapy staff assist in providing care and activities of daily living to residents 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061315	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 shift, required at least 10 CNAs. -12/15/24 had 6 CNAs for 83 residents on the day shift, required at least 10 CNAs. -12/16/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. -12/21/24 had 7 CNAs for 78 residents on the day shift, required at least 10 CNAs.	S 560	put into place to monitor the continued effectiveness of the systemic change. 4) The DON and/or designee will meet with the staffing coordinator daily to review facility census, call outs if any, and staffing needs. The DON and/or designee will monitor callouts and staffing ratios weekly until the requirement is met. The results of the audits will be forwarded to the facility Administrator and QAPI Committee for further review and recommendations as needed	
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or	S1680		1/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061315	A. BUILDING: _____ B. WING _____	C 12/24/2024

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CAREONE AT MIDDLETOWN	1040 STATE ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716

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S1680	Continued From page 3 gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061315	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MIDDLETOWN	1040 STATE ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716

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S1680	Continued From page 4 This REQUIREMENT is not met as evidenced by: Complaint #: NJ00168416 and NJ00181485 Based on review of the Nurse Staffing Reports for the weeks of 12/08/2024 and 12/21/2024, it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days. The required staffing hours and actual staffing hours are as follows: For the 2 weeks of AAS-12 staffing from 12/08/2024 to 12/21/2024, the facility was deficient in total staffing for 2 of 14 days as follows: For the week of 12/08/2024 Required Staffing Hours: 242.25 -12/08/24 had 240 actual staffing hours, for a difference of -2.25 hours. For the week of 12/15/2024 Required Staffing Hours: 244 -12/15/24 had 240 actual staffing hours, for a difference of -4.00 hours.	S1680	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1) The facility leadership team has met on an ongoing basis and continued to identify staffing challenges and areas of improvement for licenses and certified staffing needs. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. 2) All residents have the potential to be affected by this practice 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur 3) The DON conducted an audit of staffing schedules with the current facility census to ensure fulfillment of staffing requirements per shift. The facility has implemented an incentive program including referral bonuses for employees referring staff where appropriate, conducted job fairs, immediate interviews with contingency offers and expedited the onboarding process of new hires.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1680	Continued From page 5	S1680	The facility has contracted a vendor with agency staff as needed to meet staffing needs. The Director of Nursing and Director of Rehabilitation continue to partner in addressing staffing challenges. Where appropriate, the occupational therapy staff assist in providing care and activities of daily living to residents 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. 4) The DON and/or designee will meet with the staffing coordinator daily to review facility census, call outs if any, and staffing needs. The DON and/or designee will monitor callouts and staffing ratios weekly until the requirement is met. The results of the audits will be forwarded to the facility Administrator and QAPI Committee for further review and recommendations as needed	

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
315087 Y1	A. Building B. Wing Y2	2/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MIDDLETOWN	1040 STATE ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716

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 F0610	Correction	ID Prefix F0655	Correction	ID Prefix F0689	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	01/24/2025	LSC	01/24/2025	LSC	01/24/2025
ID Prefix F0745	Correction	ID Prefix F0842	Correction	ID Prefix	Correction
Reg. # 483.40(d)	Completed	Reg. # 483.20(f)(5), 483.70(h)(1)-(5)	Completed	Reg. #	Completed
LSC	01/24/2025	LSC	01/24/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/24/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061315	A. Building B. Wing	2/3/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MIDDLETOWN	1040 STATE ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/24/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 01/24/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO