STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315477	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	**493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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		
F 000	INITIAL COMMENTS Complaint #s NJ 167090, NJ 172710, NJ 175391, STANDARD SURVEY: 8/25/24-8/29/24 CENSUS: 87 SAMPLE SIZE: 18+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to consistently follow standards of clinical practice with regards to ensuring a medication was administered to a resident and not left at the	F 658	1. Resident #338 did not take the [NJ Ex Order 26.4(b)(1)] [redacted] on the evening of [NJ Ex Order 26.4], as per practitioner orders.	9/12/24

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

Electronically Signed | 09/15/2024

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F 658	Continued From page 1 bedside for 1 of 8 residents, Resident # 338, observed during medication administration. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 8/28/24 at 10:00 AM, the surveyor observed the Licensed Practical Nurse (LPN) #1 administer medication to Resident #338. The LPN #1 accompanied by the surveyor entered the resident's room and approached the resident's bedside. Resident #338 handed the LPN #1 a	F 658	8/28/24, the attending physician for Resident #338 was notified of the resident's refusal of the NJ Ex Order 26.4(b)(1) [redacted] on the evening of [redacted] by the Director of Nursing. The Director of Nursing clarified nursing documentation to include the [redacted] was refused on [redacted] LPN#2 was educated on the Policy titled, "Administering Oral Medications," which includes but is not limited to, the procedure to remain with the resident until all medications have been taken; in addition, to notify the supervisor if the resident refuses, the procedure. The NJ Ex Order 26.4(b)(1) [redacted] was immediately disposed of as per policy with use of a drug buster. Resident #338 had NJ Exec Order 26.4b1 [redacted] related to this practice. 2. All residents have the potential to be affected by this practice. The Director of Nursing provided in-service education to LPN#1 on the policy and procedure for Disposal of Non-Hazardous Medications. 3. The Director of Nursing provided LPN#2 with in-service education on the policy and procedure for Administering Oral	

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F 658	Continued From page 2 clear medicine cup with NJ Ex Order 26.4b1 [redacted] taken from the bedside table. The resident stated they were handing it to the LPN #1 because they forgot to take the NJ Ex Order 26.4(b)(1)]. The LPN #1 took the medicine cup from the resident and then administered the routine medications that the resident was scheduled to take. The LPN #1 threw out the medicine cup in the garbage bin. The surveyor interviewed the LPN #1 outside of the room about the medicine cup with the capsule. The LPN #1 stated she did not know about the medication, and she did not give to the resident. The LPN #1 stated it could have been from last night's nurse, but she was not sure. The LPN #1 acknowledged medication should not be left at the resident's bedside. The surveyor asked the LPN #1 about where the medicine cup with the capsule was. The LPN #1 accompanied by the surveyor returned to the resident's room. The LPN #1 retrieved the plastic garbage bag that contained the medicine cup with the capsule from the garbage bin. The surveyor observed the capsule in the medicine cup in the plastic bag. The LPN #1 removed the plastic bag from the resident's room and disposed of the medication. On 8/28/24 at 11:00 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated medications to be administered should not be left at the resident's bedside by the nurses. The surveyor informed the [redacted] of the above concerns. The [redacted] stated she would follow up and provide additional information. The Surveyor reviewed the electronic health	F 658	Medications. The Director of Nursing provided in-service education to all nurses on the policy and procedure of “Administering Oral Medications.” Education included but was not limited to: remain with the resident until all medications have been taken; and notify the supervisor and attending physician if the resident refuses the procedure..” The Director of Nursing provided in-service education to all nurses on the policy for “Discarding and Destroying Medications” which included but was not limited to the disposal of medications in the Drug Buster drug disposal system. 4. The Pharmacy Consultant will conduct monthly medication observations for two nurses per month x 12 months, then one nurse per month on an on-going basis. The results of the observations will be provided to the Director of Nursing, Administrator, as well as the QAPI committee monthly for review and follow-up as needed. The Director of Nursing or designee will conduct random audits of four nurses per week on rotating shifts to ensure the nurse remains with the resident until all medications are taken. Audits will be conducted weekly x 4 weeks, then monthly x 3 months, then quarterly x 2	

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F 658	Continued From page 3 record (EHR) of Resident #338. The Admission Record (a summary of important resident information), Resident #338 had diagnoses that included NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) A Comprehensive Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated NJ Ex Order 26.4(indicated the facility assessed the resident's NJ Exec Order 26.4 using a Brief Interview Mental Status (BIMS) test. Resident #338 scored a NJ Ex out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1). A physician's order dated NJ Ex Order 26.4 read: 'NJ Ex Order 26.4(b)(1) Give 1 capsule by mouth in the evening for NJ Ex Order 26.4(b)(1) A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed for the entry of NJ Ex Order 26.4(b)(1) it was signed by the nurse as administered on NJ Ex Order 26.4 at 1700 [5 PM]. On 8/28/24 at 1:44 PM, the surveyor, in the presence of the survey team, informed the U.S. FOIA (b) (6)) and the U.S. FOIA of the above concern. There was no verbal response by the facility at this time. On 8/29/24 at 8:30 AM the facility provided a follow up investigation related to the NJ Ex Order 26 medication that was found at Resident #338's bedside. The investigation included a written statement by the LPN #2 who was the assigned nurse for Resident #338 on NJ Ex Order 26.4 in the evening. The written statement revealed that LPN	F 658	quarters. Results of the audits will be provided to the Administrator, as well as the QAPI committee monthly for review and follow-up as needed. The QAPI committee meets on a monthly basis.	

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F 658	Continued From page 4 #2 gave Resident #338 the NJ Ex Order 2 capsule and did not observe the resident take the medication. The LPN #2 further revealed she did not know Resident #338 did not take the NJ Ex Order 2 medication. The surveyor reviewed the facility's provided policy titled, "Administering Oral Medications" with a last revised date of October 2010. Under Steps in the Procedure it read, " ...21. Remain with the resident until all medications have been taken ..." Additionally it read Under Reporting, "1. Notify the supervisor if the resident refuses the procedure ..." NJAC 8:39-11.2 (b); 29.2(d)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to maintain the necessary NJ Ex Order 26.4(b)(1) and services for residents who were receiving NJ Ex Order 26.4(b)(1) treatments according to standards of practice. This deficient practice was identified for one (1) of three (3) residents (Resident #35) reviewed for	F 695	1. Resident # 35's NJ Ex Order 26.4(b)(1) and NJ Ex Order 2 were immediately discarded. New NJ Ex Order 2 was provided. It was labelled and placed in a NJ Ex Order 26.4(b)(1) The Patient Centered Care Plan was immediately updated for Resident #35 to	9/12/24

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F 695	Continued From page 5 NJ Ex Order 26.4b1. This deficient practice was evidenced by: On 08/25/24 at 09:27 AM, the surveyor observed Resident #35 lying in bed with the NJ Ex Order 26.4 was not dated. The surveyor asked Resident #35 if the NJ Ex Orde had been changed weekly. Resident #35 did not know if the NJ Ex Orde was being changed weekly. The surveyor reviewed the medical records of Resident #35 The resident's Admission Record (AR; or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) A review of the Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, revealed a Brief Interview for Mental Status (BIMS) score was NJ Ex O which indicated that the resident's NJ Exec Order 26.4b was NJ Ex Order 2 The NJ Ex Order 26.4(b)(1) Order Summary Report (OSR) revealed an order date of NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b)(1) every 6 hours NJ Ex Order 26.4(b)(1) . Document any NJ Ex Order 26.4(b)(1) A review of the Patient Center Care Plan (CP) revealed there was not a care plan in place for the NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), or any NJ Ex Order 26.4(b)(1) care plans.	F 695	include NJ Ex Order 26.4(b)(1) needs including but not limited to physician's orders for NJ Ex Order 26.4(b)(1) treatment, i.e. NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Resident #35 had NJ Ex Order 26.4(b)(1) related to this practice. 2. All residents have potential to be affected. 3. The Director of Nursing and Infection Preventionist conducted an audit of all residents with Practitioner Orders for Nebulizer treatments to ensure nebulizer treatment masks and tubing were dated, clean and stored as per policy. The Director of Nursing and Infection Preventionist provided in-service re-education to all nurses on the policy and procedure for "Administering Medication through a Small Volume Nebulizer" which included but was not limited to labeling, dating and storage of nebulizers. The Director of Nursing provided In-service re-education for nurses on the importance of person-centered care plans to address residents' needs including but not limited to respiratory care plans for residents receiving nebulizer treatments or incentive spirometry. 4. The MDS Specialist conducted an audit of	

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F 695	Continued From page 6 On 8/29/24 at 11:57 AM, surveyor interviewed the U.S. FOIA (b) (6)), he stated, "that all NJ Ex Order 2 is changed every Wednesday on night shift and that it should be labeled and dated to ensure all staff are aware of when it was done. My expectation of staff is to follow facility policy. The nurse should administer medication as ordered and then NJ Ex Order 26.4(b)(1) and equipment in a labeled and dated bag. Doing these tasks ensures that the resident is not NJ Ex Order 26.4(b)(1) and keeps the equipment clean to prevent infection." During the interview the U.S. and surveyor observed the NJ Ex Order 26.4(b)(1) equipment not labeled and with NJ Ex Order 26.4(b)(1) in the NJ Ex Order 26.4(b)(The U.S. acknowledge these findings. A review of a treatment administration record (TAR) dated NJ Ex Order 26.4(b through and including NJ Ex Order 26.4(b)(1) revealed the resident had an NJ Ex Order 26.4(b)(ordered NJ Exec Order 26.4b1 daily for NJ Ex Orde and NJ Ex Orde On 8/29/24 at 12:22 PM, surveyor interviewed the U.S. FOIA (b) (6), who stated, "that the NJ Ex Order 26.4(b)(1) equipment should be labeled and dated, NJ Ex Order 26.4 in between uses and stored in a NJ Ex Order 26.4(b)(1) that is dated as per policy." Furthermore, she stated that a resident on a NJ Ex Order 26.4(b)(1) treatment should be care planned for that treatment or NJ Ex Order 26.4(b)(1) On 8/29/24 at 12:34 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated, "I expect the facility policies to be followed by all staff." During the interview the U.S. FOIA (b) and the U.S. FOIA reviewed Resident #35's CP and acknowledged that there was not a NJ Ex Order 26.4(b)(1) treatment care plan in place.	F 695	100% of residents with Practitioner Audits for nebulizer treatments and/or incentive spirometry to ensure a respiratory plan of care was in place. MDS Specialist or designee will conduct audits of all residents with practitioner orders for nebulizer treatments to ensure a respiratory care plan has been initiated. Audits will be conducted weekly x 3 weeks, then monthly x 3 months with results of the audits provided to the Administrator and the QAPI committee monthly x 3 months. The Infection Preventionist or designee will conduct audits of all residents with practitioner orders for nebulizer treatments to ensure nebulizer masks and tubing are labeled and stored according to policy. Audits will be conducted weekly x 3 weeks, then monthly x 3 months with results of the audits provided to the Administrator and the QAPI committee monthly x 3 months. The QAPI committee meets monthly and will determine the need for further audits and/or reporting.	

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F 695	Continued From page 7 A review of the policy "Administering Medication through a Small Volume Nebulizer" with a revision date of October 2010, provided by the LNHA read as follows: Purpose: the purpose of this procedure is to administer aerosolized particles of medication safely and aseptically into the resident's airway. #27) Steps in the procedure: Rinse and disinfect the nebulizer equipment according to facility protocol, or: a) wash pieces with warm, soapy water. b) rinse with hot water. c) place all pieces in a bowl and cover with isopropyl (rubbing) alcohol, soak for 5 minutes. d) rinse all pieces with sterile water (NOT tap, bottled, or distilled); and e) allow to air dry. #29) When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. N.J.A.C. 8:39-27.1(a)	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		9/12/24

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F 880	Continued From page 8 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 9 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) follow appropriate infection control practices for personal protective equipment (PPE) use when exiting an NJ Ex Order 26.4(b)(1) room to decrease the possibility of spreading infection for 1 of 4 nurses observed during medication administration and, b.) follow appropriate infection control practices and perform appropriate hand hygiene as indicated during meal service observation in 1 of 4 units (South Unit) for 1 of 2 staff observed during meal service. This deficient practice was evidenced by the following: A review of the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Clean Hands Count for Healthcare Providers, reviewed 1/8/2021, included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your	F 880	1. LPN#1 was immediately provided in-service re-education, as well as a competency by the Director of Nursing, on the policies and procedures for "Enhanced Barrier Precautions" and "Personal Protective Equipment." Resident #60 had signage on the door indicating Enhanced NJ Ex Order 26.4(b)(1) Resident #60 had NJ Ex Order 26.4(b)(1) related to this practice. Resident #338 had signage on the door indicating NJ Ex Order 26.4(b)(1) Resident #338 had NJ Ex Order 26.4(b)(1) related to this practice. US FOIA (was immediately provided in-service re-education by the Director of Nursing	

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F 880	Continued From page 10 hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry." 1. On 8/28/24 at 9:28 AM, the surveyor observed the Licensed Practical Nurse (LPN) #1 administer medication to Resident #60. The door to the resident's room had an [NJ Ex Orde] sign. [NJ Ex Orde] indicated that PPE such as gloves and [NJ Ex Order] should be worn while providing high-contact care activating with a resident to reduce the NJ Ex Order 26.4(b)(1) [redacted] The surveyor observed the LPN #1 don gloves and [NJ Ex Order] prior to entering the resident's room to administer medication. the LPN #1 administered a [NJ Ex Order] [redacted] to the resident. The surveyor observed the LPN #1 put her gloved hands under her gown into her scrub top pockets and retrieve the plastic top for the [NJ Ex Order 26.4(b)(1)]. The LPN #1 then applied a NJ Ex Order 26.4(b)(1) to the resident's [NJ Ex Orde] while the resident was lying in their bed. The LPN #1 gave Resident #60 the oral (by mouth) medications to be given. [NJ Ex Order] the LPN #1 observed the resident take their medications, the LPN #1 with her gloved hands, searched through her scrub pockets without removing any items. Upon exiting the room, the LPN #1 at the doorway removed her gown and gloves disposing the items outside the resident's room in the medication cart garbage bin. At 8/28/24 at 10:00 AM, the surveyor observed the LPN #1 administer medications to Resident #338. The door to the room of Resident #338 had an [NJ Ex Orde] sign. The surveyor observed the LPN #1 don gloves and [NJ Ex Order] prior to entering the resident's room to administer medication. The LPN #1 administered medications to the resident	F 880	and Infection Preventionist (IP) on the policies of "Handwashing/Hand Hygiene," "Enhanced Barrier Precautions," and "Assisting the Resident with In-room Meals." The resident in rooms #132 [NJ Ex Order 26] [redacted] effects related to this practice. 2. All residents have the potential to be affected by this practice. 3. The Director of Nursing and Infection Preventionist (IP) provided In-service re-education to all staff on the policies for: "Enhanced Barrier Precautions," "Personal Protective Equipment," "Handwashing/Hand Hygiene," and "Assisting the Resident with In-room Meals." The education included but was not limited to donning/doffing of PPE, including the discarding of PPE. The Infection Preventionist conducted an audit of all residents who are on Enhanced Barrier Precautions (EBP) to ensure proper signage on the door indicating the need for EBP. The Infection Preventionist and Director of Nursing provided in-service education to all CNAs on the policy and procedure for "Handwashing/Hand Hygiene," between residents, upon entering and exiting resident rooms, and during meal service assistance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315477	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	**493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470**

(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 880	Continued From page 11 and exited the room. The LPN #1 removed her [NJ Ex Order] and gloves outside doorway of the room and disposed of the PPE in the medication cart's garbage bin. On 8/28/24 at 12:45 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1 about PPE use. The LPN #1 stated when removing used PPE [NJ Ex Order] and gloves, they should be disposed of inside the room. The LPN #1 further stated gloved hands shouldn't be put inside scrub pockets under PPE [NJ Ex Order] The surveyor discussed observations during medication administration pass. The LPN #1 acknowledged she did not dispose of removed PPE prior to exiting the room and should not have disposed the used PPE in the medication cart garbage bin outside of the room. Additionally, the LPN #1 stated she should not have put gloved hands under her gown and into her scrub pockets. On 8/28/24 at 12:51 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] about PPE use and removal. The [U.S.] stated PPE should be disposed of in the resident's room, prior to exit and not outside the room in the hallway. The [U.S.] stated it was not ok to go into pockets with gloved hands while using PPE and in the resident's room. The surveyor discussed the above concerns observed during medication administration by the LPN #1. The [U.S.] acknowledged it was not appropriate protocol. On 8/28/24 at 1:44 PM, the surveyor, in the presence of the survey team, informed the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] of the above concerns observed during medication administration. There was no verbal response by the facility at this time.	F 880	The Director of Nursing provided in-service re-education to all CNAs on the use of a disposable clothing protector to be used at mealtimes, as requested by a resident. 4. The Infection Preventionist (IP) or designee will conduct random audits for PPE use and handwashing compliance including donning/doffing and disposal of PPE as well as handwashing/hand hygiene between residents and at mealtimes. Audits will be conducted on 5 staff per day x one week, then 10 staff members per week x 4 weeks, then 10 staff members per month x 3 months. Results of the audits will be reported to the Administrator and QAPI committee monthly x 4 months for review and follow up as needed. The QAPI committee meets on a monthly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315477	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	**493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470**

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F 880	Continued From page 12 On 8/29/24 at 8:30 AM, the facility provided competency of PPE use for LPN #1. There was no additional response provided by the facility. The surveyor reviewed the facility's policy titled "Enhance Barrier Precautions" with a last revised date of August 2022. The policy did not address removal and disposal of PPE. The surveyor reviewed the facility's policy titled "Personal Protective Equipment" with a last revised date of October 2018. Under Policy Interpretation and Implementation, it read, " ...5. Training on the proper donning, use, and disposal of PPE is provided upon orientation and at regular intervals ..." The policy did not further address removal and disposal of PPE. 2. On 8/28/24 at 12:05 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the facility had a communal dining area, but most of the residents preferred meals in their rooms. On 8/28/24 at 12:15 PM, the surveyor observed meal service in the South Unit. The surveyor observed the U.S. FOIA (b) (6)) approached the food cart, removed a tray and entered room # NJ Ex Orc The U.S. FOIA placed the food tray on the bedside table (BST) of the resident who resided in the right side bed and moved the BST closer to the resident. The resident requested a cup of ice. The U.S. FOIA exited the room,	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 13	F 880		

went to the ice machine, used the scoop, removed the ice, reentered room #134 delivered the cup of ice, exited the room and returned to the food cart with no observed hand hygiene.

The surveyor observed signage outside of Room # 132 which indicated the resident was on NJ Ex Order 26.4(b)(1)) which included: everyone must clean their hands, including before entering and when leaving the room; wear gloves and a NJ Ex Order for the following NJ Exec Order 26.4b1 Activities which included... 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) or NJ Ex Order 26.4(b)(1), device care or use including central line, 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) including any NJ Ex Order 26.4(b)(1)

On 8/28/24 at that same time, the surveyor observed the CNA removed a tray from the food cart, and with no observed hand hygiene, entered resident room # NJ Ex Ord placed the food tray on the BST of the resident who resided in the right side bed , removed the plastic coverings from the food items, and poured the NJ Ex Order 26.4(b)(1) into a cup. The U.S. FOIA exited the room and went directly to the linen cart with no observed hand hygiene. The surveyor observed the U.S. FOIA removed a pillowcase from the linen cart and reentered room # NJ Ex O right side. The U.S. FOIA placed the pillowcase on top of the residents clothing which the U.S. FOIA explained she used to protect the residents clothing. The surveyor observed the U.S. FOIA then went directly to the resident in room # NJ Ex O and put a towel on the resident which she again stated was used as a clothing protector. There was no observed hand hygiene when the U.S. FOIA entered the room, exited

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	315477	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	**493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470**

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F 880	Continued From page 14	F 880		

the room or between visiting the residents.

On that same date, at 12:45 PM, the surveyor discussed the breaks in infection control with the U.S. FOIA who acknowledged she should have performed hand hygiene between residents. The surveyor showed the U.S. FOIA the NJ Ex Ord signage. The U.S. FOIA stated that she was not aware that she should have performed hand hygiene when entering and exiting a resident's room who was on NJ Ex Order.

A review of the facility's policy entitled, " Handwashing/ Hand Hygiene", dated as revised and edited on 3/18/2024 revealed...the facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections...all personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections...all personnel are expected to adhere to hand hygiene policies and procedures.

A review of the facility's policy entitled; "Enhanced Barrier Precautions" dated as revised 8/2022 revealed ...the EBPs are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents...staff are trained prior to caring for residents on EBPs.

A review of the facility's policy entitled; "Assisting the Resident with In-room Meals" revised 12/2013 revealed...the purpose of this procedure is to provide appropriate assistance for residents who choose to receive meals in their rooms...place the tray on the overbed table...open cartons as necessary...assist resident as necessary...wash your hands.

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	315477	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	**493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470**

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F 880	Continued From page 15 On 8/28/24 at 1:44 PM, the surveyor discussed the above observations and concerns with the [U.S. FOIA (b)] and [U.S. FOIA (b) (6)] who acknowledged that hand hygiene should be performed according to CDC regulations including before entering and exiting a resident's room who is on [NJ Ex Ord] and between residents during meal service assistance. No further information was provided. NJAC 8:39 - 19.4(a); (n)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061619	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	1. The facility leadership team has met on ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified staffing needs. 2. Any resident has the potential to be affected. 3.	9/30/24

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

Electronically Signed | 09/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061619	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

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S 560	Continued From page 1 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 Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 08/11/2024 to 08/24/2024, the facility was deficient in CNA staffing for residents on five (5) of 14 day shifts as follows: -08/11/24 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -08/12/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/14/24 had 9 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/17/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. -08/18/24 had 8 CNAs for 83 residents on the day	S 560	The facility has implemented a significant above market rate for nurses and certified nursing assistants. The facility has implemented an incentive program including sign-on bonuses for new hires, and referral bonuses for employees referring staff where appropriate. The facility continues to conduct ongoing job fairs, internally and externally with immediate interviews and contingency offers. The facility implemented an expedited onboarding process to new hires. The facility will use agency staff as needed to meet staffing needs. 4. The DON and/or Designee meets with the staffing coordinator daily to review facility census, call outs if any, and staffing needs. The DON and/or Designee will monitor call outs and staffing ratios weekly until the requirement is met. The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061619	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	**493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470**

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S 560	Continued From page 2 shift, required at least 10 CNAs. On 08/28/24 at 12:46 PM, the surveyor interviewed the Certified Nursing Assistant/ Staffing Coordinator (CNA/SC). The CAN/SC stated she was aware and based the staffing schedule on the state regulations. The CNA/SC stated that staffing regulations were met majority of the time. On 8/29/24 at 9:30 AM, the surveyor asked the Director of Nursing, and the Licensed Nursing Home Administrator for any policy related to sufficient staffing. No further information was provided.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315477	A. Building B. Wing	10/21/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 09/12/2024	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 09/12/2024	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 09/12/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061619 (Y1)	A. Building B. Wing (Y2)	10/21/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

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 09/30/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315477	A. BUILDING **01** B. WING _____	**08/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	**493 BLACK OAK RIDGE ROAD** **WAYNE, NJ 07470**

(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/28/2024 and 08/29/2024, and Care One at Wayne was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Care one at Wayne is a two-story building with a partial basement built in 1966 with an addition built in 2023. Acute care is located on the first floor and therapy is in the basement. The facility is composed of Type II protected construction and divided into four - smoke zones. The 500 KW generator does approximately 75 % of the existing building and the 350 KW generator does 100% of the addition building as per the Regional Maintenance Director.	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		8/30/24

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

Electronically Signed | 09/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315477	A. BUILDING **01** B. WING _____	**08/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	**493 BLACK OAK RIDGE ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 1 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/28/2024 in the presence of U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that 2 of 5 kitchen cooking equipment's wet chemical fire suppression systems nozzles were in the proper position to protect against fire in accordance with NFPA 101: 2012 Edition, Section 19.3.2.5.1 and NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation in the facility kitchen at 1:40 PM, revealed that the wet chemical fire suppression system (over the cooking equipment) had two suppression spray nozzles aimed upward and not positioned to protect the cooking equipment. In an interview at that time, the U.S. FOIA (and U.S. FO confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 8/28/2024.	K 324	1. The Director of Environmental services immediately contacted NJ Ex Order 26.4(b)(1) (the vendor) for a service call to adjust the positioning of the 2 nozzles for the wet chemical fire suppression system. 8/30/24 the Vendor adjusted the nozzles over the appliance line. All drops are now positioned as per regulation over appliances. No residents had untoward effects related to this practice. 2. All residents have the potential to be affected by this practice. 3. The Regional Environmental Services Director provided in-service education to the U.S. FOIA (b) (6) and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315477	A. BUILDING **01** B. WING _____	**08/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	**493 BLACK OAK RIDGE ROAD** **WAYNE, NJ 07470**

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K 324	Continued From page 2 NJAC 8:39-31.2(e) NFPA 96	K 324	U.S. FOIA (b) (6) regarding proper positioning of all nozzles of the wet chemical fire suppression system (over the cooking equipment) to protect the cooking equipment. NJ Ex Order 26.4(b)(1) (the vendor) will conduct semi-annual inspections on an on-going) of the suppression system in the dietary department to ensure proper alignment of all nozzles. 4. The Environmental Services Director or designee will conduct routine inspections of the suppression system in the dietary department to ensure proper alignment of all nozzles. The inspections will be weekly x 4 weeks, then monthly x 3 months, then quarterly x 2 quarters. Results of the inspections will be provided to the Regional Environmental Services Director as well as the QAPI committee monthly for review and follow-up as needed. The QAPI committee meets monthly.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		9/12/24

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K 345	Continued From page 3 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 8/28/2024 and 8/29/2024 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that smoke detection sensitivity testing of the smoke detectors were completed in accordance with NFPA 72 National Fire Alarm and Signaling Code [2010 Edition] Section 14.4.5.3.2. This deficient practice had the potential to affect all residents and was evidenced by the following: 1. Observations on 08/28/24 from 9:10 AM to 3:45 PM, revealed smoke detectors were in the corridors, the resident rooms, and other concealed areas throughout the building. 2. A review of the facility's "Inspection and Testing Reports," dated 02/23/24, provided by the U.S. FO on 8/29/2024, revealed the report had no reference to a smoke detection sensitivity test. In an interview at the time of the observations, the U.S. FO confirmed the smoke sensitivity testing was not completed on the smoke detectors. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were notified of the deficient practice at Life Safety Code survey exit conference at 3:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	1. The Fire Alarm System was installed February 2023. The smoke detection sensitivity test was performed 9/11/2024. No residents had untoward effects related to this practice. 2. All residents have the potential to be affected by this practice. 3. The vendor, NJ Ex Order 26.4b1 will perform inspection of the Fire Alarm system (smoke detection sensitivity test) every two years beginning September 11, 2024 with the next scheduled inspection September 11, 2026. The Environmental services director has sent a calendar invite to the vendor for this scheduled inspection date. 4. The Environmental Service Director or designee will maintain the calendar reminder for the Fire Alarm Vendor to conduct the bi-annual inspection of the smoke detection sensitivity test.	

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K 345	Continued From page 4	K 345	Results of the inspections will be provided to the Regional Environmental Services Director, the facility Administrator. as well as the QAPI committee on a bi-annual basis for review and recommendation as needed. The QAPI committee meets monthly.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/28/2024 in the presence of the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide automatic fire sprinkler protection to all	K 351	1. The Director of Environmental services immediately contacted NJ Exec Order 26.4b1 [redacted] (the vendor). A quote and purchase order have been obtained	9/30/24

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K 351	Continued From page 5 areas of the facility in accordance with NFPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations between 10:33 AM and 3:00 PM at stairwells A, B, C and D, revealed there was no fire sprinkler coverage under first accessible landing. In an interview at the time, the U.S. FO and U.S. FOIA (b) confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the findings at the life safety Code survey exit on 08/29/2024. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351	and the installation of automatic fire sprinkler protection (sprinkler heads) to the first accessible landing in Stairwells A, B, C and D has been scheduled for 9/27/2024. No residents had untoward effects related to this practice. 2. All residents have the potential to be affected by this practice. 3. The Regional Environmental Services Director conducted environmental rounds with the Environmental Services Director to ensure automatic fire sprinkler protection was in all areas of the facility in accordance with NFPA 13 and NFPA 101:2012, Sections 9.7 and 19.3.5.1. 4. The Environmental Services Director or designee will ensure quarterly inspections are maintained of the automatic sprinkler system by an approved vendor (i.e. Fire Security Technology). Results of the quarterly inspections will be provided to the Regional Environmental Director; the facility Administrator as well as the QAPI committee monthly for review and recommendation as needed. The QAPI committee meets monthly.	
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101	K 362		8/30/24

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K 362	Continued From page 6 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/28/2024 in the presence of U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined the facility failed to ensure that corridor walls were constructed to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6.2 and 19.3.2.7. This deficient practice had the potential to affect residents and was evidenced by the following: 1. An observation at 3:29 PM with the U.S. FO and U.S. FOIA (b) revealed a hole in the wall above the corridor door in the ceiling next to room #103.	K 362	1. The penetration above the corridor door in the ceiling next to room #103 was immediately repaired on 8/28/24 by the Environmental Services Director. The penetration above the corridor door in the ceiling next to room #101 was immediately repaired on 8/28/24 by the Environmental Services Director. No residents had untoward effects related to this practice. 2.	

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K 362	Continued From page 7 2. An observation at 3:33 PM with the U.S. FO and U.S. FOIA (b) revealed a hole in the wall above the corridor door in the ceiling next to room #101. In an interview at the time, the U.S. FO and U.S. FOIA (b) confirmed the observation. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were notified of the deficient practice at Life Safety Code survey exit conference on 08/29/2024. N.J.A.C. 8:39-31.2(e)	K 362	All residents have the potential to be affected by this practice. The Regional Environmental Services Director conducted facility rounds with the Director of Environmental Services to demonstrate the procedure on how to inspect for any holes/ penetration in the facility walls. 3. The Regional Environmental Services Director provided in-service education to the U.S. FOIA (b) (6) to immediately inspect areas after any service and/or repair work has been completed by facility vendors. 4. The Environmental Services Director or designee will conduct routine inspections of the facility's walls to ensure there are no holes or penetrations in the walls. The inspections will be conducted weekly x 4 weeks, then monthly, on-going. Results of the inspections will be provided to the Regional Environmental Services Director, the facility Administrator. as well as the QAPI committee monthly for review and recommendation as needed. The QAPI committee meets on a monthly basis.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall	K 521		8/30/24

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K 521	Continued From page 8 comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/28/2024 in the presence of U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), it was determined that the facility failed to maintain their Packaged Terminal Air Conditioner (PTAC) units in safe condition in accordance with NFPA 101:2012 Edition, Section 19.5.2.1. This deficient practice was identified for 7 of 68 PTAC units observed, had the potential to affect the residents in 7 rooms, and was evidenced by the following: During the tour between 8:30 AM and 3:35 PM in the presence U.S. FO and U.S. FOIA (b the surveyor observed the following: Room# 110,117,156,157,181,182 and 184 PTAC units filters were clogged and dirty. In an interview at the time, the U.S. FO and U.S. FOIA (confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the findings at the Life Safety Code survey exit on 08/29/2024.	K 521	1. The Environmental Services Director immediately cleaned the filters for the Packaged Terminal Air Conditioner (PTAC) units for rooms# 110, 117, 156, 157, 181, 182 and 184. No residents had untoward effects related to this practice. 2. All residents have the potential to be affected by this practice. 3. The Regional Environmental Services Director provided in-service education to the U.S. FOIA (b) (6) on the importance of maintaining the Packaged Terminal Air Conditioner (PTAC) units in safe condition in accordance with NFPA 101:2012 Edition, Section 19.5 2.1. The Environmental Services Director has implemented a monthly cleaning schedule for all PTAC units' filters within the facility. All employees in the Environmental	

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K 521	Continued From page 9 N.J.A.C. 8:39 - 31.2(e) NFPA 90A.	K 521	Services department were educated by the Environmental Services Director, with regards to the monthly cleaning schedule for the PTAC filters. 4. The Environmental Services Director will conduct inspections of 10 PTAC units to ensure the filters are cleaned as per the implemented cleaning schedule. Audits will be conducted weekly x 4 weeks, then monthly x 3 months, then quarterly x 3 quarters. The results of the inspection will be provided to the Regional Environmental Services Director, the facility Administrator. as well as the QAPI committee annually for review and follow-up as needed. The QAPI committee meets on a monthly basis.	
K 908 SS=F	Gas and Vacuum Piped Systems - Inspection and CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on	K 908	1.	10/16/24

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K 908	Continued From page 10 08/28/2024 in the presence of U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to inspect, maintain, and test the piped-in Oxygen system as part of a maintenance program in accordance with NFPA 99. This deficient practice had the potential to affect all residents and was evidenced by the following: 1. A review of the facility's annual medical gas system inspection assessment report dated 01/26/2024 indicated that medical gas area alarm inspection test in the following rooms: NJ Ex Order 26.4b1 [redacted] failed. Vendor comments "sensor stuck at 30". There were no repaired records provided by the facility. 2. A review of the facility's annual medical gas system inspection assessment report dated 2/16/2024 indicated the following: change over in use failed, emergency reserve in use failed and emergency reserve cylinder pressure low failed. Vendor comments "Do not activate." There were no repair records provided by the facility. In an interview at 3:15 PM, the U.S. FOIA [redacted] and U.S. FO [redacted] confirmed the findings. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference on 8/29/2024. NJAC 8:39-31.2(e) NFPA 99	K 908	The Environmental Services Director immediately contacted NJ Exec Order 26. [redacted] and NJ Exe [redacted] (the vendors) for repair services. Invoices and Purchase Orders were obtained to replace the vacuum gauge/sensor stuck at 30 for rooms including # 103-105, 127-131, 147, 148. The Environmental Services Director immediately contacted NJ Ex Order 26.4(b) [redacted] and NJ Ex O [redacted] (the vendors) for repair services. Invoices and Purchase Orders were obtained to replace the Emergency Reserve Cylinder. There are no residents residing in the facility with orders for suctioning, at this time. No residents had untoward effects related to this practice. 2. All residents have the potential to be affected by this practice. 3. The Director of Nursing conducted an audit of all residents with orders for NJ Ex Order 26.4b1 who reside in rooms including # NJ Ex Order 26.4(b)(1) [redacted]. Residents with practitioner orders for NJ Ex Order 26. [redacted] were provided with alternate means of NJ Ex Order 26.4 [redacted] including but not limited to NJ Ex Order 26.4b1 [redacted]. The Director of Nursing conducted an audit of all residents with practitioner orders for NJ Ex Order 26.4b1 [redacted] who reside in rooms	

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K 908	Continued From page 11	K 908	including # NJ Ex Order 26.4(b)(1). There are no residents with NJ Ex Order 26.4b1 orders at this time. Residents with NJ Ex Order 26.4b1 orders who are admitted to rooms including # NJ Ex Order 26.4(b) will be provided with alternate means of NJ Ex Order 26.4b1, including NJ Ex Order 26.4b1 machines. The Regional Environmental Services Director provided in-service education to the U.S. FOIA (b) (6) on the requirements to inspect, maintain and test the piped-in Oxygen system as part of the maintenance program in accordance with NFPA 99. Repair was compelted by vendor on 10/16/2024. 4. The Environmental Services Director will monitor the annual inspection by the vendor of the Gas and Vacuum Piped Systems. The results of the inspection will be provided to the Regional Environmental Services Director, the facility Administrator. as well as the QAPI committee annually for review and follow-up as needed. The QAPI committee meets on a monthly basis.	

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
315477 Y1	A. Building 01 - BUILDING B. Wing Y2	10/21/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WAYNE	493 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	08/30/2024	LSC K0345	09/12/2024	LSC K0351	09/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0362	08/30/2024	LSC K0521	08/30/2024	LSC K0908	10/16/2024
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	
8/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO