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 06/23/2023

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 000	INITIAL COMMENTS COMPLAINT #'s: 154746, 151002, 164246 CENSUS: 57 SAMPLE SIZE: 15 plus 4 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were not cited for this survey.	F 000		

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

Electronically Signed | 07/12/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 06/23/2023

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 is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 9 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1. HOW THE CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE. Care One at Wayne was found to have failed to maintain the required minimum direct care staff to resident ratio by the State of New Jersey on 9 of the 14 day shifts (5/28/23, 5/31/23, 6/4/23, 6/5/23, 6/6/23, 6/7/23, 6/8/23, 6/9/23, 6/10/23). There were no negative impacts (change of condition, accidents/incidents, acute transfers) related to direct care staffing needs on day shift 5/28, 5/31, 6/4, 6/5, 6/6, 6/7, 6/8, 6/9, 6/10 2023. 2. HOW THE FACILITY WILL IDENTIFY	7/12/23

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

Electronically Signed | 07/12/23

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 06/23/2023

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 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: 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. The surveyor requested staffing for the weeks of 05/28/2023 to 06/10/2023. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -05/28/23 had 5 CNAs for 52 residents on the day shift, required 6 CNAs. -05/31/23 had 5 CNAs for 48 residents on the day shift, required 6 CNAs. -06/04/23 had 5 CNAs for 54 residents on the day shift, required 7 CNAs. -06/05/23 had 6 CNAs for 54 residents on the day shift, required 7 CNAs. -06/06/23 had 6 CNAs for 54 residents on the day shift, required 7 CNAs. -06/07/23 had 5 CNAs for 54 residents on the day shift, required 7 CNAs.	S 560	OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTIVE AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents admitted on 5/28, 5/31, 6/4, 6/5, 6/6, 6/7, 6/8, 6/9, 6/10 2023 had potential impact on care needs on day shift related to minimum direct care staff to resident ratios not being met. 3. WHAT MEASURES WILL BE PUT IN PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. Director of Nursing will meet with Staffing Coordinator daily prior to schedule completion to compare CENSUS to scheduled DIRECT CARE staff to resident ratio in compliance with the Statute for New Jersey. Certified Nurses Aide job posting on Indeed updated bi-weekly by HR department in efforts to increase staffing pool, noting competitive rates and sign-on bonuses. Job fair planned to be on 8/9/23. Wage grid increased on 7/1/23 based on years of experience. Orientation being held by center weekly/PRN to accommodate new hires. 4. HOW THE FACILITY WILL MONITOR IT CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTIVE WILL NOT RECUR. All schedules will be reviewed weekly by Administrator to ensure compliance with the required minimum direct care staff to resident ratio x4 weeks then monthly x2. All findings will be reviewed at the quarterly QAPI meeting, committee will make further	

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 06/23/2023

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 560	Continued From page 2 -06/08/23 had 6 CNAs for 54 residents on the day shift, required 7 CNAs. -06/09/23 had 6 CNAs for 53 residents on the day shift, required 7 CNAs. -06/10/23 had 6 CNAs for 53 residents on the day shift, required 7 CNAs. On 06/20/23 at12:22 PM, the surveyor interviewed the Staffing Coordinator (SC), who stated she was aware of the state's minimum staffing ratios and that they were "sometimes and sometimes not" meeting the ratios. On 06/23/23 at 10:20 AM, the survey team met with the Director of Nursing and the Licensed Nursing Home Administrator (LNHA), they both acknowledged that they were aware of the staffing ratios and that they were "trying to meet them." The LNHA stated that they were "really struggling to get people in the door."	S 560	recommendations as needed.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061619 Y1	A. Building B. Wing Y2	7/21/2023 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 07/12/2023	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
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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	
6/23/2023	☐ 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
	315477	A. BUILDING **01** B. WING _____	**06/23/2023**

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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 06/20/2023. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/20/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Careone at 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 located in the basement. The facility is composed of Type II protected construction and divided into four - smoke zones. The generator does approximately 75 % of the building as per the Regional Maintenance Director. The current occupied beds are 59 of 74.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour.	K 311		8/1/23

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

Electronically Signed | 07/12/2023

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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 _____	**06/23/2023**

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 311	Continued From page 1 An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the vertical openings, four of four stairway exit doors on the 1st and 2nd floors were equipped with 45-minute fire-rated doors and not the required one-hour fire rated doors in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.3.4.2. This deficient practice had the potential to affect all 59 residents. Findings include: An observation at 06/20/23 at 12:13 PM revealed that the stairway doors were not the required one-hour fire rating. The US FOIA (b)(6) was present at time of inspection and verified the label on the door was only 45 minutes. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 311	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THIS PRACTICE. All fire doors within building audited and 7 doors found to be 45 minute fire rated and not the required 1 hour fire rated door. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. The construction team and US FOIA (b)(6) [redacted] were educated on regulation that stairwell doors are to be 60 minute rating not 45 minute rating. All residents have the potential to be affected. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. The 7 stairwell doors will be replaced with 60 minute fire rated doors. Doors have been ordered with expected delivery date 9/25/2023. The doors will be installed upon delivery. A time-limited waiver has been requested because the doors are not a stock item and they are fabricated from the project shop specific drawings with a typical led time 8-10	

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 _____	**06/23/2023**

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 311	Continued From page 2	K 311	weeks, we have paid to expedite this order for a 5-7 week lead time. Order placed from Kelly Brothers. 4. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. The Maintenance Director will monitor doors total 1 hour of fire rating to be in compliance with NFPA 101 Life Safety code sections 8.3.4.2. the doors will be part of routine weekly maintenance rounds, reported quarterly at QA meeting. 5. TIMEFRAME. To be completed by 9/25/2023	
K 918 SS=F	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 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	K 918		8/15/23

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 _____	**06/23/2023**

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 918	Continued From page 3 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 record review and interview, the facility failed to ensure the three year load bank test was completed on the existing emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1 This deficient practice had the potential to affect all 59 residents. Findings include: A document review of the generator reports for 2022 and 2023 provided by the US FOIA (b)(6) revealed a three year load bank test had not been completed for the emergency generator. During an interview at 12:20 PM on 06/20/23 the US FOIA (b)(6) confirmed the three year load bank test had not been completed on the existing emergency generator. NJAC 8:39-31.2(e). 31.2(g)	K 918	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THIS PRACTICE. Generator did not have a load bank test in 3 years. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. Maintenance Director educated the need for Generator load bank test every 36 months. All the residents have the potential to be affected. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. The Maintenance Director or	

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 _____	**06/23/2023**

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CAREONE AT WAYNE	**493 BLACK OAK RIDGE ROAD** **WAYNE, NJ 07470**

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K 918	Continued From page 4 NFPA 99, 110	K 918	designee will have generator load bank test done. A calendar reminder will be added to ensure testing is done as scheduled on both Outlook account, Generator log book and Maintenance Office posting for date due in 2026. 4. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. The Maintenance Department will monitor the testing and will ensure the 36 month load bank test will occur in 2026. The results of the Environmental Audit Tool Quality Assurance Performance Improvement Committee as to when the next testing will be needed. The tracking of date will be carried over as part of quarterly QA committee minutes for completion. 5. TIMEFRAME. 36 month load bank test will be completed by 8/15/2023	

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 _____	R **08/25/2023**

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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{E 000}	Initial Comments Facility is in compliance with K918. The facility is not in compliance with K311 and they are requesting a time-limited waiver. SA recommends approval. CMS approved the time-limited waiver request for K311 on 8/25/2023.	{E 000}		
{K 000}	INITIAL COMMENTS	{K 000}		

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

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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 01 - BUILDING B. Wing	8/25/2023

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 Reg. # NFPA 101 LSC K0311	Correction Completed 08/01/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 08/15/2023	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

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/23/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO