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 _____	03/09/2023

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 STANDARD SURVEY: Recertification CENSUS: 88 SAMPLE: 20 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, it was determined the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for one (Resident #12) of one resident reviewed for Ex.Order 26.4(b)(1) and services. Specifically, the facility failed to ensure staff arranged a timely Ex.Order 26.4(b)(appointment for Resident #12 to facilitate potential Ex.Order 26.4(b)(1) [redacted]. Findings included:	F 684	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 12's Ex.Order 26.4(b)(1) was removed on Ex.Order 26.4(b)(1) [redacted] days which was successful. Resident had a follow up appointment with Ex.Order 26.4(b)(1 on 3 Ex.Order 26.4 and recommendations were carried out. How the facility will identify other residents having the potential to be affected by the	4/10/23

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

Electronically Signed | 03/31/2023

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F 684	Continued From page 1 Review of a "Physician Orders for Consultation" policy, last revised 01/05/2022, revealed, in pertinent part, "The center will assist residents with obtaining services as needed including making appointments and arranging transportation." Review of an "Admission Record" revealed the facility admitted Resident #12 on Ex.Order 26.4(b)(1) According to the record, the resident's diagnoses included Ex.Order 26.4(b)(1) The record also identified a Ex.Order 26.4(b)(1) for the resident with an onset date of Ex.Order 26.4(b)(1) Review of a quarterly Minimum Data Set (MDS), dated Ex.Order 26.4(b)(1), revealed Resident #12 had Ex.Order 26.4(b)(1) as evidenced by a Brief Interview for Mental Status (BIMS) score of Ex.Order 26 of 15. According to the MDS, the resident required Ex.Order 26.4(b)(1) The MDS identified the resident was always Ex.Order 26.4(b)(1), that Ex.Order 26.4(b) was not rated, and the resident had an Ex.Order 26.4(b)(1). Review of a "Progress Note" titled "Resident Evaluation," dated Ex.Order 26.4(b)(1) at 6:45 PM, revealed the resident was admitted from the hospital with Ex.Order 26.4(b)(1). Review of "Clinical Physician Orders" revealed an order dated Ex.Order 26.4(b)(1) that directed staff to schedule an appointment with Ex.Order 26.4(b)(1) for Resident #12 related to Ex.Order 26.4(b)(1). Review of a care plan, dated Ex.Order 26.4(b)(1), revealed Resident #12 had Ex.Order 26.4(b)(1)	F 684	same deficient practice. Any resident who requires a follow up appointment at the center has the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 1. The ADON immediately provided education to nursing staff and unit secretary on setting up follow up appointments and implemented a new admission discharge paperwork review. 2. The facility reinforced the review of 24 hour documentation during clinical meetings. 3. The facility provided re-education and in - servicing on scheduling of appointments. 4. New admissions follow up appointments to be reviewed in morning meeting. 5. Appointments that have been scheduled will be put into PCC home page. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. 1. The Director of Nursing (DON)/ designee will review 24 hour reports and new admission discharge paperwork daily. An audit will be conducted weekly x 4 weeks, then twice monthly for two months. 2. The DON/ designee will present the results of the audits to the quality assurance performance improvement committee for review on a monthly basis for three months. The	

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F 684	Continued From page 2 Ex.Order 26.4(b)(1) in place related to Ex.Order 26.4(b)(1). The plan directed staff to maintain the resident's Ex.Order 26.4(b)(1) and report signs and symptoms of Ex.Order 26.4(b)(1) During an interview on 03/06/2023 at 11:50 AM, Family member #1 stated Resident #12 had a Ex.Order 26.4(b)(1) in place for over three weeks and staff were supposed to have it removed. During an interview on 03/08/2023 at 10:45 AM, the Unit Secretary stated when he received a hospital referral to make an outside appointment for a resident, he set up the appointment. He stated typically the nurses told him when there were new referral orders. He noted he was having trouble setting up Ex.Order 26.4(b)(1) appointment for Resident #12 as messages he was reportedly leaving were not addressed by Ex.Order 26.4(b)(1) office staff. He stated when he had trouble setting up an appointment, he notified the unit managers, social worker, and Director of Nursing (DON) verbally or via email and a nurse notified the physician. He indicated he contacted the Ex.Order 26.4(b)(1) office three times, but noted he had no documentation showing such attempts. The Unit Secretary also provided no evidence he notified any other staff member that he was having difficulty getting the resident's appointment made until the week during survey from 03/06/2023 to 03/09/2023. During an interview on 03/08/2023 at 11:20 AM, Unit Manager (UM) #1 stated she notified the ordering physician's office that morning that staff was having difficulty setting up Resident #12's	F 684	committee will review and revise the plan if needed.	

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F 684	Continued From page 3	F 684		

Ex.Order 26.4(b)(appointment (as ordered on Ex.Order 26.4(b)(1)).

During an interview on 03/08/2023 at 11:22 AM, Licensed Practical Nurse (LPN) #4 stated she entered orders for outside appointments, noting the Unit Secretary typically scheduled the associated appointments, though the nurses could schedule them as well. LPN #4 noted she did not remember if she told the Unit Secretary to make an appointment for Resident #12 as directed in the Ex.Order 26.4(b)(1) order after she entered the order in the system. She acknowledged she did not set up Ex.Order 26.4(b)(1) appointment for Resident #12.

During a follow-up interview on 03/08/2023 at 1:25 PM, the Unit Secretary clarified he became aware of the need to schedule Resident #12's Ex.Order 26.4(b)(appointment the Friday of the prior week (on Ex.Order 26.4(b)(1)) when, on Ex.Order 26.4(b)(1), he overheard the ordering physician explain that the resident's Ex.Order 26.4(b)(1) could not be discontinued until a follow up appointment occurred with Ex.Order 26.4(b)(The Unit Secretary noted that he, therefore, attempted to set up Resident #12's Ex.Order 26.4(b)(appointment on Friday, 0 Ex.Order 26.4(b)(1) (over three weeks from the original order date).

During an interview on 03/09/2023 at 9:22 AM, Resident #12's Physician stated the facility normally scheduled an appointment to have a resident seen within two weeks in response to an order for an outside appointment. Regarding the Physician's Ex.Order 26.4(b)(1) order directing staff to arrange Ex.Order 26.4(b)(1) appointment for Resident #12, the Physician noted Resident #12 Ex.Order 26.4(b)(1) [redacted] (two weeks after the order date), explaining that, by that time, the outside agency would not have seen Ex.Order 26.4(b)(1)

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F 684	Continued From page 4 positive resident. During an interview on 03/09/2023 at 12:30 PM, the DON stated once staff received a physician's order for an outside appointment, the unit secretary or a nurse usually made the appointment. She stated social services staff sometimes helped make outside appointments as well. The DON noted appointments were scheduled based on an outside provider's availability. She stated staff were to notify the physician and DON if they were unable to schedule an appointment. She stated she expected staff to attempt to make Resident #12's Ex.Order 26.4(b) appointment prior to Ex.Order 26.4(b)(1) During an interview on 03/09/2023 at 1:45 PM, the Nursing Home Administrator (NHA) stated the unit secretary set up most outside appointments for residents. He stated staff followed hospital orders regarding when to have an ordered appointment made, which he noted was typically within 14 days (about two weeks). The NHA noted staff first attempted to make Ex.Order 26.4(b)(1) appointment for Resident #12 on Ex.Order 26.4(b)(1) The NHA identified that the facility needed a backup process to ensure appointments were made timely.	F 684		
F 689 SS=D	New Jersey Administrative Code § 8:39-27.1(a) 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	F 689		4/10/23

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F 689	Continued From page 5 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 (Resident #12) of 3 residents reviewed for Ex.Order 26 Specifically, the facility failed to ensure a thorough investigation was done to include a root cause analysis after Resident #12 had Ex.Order 26.4(b)(1) [redacted] Findings included: The "Falls Clinical Protocol" policy and procedure, revised March 2018, was provided by the Director of Nursing (DON) on 03/09/2023 at 1:49 PM. The policy specified, in pertinent part, "For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. Often multiple factors contribute to a falling problem. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. After a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. Many categories of medications, and especially combinations of medications in several of those categories, increase the risk of falling. The staff and physician will continue to collect and evaluate	F 689	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 12 had Ex.Order 26.4(b)(1) [redacted] and Ex.Order 26.4(b)(1) , interventions were put in place to minimize the potential for major injury. How the facility will identify other residents having the potential to be affected by the same deficient practice. Any resident has the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 1. Incident reports will be reviewed daily during morning meeting with the interdisciplinary team. 2. The root cause of the fall will be investigated with each fall. 3. Fall interventions will continue to be implemented and revised as needed each fall. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur. 1. The Director of Nursing (DON)/ designee will monitor and review incident reports daily x 4 weeks then twice monthly for two months to monitor fall interventions and root causes of falls. The	

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F 689	Continued From page 6 information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable." A review of the "Admission Record" for Resident #12 revealed the facility admitted the resident with diagnoses that included Ex.Order 26.4(b)(1) [redacted] The quarterly Minimum Data Set (MDS) dated Ex.Order 26.4(b)(1) revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score Ex.Order [redacted] which indicated the resident had Ex.Order 26.4(b)(1) [redacted] The MDS indicated the resident required Ex.Order 26.4(b)(1) [redacted] The MDS further indicated the resident was always Ex.Order 26.4(b)(1) and had Ex.Order 26.4(b)(1) [redacted] A review of Resident #12's care plan, initiated on Ex.Order 26.4(b)(1) [redacted] and last revised on Ex.Order 26.4(b)(1) revealed the resident was Ex.Order 26.4(b)(1) due to Ex.Order 26.4(b)(1) [redacted]. The interventions directed staff to administer medication per physician's order (added Ex.Order 26.4(b)(1) [redacted]); maintain the resident's bed in the low position (added 01 Ex.Order 26.4(b)(1) [redacted]); Ex.Order 26.4(b)(1) [redacted] obtain a Ex.Order 26.4(b)(1) with Ex.Order 26.4(b)(1) [redacted]); send the resident to the emergency room (ER) for evaluation and treatment due to a change in Ex.Order 26.4(b)(1) (added Ex.Order 26.4(b)(1) [redacted]); offer the	F 689	audits will be presented the the administrator/ designee. 2. The DON/ designee will present the results of the audits to the quality assurance performance improvement committee for review on a monthly basis for 3 months, The committee will review and revise the plan if needed.	

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resident assistance out of bed and a snack in the common area if staff noticed the resident was attempting to get out of bed (added Ex.Order 26.4(b)(1)); and Ex.Order 26.4(b)(1)).

Review of the resident's "Behavior Care Plan," initiated Ex.Order 26.4(b)(1), revealed the resident placed themself on the floor related Ex.Order 26.4(b)(1). The care plan interventions indicated staff would attempt to redirect the resident back to their resting place. If unsuccessful, staff would ensure the area the resident was in did not pose a hazard to the resident or others.

Review of facility incident documentation dated Ex.Order 26.4(b)(1) at 12:20 PM, revealed Resident #12 had a Ex.Order 26.4(b)(1) on 0 Ex.Order 26.4(b)(1). The report indicated staff witnessed Resident #12 slide out of their wheelchair onto the floor; Ex.Order 26.4(b)(1) report indicated there were no Ex.Order 26.4(b witnessed, but orders were received for an Ex.Order 26.4 The documentation indicated the interdisciplinary team (IDT) met on Ex.Order 26.4(b)(1) to discuss the incident and noted the Ex.Order 26.4 were Ex.Order 26.4(b)(1) and the care plan was revised to include to obtain Ex.Order 26.4(b)(1) rule out medical conditions, a non-slip material to the wheelchair, and Ex.Order 26.4(b)(1) There was no further information provided on why the resident slid out of their wheelchair or evidence that a root cause analysis was completed to determine the Ex.Order 26.4(b)(1)

A review of facility incident documentation dated Ex.Order 26.4(b)(1) at 11:02 PM, revealed Resident #12 got out of bed and ambulated in the hallway

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without assistance. The report indicated the certified nursing assistant (CNA) attempted to assist the resident to sit in their wheelchair, but the resident became Ex.Order 26.4(b)(1) " and refused to sit in the wheelchair and sat on the floor. The report indicated there were Ex.Order 26.4(b)(1). The report further indicated the IDT met to review and discuss the incident on Ex.Order 26.4(b)(1) and the care plan was updated to reflect the resident's Ex.Order 26.4(b)(1) and placed themselves of the floor. There was no further information as to why the resident started to pace, what care was provided prior to the resident's sudden Ex.Order 26.4(b)(1) without their wheelchair, and what actions were taken other than to assist the resident to sit in their wheelchair. Further, there was no evidence that a root cause analysis was completed to determine the Ex.Order 26.4(b)(1)

A review of facility incident documentation dated Ex.Order 26.4(b)(1) at 11:05 PM, revealed the nurse was called to the resident's room by CNA #9. The resident was observed sitting on the floor with their legs extended. The report indicated the bed was in the lowest position and the resident's description of the incident was that Ex.Order 26.4(b)(1) The report indicated the resident was assessed, Ex.Order 26.4(b)(1) were identified, and the resident was assisted from the floor into their wheelchair. The resident was then assisted to the common area and provided a snack. The report indicated witness statements were obtained from CNA #8 and CNA #9. CNA #8 stated she rendered care to the resident at 9:45 PM and the resident was in bed, in the lowest position, and the resident had their call light within reach. CNA #9 stated she completed rounds, found the resident on the floor, and called the nurse. The

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report further indicated the IDT met on Ex.Order 26.4(b)(1) to discuss and review the incident and the care plan was revised to indicate the staff would offer the resident assistance out of bed and a snack in the common area if the staff noticed the resident attempted to get out of bed. There was no further information provided to include why Ex.Order 26.4(b)(1) or evidence that a root cause analysis was completed to determine the cause of Resident #12's Ex.Orde

A review of facility incident documentation dated Ex.Order 26.4(b)(1) at 4:00 AM, revealed nursing staff heard a noise in the hallway in front of Resident #12's room and responded. The staff observed the resident lying supine with their bilateral lower extremities extended and their bilateral upper extremities at their side. The resident had Ex.Order 26.4 [redacted] The report indicated witness statements were obtained and CNA #6 was interviewed and stated she was in another resident's room when Resident #12 fell and the last time she had observed Resident #12, the resident was in bed asleep. The document indicated the IDT met on Ex.Order 26.4(b)(1) to discuss and review the incident. The resident was found on the floor in their room. The resident was evaluated and found to have Ex.Order 26.4(b)(1) [redacted] There was an order obtained to send the resident to the emergency room (ER) for an evaluation. The care plan was reviewed, and the plan was to update the care plan upon the resident's return to Ex.Order 26.4(b)(1). There was no further information provided as to why the resident Ex.Order 26.4(b)(1) or evidence that a root cause analysis was completed to determine the cause of Resident #12's Ex.Order 2

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A review of facility incident documentation dated 0[Ex.Order 26.4(b)(1)] at 10:20 PM, revealed Resident #12 was found on the floor mid-way to their roommate's bed. The report indicated the resident was assessed by Registered Nurse (RN) #3 and [Ex.Order 26.4(b)(1)] were identified, and [Ex.Order 26.4(b)(1)] were initiated. The report indicated witness statements were obtained and CNA #10 was interviewed and stated she last observed Resident #12 in bed. CNA #10 stated she answered another resident's call light and when she exited that resident's room, she saw Resident #12 on the floor between the two beds. The report further indicated the IDT met to discuss and review the incident on [Ex.Order 26.4(b)(1)]. The environment was assessed and was free from clutter. Staff immediately responded and performed a full body assessment; [Ex.Order 26.4(b)(1)] were identified. The resident's care plan was reviewed with the IDT and found to be relevant. The plan was to continue to monitor the resident and update the care plan as needed. There was no further information provided on why the resident was found on the floor or evidence that a root cause analysis was completed to determine the cause [Ex.Order 26.4(b)(1)].

CNA #7 was interviewed on 03/08/2023 at 10:06 AM. She stated she monitored Resident #12 closely because the resident often attempted to ambulate independently and was not steady. CNA #7 stated if the resident was having a good day, she would walk with the resident hand over hand to the bathroom, and the resident would be able to independently transfer. CNA #7 stated if the resident had a difficult day, the resident would need more help with transfers and utilized a wheelchair for mobility.

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Unit Manager (UM) #1 was interviewed on 03/09/2023 at 11:50 AM She stated that when a resident had a fall, an RN assessed the resident for injuries. If it was safe to move the resident, staff helped the resident up. The family/physician were notified, and the resident would be sent out to the hospital if there were injuries. UM #1 stated nursing staff completed incident reports and documented the status of the resident in the record. UM #1 stated staff asked the patient immediately what happened. If the resident was unable to tell the staff, then the staff would monitor the resident. UM #1 stated the incident report then went to the DON for review. Per UM #1, nursing staff would initiate interventions if the resident were able to tell the staff what happened, and the nursing staff would update the resident's care plans. UM #1 stated that on Ex.Order 26.4(b)(1), the resident was on the floor. She stated Ex.Order 26.4(b)(1) was witnessed by the Activity Director (AD). She stated she made the resident comfortable by putting a pillow behind the resident's head and started Ex.Order 26.4(b)(1) and waited for an RN to assess the resident. UM #1 stated the resident could not tell her what happened. The resident complained of Ex.Order 26.4(b)(1) UM #1 stated she notified the physician/family and obtained orders for Ex.Order 26.4(b)(1) UM #1 stated staff concluded the resident got up to walk on their own and was unsteady on their feet. UM #1 stated she felt the reason the resident kept Ex.Order 26.4(b)(1) was due to their Ex.Order 26.4(b)(1).

The AD was interviewed on 03/09/2023 at 11:37 AM. She stated that on Ex.Order 26.4(b)(1), she observed the resident slide out of their wheelchair onto the floor. The AD stated the resident had Ex.Order 26.4(b)(1) and staff would have to redirect the resident. The AD stated on Ex.Order 26.4(b)(1), the

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resident was in the activity room on Station Two, and she provided redirection to the resident.

CNA #6 was interviewed on 03/09/2023 at 12:15 PM. She stated she did not remember the exact day Resident #12 had Ex.Order 26.4(January 2023, but the resident Ex.Order 26.4(b)(1) during night shift and staff kept a close eye on the resident because the resident was Ex.Order 26.4(b)(1). CNA #6 stated she helped the resident to bed, and when she went back to check on the resident, the resident was on the floor. Per CNA #6, the resident was Ex.Order 26.4(b)(1) and the first thing she did was make sure the resident was comfortable and she went to get the nurse, completed Ex.Order 26.4(b)(1), and completed a witness statement. CNA #6 stated the resident liked to wander so she would get the resident a magazine or other things/tasks to do in the day room.

The DON was interviewed on 03/09/2023 at 12:30 PM. She stated the process after a resident fell was the aide or whoever found the resident would get the nurse, and the nurse would complete a head-to-toe assessment. Based on the assessment, interventions would be added, and the resident would be sent back to bed or to the hospital. The DON stated the nurse would start the incident report and completed most of the incident form to include what happened, what actions were taken, physician/family notification, and witness information. The DON stated the nurse completed everything except the IDT notes. The DON stated the information was also documented in the facility's electronic system, and managers had the capability to print it out and IDT review it in the morning meeting. The DON stated there was a notification in the electronic system when incident reports were

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generated, and this was how she was notified of incidents/falls. She stated the IDT review was typically conducted in morning meetings, and the IDT consisted of the UM, the DON, the Administrator, activities staff, therapy staff, and other managerial staff. The IDT reviewed the incident report and discussed what happened, reviewed the care plan, and implemented interventions related to falls. The DON stated she completed the IDT notes about the review after the meeting. The DON stated the team's approach for interventions were discussed and the IDT team had a collaborative discussion. She stated if the resident was alert and oriented, the staff would interview the resident about the incident. She stated that specifically for Resident #12's Ex.Order 26.4(b)(1), the staff felt medically there was something going on with the resident but was not sure because the resident was not Ex.Order 26.4(b)(1). The DON stated the team decided to implement a non-slip material to the resident's wheelchair to help the resident from sliding out. Per the DON, for the resident's Ex.Order 26.4(b) Ex.Order 26.4(b)(1), the team felt the resident was having Ex.Order 26.4(b)(1) and the staff updated the care plan to reflect that Ex.Order 26.4(b)(1). The DON stated she worked night shift when the resident Ex.Order 26.4(b)(1). According to the DON, the resident was not able to tell staff what the resident was trying to do when they Ex.Order 26.4(b)(1) the DON, staff were not able to figure out why the resident Ex.Order 2 so the intervention of getting the resident up out of bed, into the common area, and offering a snack was implemented because the resident did not know what they wanted or what they wanted to do. The DON stated that for the resident's Ex.Order 26.4(b) the resident was found on the floor in front of their room in the supine position. The IDT decided to implement Ex.Order 26.4(b)(1) as an intervention.

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F 689	Continued From page 14 The DON stated that for the Ex.Order 26.4(b)(1) the resident was in Ex.Order 26.4(b)(1) The staff documented the resident could not tell staff what the resident was trying to do. The IDT reviewed the resident's care plan and would monitor. The DON stated her expectation after a fall was that staff figure out why a resident fell to ensure staff prevented further falls from occurring. The DON acknowledged staff did not review root cause analysis of falls. The Administrator was interviewed on 03/09/2023 at 1:38 PM. He said his expectation during the morning (IDT) meeting was to review and discuss how to minimize falls. He said the IDT reviewed the resident and the resident's record and implemented appropriate interventions. Per the Administrator, the staff implemented many interventions such as fall mats, toileting, non-pharmacological interventions, and reviewed medication management. The Administrator said based on chart review and interviews was how staff determined what interventions needed to be put in place. The Administrator acknowledged the staff did not review Resident #12 for root cause analysis Ex.Order 26.4(b)	F 689		
F 692 SS=D	New Jersey Administrative Code § 8:39-27.1(a) 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-	F 692		4/10/23

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F 692	Continued From page 15 §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; §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, record review, facility policy review, and interviews, it was determined the facility failed to address the Registered Dietician (RD)'s recommendation for 1 (Resident #46) of 2 residents reviewed for nutrition. Findings included: Review of a facility policy titled, "Weight Assessment and Intervention," dated 06/15/2022, did not specify how the RD recommendations are communicated between the RD and the physician. A review of an "Admission Record" indicated the facility admitted Resident #46 with diagnoses that include Ex.Order 26.4(b)(1) [redacted] The quarterly Minimum Data Set (MDS), dated Ex.Order 26.4(b)(1), revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score Ex.Order [redacted]	F 692	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1. The Registered Dietitian and nursing staff were made aware of deficient practice. The corrective action will be accomplished by way of staff education, logging, and frequent auditing, to ensure resident # 46 nutritional interventions are included as physician orders. The physician was notified of the recommendation and the Ex.Order 26.4(b)(1) [redacted] was ordered. 2. The Director of Nursing and dietitian performed an audit on residents who were seen by dietitian in the last 6 months. No other residents were affected by the practice. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents have the potential to be	

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F 692	Continued From page 16 which indicated the resident had Ex.Order 26.4(b)(1) . Per the MDS, Resident#46 required Ex.Order 26.4(b)(1) , and had Ex.Order 26.4(b)(1) Review of Resident #46's care plan, dated Ex.Order 26.4(b)(1) revealed the resident was Ex.Order 26.4(b)(1) related to Ex.Order 26.4(b)(1) . The resident was also at Ex.Order 26.4(b)(1) related to multiple Ex.Order 26.4(b)(1) The care plan interventions indicated staff would encourage and assist the resident as needed with consuming food, fluids, and/or supplements during and between meals and staff would notify the physician and responsible party of significant weight changes. A review of Resident #46's nutrition "Progress Notes" electronically signed by RD #14 and dated Ex.Order 26.4(b)(1) 3 at 3:31 PM, revealed the resident had been hospitalized from Ex.Order 26.4(b)(1) with a diagnosis of Ex.Order 26.4(b)(1) The resident's weight had been stable between Ex.Order 26.4(b)(1) pounds over the past three months. The RD noted the resident's Ex.Order 26.4(b)(1) was Ex.Order 26.4(b)(1) on Ex.Order 26.4(b)(1) , which was Ex.Order The RD suggested a Ex.Order 26.4(b)(1) to help better meet the resident's protein needs. Further review of Resident #46's care plan, revealed the facility revised the care plan	F 692	affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 1. The DON and dietitian immediately provided education to the nursing staff regarding the importance of communicating dietitian recommendations with physician. Education also includes ensuring all physician approved recommendations are entered in the residents chart, weight monitoring, laboratory results review, and care plan update. 2. The DON revised communication process on dietitian recommendations with the physician for any therapeutic diet, supplements, and laboratory tests. This includes order entry checks and 24 hour report review. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur. 1. The Director of Nursing (DON)/ designee will perform an audit of dietitian recommendation on therapeutic diets and lab work results, 2 times for 2 weeks, once a week for 2 weeks, and then monthly for 2 months. 2. The DON/ designee will perform weight audits once a month for three months. 3. The DON to present results of audits at QAPI monthly x 2 months and then during the first quarterly QAPI. 4. Outcomes of the audits will be reviewed by the QAPI committee for any recommendations.	

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F 692	Continued From page 17 Ex.Order 26.4(b)(1) due to the resident's Ex.Order 26.4(b)(1). The care plan intervention added, revealed the staff would provide the resident a Ex.Order 26.4(b)(1) t as ordered. A review of Resident #46's physician "Order Summary Report" dated Ex.Order 26.4(b)(1), revealed there was not an active order for the staff to administer the Ex.Order 26.4(b)(1) to the resident. On 03/06/2023 at 12:18 PM, the surveyor observed staff feed Resident #46 as the resident sat in their bed. In an interview on 03/08/2023 at 10:55 AM, Licensed Practical Nurse (LPN) #16 stated the RD's recommendations, were "flagged" (fold over a corner on the paper or offset the recommendation from the other papers) for the nurse to see. Per LPN #16, the nurse would notify the physician of the RD's recommendations to determine whether the physician wanted to implement the recommendation. LPN #16 reviewed Resident #46's medical record and reported the last RD recommendation for Resident #46 was on Ex.Order 26.4(b)(1) 2. During an interview on 03/08/2023 at 11:05 AM, RD #14 acknowledged the Ex.Order 26.4(b)(1) she suggested for Resident #46 on Ex.Order 26.4(b)(1) had not been implemented. During an interview on 03/09/2023 at 8:37 AM, the Administrator reported he expected the RD to place their recommendations in the resident's paper chart and flag the order for the nurse to address or place the order into the resident's electronic medical record.	F 692		

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F 692	Continued From page 18 In an interview on 03/09/2023 at 9:02 AM, the Director of Nursing (DON) stated she expected the RD's recommendation for Resident #46 to be entered into the resident's electronic medical record and for the nurse to contact the physician to verify the order.	F 692		
F 761 SS=D	New Jersey Administrative Code § 8:39-27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		4/10/23

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F 761	Continued From page 19 by: Based on observations, interviews, and facility policy review, the facility failed to ensure 1 (medication cart for Rooms 1-18) of 4 medication carts were locked on two occasions to prevent unauthorized access. Findings included: Review of a facility policy titled, "Security of Medication Cart," revised April 2007, revealed, "The medication cart shall be secured during medication passes. 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry." The policy further revealed, "4. Medication carts must be securely locked at all times when out of the nurse's view." On 03/06/2023 at 10:33 AM, the surveyor observed the medication cart for Room 1-18 was unlocked, unattended, and not within sight of any staff member. During an interview on 03/06/2023 at 10:40 AM, Unit Manager (UM) #2, stated he was unaware he left the medication cart unlocked, but if he did, it was a mistake. UM #2 stated the risk of leaving the medication cart unlocked was that anyone could have access to the medications in the cart. On 03/07/2023 at 3:22 PM, the surveyor observed the medication cart for Room 1-18 was unlocked, unattended, and not within sight of any staff member. During an interview on 03/07/2023 at 3:26 PM, Registered Nurse (RN) #12, stated she had unlocked the cart and walked away to call the laundry department. RN #12 said the risk of	F 761	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The medication carts were immediately locked, and Unit Manager # 2 and Registered Nurse # 12 were educated on the importance of locking their med carts. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 1. The ADON immediately provided education to nursing staff on locking cart and implemented a medication cart check system which includes the importance of keeping the med carts securely locked as well as within the view of the nurse when applicable. 2. The pharmacy consultant will include medication cart checks on monthly visit. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur. 1. The Director of Nursing (DON)/ designee will perform an audit of 4 med cart check system weekly x 4 weeks, then 2 med carts every 2 weeks for 4 weeks and evaluate the outcomes. 2. The DON/ designee to present results of audits at QAPI monthly x 2 months and then during	

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F 761	Continued From page 20 leaving an unlocked/unattended medication cart was that residents, visitors, and other staff members had access to the cart and the medications. During an interview on 03/09/2023 at 9:29 AM, the Assistant Director of Nursing (ADON), stated she expected the nursing staff to keep medication carts locked. The ADON said the risk of an unlocked or unattended medication cart was that residents or other staff would have access to the medication and needles. During an interview on 03/09/2023 at 9:14 AM, the Director of Nursing (DON), stated she expected the nursing staff to keep the medication carts locked when they left the medication cart unattended. The DON said the risk of leaving a cart unlocked and unattended was that anyone would have access to the medication cart. During an interview on 03/09/2023 at 9:01 AM, the Administrator stated he expected nursing staff to keep medication carts locked if the medication carts were not within staffs' line of sight. The Administrator said the risk of the medication carts being unlocked and unattended was that others could have access to the medication carts.	F 761	the first quarterly QAPI. 3. The outcomes of the audits will be reviewed by the QAPI committee for any recommendations.	
F 809 SS=E	New Jersey Administrative Code § 8:39-29.7(a) Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident	F 809		4/10/23

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F 809	Continued From page 21 needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, document review, and facility policy review, the facility failed to provide a nourishing snack at bedtime when there was more than 14 hours between a substantial evening meal and breakfast the following day for 53 of 88 residents. Findings included: Review of facility policy titled, "Frequency of Meals" dated July 2017, revealed, "1. The facility will serve at least three (3) meals or their equivalent daily at scheduled times. There will not be more than a fourteen (14) hour span between the evening meal and breakfast." The policy further revealed, "5. Nourishing snacks will be available for residents who need or desire additional food between meals. 6. Evening snacks will be offered routinely to all residents. Timing of the snack will consider relevant factors (e.g., individuals with gastroesophageal reflux disease may be advised not to eat too close to	F 809	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility administrator and DON immediately coordinated with the food service director to ensure nourishing snacks and beverages in the morning, after lunch, and night snacks are available to the residents, and compliments the serving of the residents three meals. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 1. The food service director and DON	

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F 809	Continued From page 22 bedtime). 7. Residents will also be offered nourishing snacks if the time span between the evening meal and the next day's breakfast exceeds fourteen (14) hours. Nourishing snacks are items from the basic food groups, offered either separately or with each other." Review of the facility's "Meal Delivery Schedule," updated 02/17/2023, revealed dinner mealtime started at 4:30 PM and the breakfast meal started at 7:30 AM, which was 15 hours between meals. A review of a list of residents provided by the facility revealed 12 residents received a snack at 2:00 PM, and 35 residents received a snack at 7:00 PM. During an interview on 03/07/2023 at 12:30 PM, Resident #236 stated it was a long time between dinner and breakfast and the facility did not offer the resident a snack between the meals. During an interview on 03/07/2023 at 1:46 PM, Resident #71 stated snacks were not offered. The resident thought the doctor had to order snacks before the facility provided or offered snacks. During an interview on 03/07/2023 at 2:01 PM, Resident #233 stated staff did not provide nor offer snacks to the residents. Resident #233 stated to get snacks, the resident must ask for them. During an interview on 03/07/2023 at 2:03 PM, Resident #20, stated the staff did not offer snacks at any time. On 03/07/2023 at 2:33 PM, the surveyor	F 809	immediately provided education to nursing and culinary staff regarding the importance of serving three meals and nourishing snacks to residents. Education also includes ensuring time between nighttime snack and breakfast does not exceed 14 hours. 2. The food service director/ designee will ensure morning, afternoon, and nighttime snacks and beverage are available in the unit for staff to serve. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur. 1. The Food Service Director (FSD)/ Director of Nursing (DON)/ designee will perform an audit of hour of meals serving for breakfast, lunch, and dinner 2 x for 2 weeks, once a week for 2 weeks. 2. The FSD/ DON/ designee will perform an audit of nourishing snacks and beverage availability in the units 2 x week for 2 weeks, and 1 x week for 2 weeks. 3. The FSD/ DON to present results of audits at QAPI monthly x 2 months and then during the first quarterly QAPI. 4. The outcomes of the audits will be reviewed by the QAPI committee for any recommendations. 5. The food service director or designee will interview 10 residents weekly to ensure bedtime snacks have been offered. Interviews will be conducted weekly for 4 weeks, and every other week for 4 weeks. The FSD to present results of audits at QAPI monthly x 2 months and then during the first quarterly QAPI. The outcomes of the audits will be reviewed by the QAPI committee for any recommendations.	

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 _____	03/09/2023

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 809	Continued From page 23	F 809		

observed the dietary department provided snacks to the residents with dietary orders for snacks. No other residents were offered snacks.

On 03/07/2023 at 12:35 PM, the surveyor observed the nutrition room for Hall 1-18 had four 8 ounce (oz) shakes and medication pass liquid supplements in the refrigerator; the freezer was empty. In the dry pantry area, there were a few cookies and a few bags of potato chips.

On 03/08/2023 at 1:17 PM, the nutrition room for Rooms 1-30 contained four 8 oz milks and nine 8 oz. juices in the refrigerator. There was nothing in the freezer. The dry pantry had saltine crackers, potato chips, and cookies. Observation of the nutrition room for Rooms 31-47 revealed nine 8 oz. waters, nine 8 oz colas (3 diet, 4 diet ginger ale, 1 ginger, 1 cola), and nothing in the freezer or pantry. Additionally, the nutrition room for Rooms 48-67 revealed one 8 oz. milk, two 8 oz. yogurts, and twelve 8 oz colas (6 diet, 4 ginger, 2 cola). The pantry had saltine crackers, graham crackers, and oatmeal cookies.

During an observation on 03/08/2023 at 2:30 PM, dietary provided snacks labeled with residents' names. No additional snacks were observed. Staff were not observed to offer snacks to other residents.

During an interview on 03/07/2023 at 1:48 PM, Licensed Practical Nurse (LPN) #13 stated the dietary department brought snacks only for the residents with a diet order to receive snacks.

During an interview on 03/07/2023 at 1:50 PM, Unit Manager (UM) #2, stated if a resident asked for a snack, staff could get them a snack, but

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	315087	A. BUILDING _____ B. WING _____	03/09/2023

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 809	Continued From page 24	F 809		

normally snacks were not routinely given to the residents. UM #2 stated staff could get the residents a snack but only if the resident asked.

During an interview on 03/07/2023 at 2:55 PM, the Food Service Director (FSD) stated nursing staff completed a diet slip for snack requests then he visited with the resident to find out what types of snacks the resident wanted to receive. The FSD stated currently 12 residents received snacks at 2:00 PM and 35 residents received a snack at 7:00 PM.

A follow-up interview on 03/07/2023 at 3:43 PM with the FSD, confirmed the dietary department only provided snacks to residents who had a diet order for snacks. He stated he thought there were other snacks available, but he was unsure if nursing staff were offering or providing snacks to the other residents. He stated it was the dietary staff's responsibility to restock the refrigerator and pantry but did not leave extra sandwiches, puddings, or ice cream in the nutrition room refrigerator or freezer. The FSD stated they only stocked snacks such as a bag of chips, saltine crackers, or cookies in the nutrition room pantry for after hours. According to the FSD, all residents could have a snack, they just had to ask for one.

During an interview on 03/09/2023 at 8:35 AM, Registered Dietician (RD) #14 stated she expected the dietary staff to make sure the refrigerator and pantries were stocked with food that provided the nutrition needed and expected nursing staff to provide snacks to residents. RD #14 stated she was unaware that all residents were not offered or provided snacks.

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F 809	Continued From page 25	F 809		

During an interview on 03/09/2023 at 9:29 AM, the Assistant Director of Nursing (ADON), stated she expected the dietary department to provide snacks based on the dietician's recommendation. The ADON stated dietary staff were responsible for stocking the refrigerators and pantries in the nutrition rooms, and the nursing staff were responsible for providing the snacks to the residents. The ADON stated the risk of not providing snacks for a resident who had diabetes was a low blood sugar and other residents could have weight loss or be hungry.

During an interview on 03/09/2023 at 9:14 AM, the Director of Nursing (DON) stated she expected dietary staff to keep snacks on the resident units. The DON stated she had not completed any audits to verify snacks were provided to residents. She stated the risk of the residents not being provided snacks could be weight loss, hunger, or if a resident with diabetes did not get a snack, the resident could experience low blood sugar.

During an interview on 03/09/2023 at 9:01 AM, the Administrator stated he expected dietary staff to provide residents' snacks at 10:00 AM, 2:00 PM, and 7:00 PM. He stated dietary staff brought snacks to the resident units and nursing staff were expected to pass those snacks out to the residents. The Administrator stated the risk of a resident not getting a snack could be weight loss.

New Jersey Administrative Code § 8:39-17.4(b)

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	061315	A. BUILDING: _____ B. WING _____	03/09/2023

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S 000	Initial Comments Census: 88 Sample Size: 20 TYPE OF SURVEY: Recertification The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of 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, facility document review, facility policy review, and New Jersey Department of Health (NJDOH) memo dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing for residents on 14 of 14 day shifts for the week of 02/19/2023 - 02/25/2023 and 02/26/2023 - 03/04/2023. This deficient practice had the potential to affect all residents.	S 560	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The leadership team has met on ongoing basis and continues to identify staffing challenges and areas of improvement for Certified Nursing Assistant staffing needs. How the facility will identify other residents having the potential to be affected by the	4/10/23

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

Electronically Signed | 03/31/23

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S 560	Continued From page 1 Findings included: A review of the facility's undated policy titled, "Staffing Requirements," specified, "The center will employ staff in sufficient number and with sufficient ability and training to provide the basic care and resident assistance and supervision required, based on assessment of the acuity of resident's needs. Procedure 1. Staffing schedules will be developed, maintained, and implemented for all employees." The policy further specified, "5. Staffing levels will be developed and implement based on assessed current and changing needs of the residents during each 24 hour period." Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aid 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 certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each	S 560	same deficient practice. Residents have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 1. The center has implemented significant above market rates for nurses and Certified Nursing Assistants. Incentives include tuition reimbursement, sign on bonus program, and additional training if not certified. 2. The center continues to conduct ongoing job fairs with immediate interviews, as well as walk in applicants and has the ability to expediate contingency offers at the time of interview. 3. The center continues to supplement with agency until staff is hired and has secured multiple contracts to assist with filling open positions. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur. 1. The Director of Nursing (DON)/ designee will monitor the certified nursing aide staffing ratios daily and document a weekly review of the daily staffing x 4 weeks the twice monthly for two months to monitor. The audits will be presented to the Administrator. 2. The DON/ designee will present the results of the audits to the quality assurance performance improvement committee for review on a monthly basis for 3 months, The committee will review and revise the plan if needed.	

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S 560	Continued From page 2	S 560		

direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties.

1. A review of the "Nurse Staffing Report," completed by the facility for the week of 02/19/2023 - 02/25/2023, revealed staff-to resident ratios that did not meet minimum requirements. The facility was deficient in CNA staffing for residents on 7 of 7 days shifts as follows:

- 02/19/2023 had 9 CNAs for 85 residents on the day shift, required 11 CNAs.
- 02/20/2023 had 8 CNAs for 84 residents on the day shift, required 10 CNAs.
- 02/21/2023 had 8 CNAs for 83 residents on the day shift, required 10 CNAs.
- 02/22/2023 had 8 CNAs for 83 residents on the day shift, required 10 CNAs.
- 02/23/2023 had 8 CNAs for 83 residents on the day shift, required 10 CNAs.
- 02/24/2023 had 7 CNAs for 83 residents on the day shift, required 10 CNAs.
- 02/25/2023 had 7 CNAs for 87 residents on the day shift, required 11 CNAs.

2. A review of the "Nurse Staffing Report," completed by the facility for the week of 02/26/2023 - 03/04/2023, revealed staff-to-resident ratios that did not meet minimum requirements. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

- 02/26/2023 had 7 CNAs for 86 residents on the day shift, required 11 CNAs.
- 02/27/2023 had 6 CNAs for 86 residents on the day shift, required 11 CNAs.
- 02/28/2023 had 5 CNAs for 86 residents on the

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	061315	A. BUILDING: _____ B. WING _____	03/09/2023

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S 560	Continued From page 3	S 560		

day shift, required 11 CNAs.
- 03/01/2023 had 8 CNAs for 86 residents on the day shift, required 11 CNAs.
- 03/02/2023 had 7 CNAs for 86 residents on the day shift, required 11 CNAs.
- 03/03/2023 had 7 CNAs for 86 residents on the day shift, required 11 CNAs.
- 03/04/2023 had 7 CNAs for 86 residents on the day shift, required 11 CNAs.

On 03/08/2023 at 3:50 PM, the Staff Coordinator (SC) stated the minimum staffing ratios were one certified nurse aide to every eight residents for the day shift, one direct care staff member to every 10 residents for the evening shift, and one direct care staff member to every 14 residents for the night shift. The SC indicated she, the Administrator, and Director of Nursing (DON), were responsible for staffing and acknowledged the facility did not meet the minimum staff ratios for the day shift CNAs for 02/19/2023 through 03/04/2023. The SC stated she expected the facility to follow the state minimum staffing guidelines but stated the facility just did not have enough staff.

On 03/09/2023 at 8:18 AM, the DON revealed she was aware the day shift CNA coverage for 02/19/2023 through 03/04/2023 did not meet the minimum guidelines. The DON stated staffing was a struggle, and she had advertisement on websites with incentive bonuses and gave current employees incentives to work. The DON stated she expected the state staffing minimum ratio to be met.

On 03/09/2023 at 9:11 AM, the Administrator stated the facility tried to be fully staffed by offering incentives, sign on bonuses, referral bonuses, and the use of agency staff for CNAs

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S 560	Continued From page 4 and nurses. The Administrator stated he was aware the minimum staffing ratios were not met for day shift CNA coverage for 02/19/2023 through 03/04/2023. The Administrator stated he expected the state staffing minimum requirements to be met. The Administrator indicated the SC coordinated staffing and he and the DON were responsible for sufficient staffing.	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
315087 Y1	A. Building B. Wing Y2	4/24/2023 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 F0684	Correction	ID Prefix F0689	Correction	ID Prefix F0692	Correction
Reg. # 483.25	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	04/10/2023	LSC	04/10/2023	LSC	04/10/2023
ID Prefix F0761	Correction	ID Prefix F0809	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(f)(1)-(3)	Completed	Reg. #	Completed
LSC	04/10/2023	LSC	04/10/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/9/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061315		4/24/2023

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 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 04/10/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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
3/9/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315087	A. BUILDING **01** B. WING _____	**03/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 03/07/2023 to 03/09/2023 and Careone at Middletown 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 Middletown is a two-story Type II Protected building that was built in 1967. The facility is divided into 12 smoke zones.	K 000		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are	K 761		4/10/23

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

Electronically Signed | 03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315087	A. BUILDING **01** B. WING _____	**03/09/2023**

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
K 761	Continued From page 1 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on interviews, document review, facility policy review, and review of a Centers for Medicare and Medicaid Services (CMS) memorandum, it was determined the facility failed to inspect all fire-rated doors required by National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) 2012 edition sections 8.3.3.1, 19.7.6 and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition sections 5.2.1. This deficient practice had the potential to affect 88 residents. The facility identified 11 fire-rated doors. Findings included: Review of a facility policy titled, "Fire and Smoke Barrier Doors," dated 01/2019, specified, "Fire and smoke barrier doors are strategically located throughout the facility and such doors remain operable at all times." Review of the Centers for Medicare and Medicaid Services (CMS) memorandum with a subject of "Fire and Smoke Door Annual Testing Requirements in Health Care Occupancies," dated 07/28/2017, specified, "Annual inspection and testing of fire door assemblies in accordance with NFPA 80 are still required in health care occupancies by LSC section 8.3.3.1, which is applicable to all occupancy chapters." The memorandum further specified, "Full compliance with the annual fire door assembly inspection and testing in accordance with 2010 NFPA 80 is required by January 1, 2018."	K 761	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The fire rated doors were immediately inspected with no untoward findings. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 1. The Director of Maintenance immediately inspected all fire rated doors. There were no untoward findings. 2. Annually, the Director of Maintenance will inspect all facility's fire rated doors, with the oversight by Administrator and Regional Director of Environmental Services. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur. 1. The Director of Maintenance/ designee will perform an inspection of all fire rated doors on the first Tuesday of February annually with findings reported to QAPI committee. 2. Annual inspection of all fire rated doors will continue on an on going	

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	315087	A. BUILDING **01** B. WING _____	**03/09/2023**

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

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K 761	Continued From page 2 A review of the facility's life safety code documentation revealed there was no annual inspection of all fire-rated doors for the past 12 months. In an interview on 03/08/2023 at 6:11 PM, the Regional Director of Environmental Services (RDES) stated he was not aware of the code requirements to annually inspect the fire-rated doors. The RDES acknowledged the findings and stated he expected all life safety code requirements to be followed. During an interview on 03/08/2023 at 6:15 PM, the Administrator stated he was not aware of the requirements to annually inspect all fire-rated doors. The Administrator stated he expected all life safety code requirements to be followed. In an interview on 03/09/2023 at 12:11 PM, the Director of Maintenance stated he was not aware of the code requirements to annually inspect the fire-rated doors. The Director of Maintenance acknowledged the findings and stated he expected all life safety code requirements to be followed.	K 761	basis, with the oversight of the Administrator and Regional Director of Environmental Services. Findings will continue to be reported to the QAPI committee, monthly on an ongoing basis.	
K 918 SS=F	New Jersey Administrative Code 8:39-31.1(c) Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		4/10/23

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	315087	A. BUILDING **01** B. WING _____	**03/09/2023**

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K 918	Continued From page 3 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interviews, document review, and facility policy review, it was determined the facility failed to: - ensure generator sets were inspected weekly; - exercise the emergency generator 12 times each year for at least 30 minutes in 20- to 40-day intervals; and - document the time needed by the generator to transfer power to the building was within the	K 918	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1. The generator set was inspected immediately and exercised under a non load run. There were no untoward findings, the transfer time was within regulation. 2. The generator set was run	

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K 918	Continued From page 4 10-second time frame, accordance National Fire Protection Association (NFPA) 99 and 110. This deficient practice had the potential to affect 88 residents who resided in the facility. Findings included: Review of a facility policy titled, "Emergency Generator and Lighting," edited 04/23/2019, specified, "The facility plans for alternate sources of energy in the event of a crisis or disaster situation to maintain temperatures, to protect resident health and safety, and for the sanitary storage of provisions." The policy further specified, "4. The Maintenance Director or designee maintains inspection, testing, maintenance requirements, and fuel provisions for the generator." A review of the "Emergency Generator Inspection Monthly Log" for the previous 12 months indicated there was no documented certification that the generator would start and transfer power to the building within ten seconds, since no load test was conducted for the previous 12 months. The monthly logs also revealed the facility's emergency generator was not tested under load 12 times for 30 minutes in the last 12 months. Further review of the monthly logs revealed there were no documented exercises of the transfer switches monthly for the last 12 months. Furthermore, the monthly logs revealed the generator was not inspected weekly on 03/14/2022, 06/20/2022, 06/27/2022, and from 07/18/2022 to 03/09/2023. In an interview on 03/08/2023 at 6:11 PM, the Regional Director of Environmental Services (RDES) stated he was aware the generator	K 918	under a load test on 3/17/23, There were no uninterrupted findings, the transfer time was within regulation. 3. Documentation/ logging of these inspections completed. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 1. The Director of Maintenance immediately inspected the generator sets. There were no untoward findings with inspection, the transfer time was within regulation and documentation/ logging of these inspections completed. 2. The Director of Maintenance exercised the generator under a non load run, immediately. There were no uninterrupted findings, the transfer time was within regulation and documentation/ logging of these inspections completed. . 3. The Director of Maintenance exercised the generator under a load test on 3/17/23. There were no uninterrupted findings, the transfer time was within regulation and documentation/ logging of these inspections completed. 4. The Administrator and Regional Director of Environmental Services will provide oversight to ensure the generator sets will be inspected weekly with 12 times per year 30 minute load runs. 5. Documentation of inspections, non load	

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K 918	Continued From page 5 required weekly inspection, and he was responsible for the completion of the weekly generator inspections. The RDES stated the vendor account where he inputted the information had been suspended since 07/2022, and he was out for surgery from 12/2022 to 02/2023. The RDES indicated he had pictures of the generator panel from 07/2022 to 12/2022 and from 02/2023 to 03/09/2023 but had nothing documented. According to the RDES, when he was out for surgery, the Maintenance Technician (MT) was supposed to complete the weekly inspections. The RDES acknowledged the findings and stated he expected all life safety code requirements to be followed. During an interview on 03/08/2023 at 6:15 PM, the Administrator stated he was aware of the generator weekly and monthly inspection, testing, and maintenance code requirements. The Administrator stated he had not looked at the weekly or monthly generator inspection maintenance but would start reviewing it. Per the Administrator, he expected all life safety code requirements to be followed. In an interview on 03/09/2023 at 9:49 AM, the MT stated he was responsible for the monthly generator preventative inspection, testing, and maintenance. The MT indicated he tested the generator under load, but it was not documented because he was not taught to document the generator was tested under load. The MT stated he did not document the time it took for the generator to transfer power because he was not aware it had to be documented. The MT acknowledged the findings and indicated he expected all life safety code requirements to be met and followed.	K 918	runs and load runs will be logged accordingly, and reviewed by the Administrator/ Regional Director of Environmental Services, weekly/ monthly, and on an on going basis. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur. 1. The Director of Maintenance/ designee will inspect the generator sets weekly and exercise a non load run. This inspection will be documented in a log with the findings reported to QAPI monthly, on an on going basis. 2. The Director of Maintenance/ designee will exercise the emergency generator 12 times each year for at least 30 minutes in a 20 to 40 day interval. On an on going basis. 3. The Director of Maintenance/ designee will document the time needed for the generator to transfer power to the building was within 10 second time frame, monthly on an on going basis, with findings reported to QAPI monthly. 4. The Administrator and Regional Director of Environmental Services will continue to provide oversight of this process. Findings will continue to be reported to QAPI committee, monthly on an on going basis.	

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K 918	Continued From page 6 During an interview on 03/09/2023 at 12:11 PM, the Director of Maintenance stated he was responsible for ensuring the generator was inspected, tested, and maintained per the life safety code, but he had just started in the position in 10/2022 and had not been trained on all the life safety code requirements related to the generator. The Director of Maintenance indicated he had not looked at the generator weekly or monthly documentation. The Director of Maintenance acknowledged the findings and stated he expected all life safety code requirements to be followed. New Jersey Administrative Code 8:39-31.2(g)	K 918		

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)
315087	A. Building 01 - MAIN BUILDING 01 B. Wing	4/24/2023

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 Reg. # NFPA 101 LSC K0761	Correction Completed 04/10/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 04/10/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
3/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO