STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. BUILDING **01** B. WING _____	**10/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WALL	**2621 HIGHWAY 138** **WALL, NJ 07719**

(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 10/17/2023. 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 10/17/23 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 Wall is a Two-story building with a basement that was built in 2004, It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator does approximately 50 % of the building as per the Maintenance Director. The current occupied beds are 85 of 138.	K 000		
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 acceptance, maintenance and testing are readily available.	K 345		11/30/23

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

Electronically Signed | 11/04/2023

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.

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	315485	A. BUILDING **01** B. WING _____	**10/17/2023**

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K 345	Continued From page 1 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke detector in room 219 was not in alarm in accordance with NFPA 72 (2010 edition) section 14.3.1. This had the potential to affect all 85 residents who resided at the facility. Findings include: An observation on 10/17/23 at 12:57 PM revealed the smoke detector in room 219 was an activated alarm as indicated by the red light that was illuminated on the smoke detector. When checking the main fire alarm control panel on the [redacted]-floor, room [redacted] did not show it was activated. The Maintenance Director was present at the time of inspection and confirmed the smoke detector was in alarm. NJAC 8:39-31.1(c), 31.2(e) NFPA 70,72	K 345	K 345 (F) 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Smoke detector in Room 219 was indicating alarm mode when no hazard was indicated 2.How the facility will identify other residents having the potential to be affected by the same deficient practice All residents residing in facility have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not reoccur Director of Maintenance and vendor tested the smoke detector on panel and found to be working properly. Smoke detector was replaced on 10/24/23 with no further issues. Alarm signal has been resolved. 4. How the facility will monitor its corrective action to ensure that the deficient practice will not recur Director of Maintenance or Designee will audit all resident room smoke detectors to ensure they are not in alarm state. The Director of Maintenance or Designee	

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	315485	A. BUILDING **01** B. WING _____	**10/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WALL	**2621 HIGHWAY 138** **WALL, NJ 07719**

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K 345	Continued From page 2	K 345	will audit the alarm panel and smoke detectors weekly x4 weeks, then monthly ongoing. The results of the audit will be presented to the Quality assurance Committee monthly X3 then quarterly ongoing. Adjustments to the plan will be made based on the outcome of the audit and presented to the committee. Completion Date: 11/30/2023	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke detection was installed in rooms open to the corridor in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.1. This had the potential to affect all 85 residents who resided at the facility. Findings include: An observation on 10/17/23 at 12:53 PM revealed no smoke detectors were located in the resident lounge near room [redacted] that was open to the corridor. During an interview at the time of the observation, the Maintenance Director confirmed the smoke detectors were not installed in the resident	K 347	K 347 (F) 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by this deficient practice. A Smoke detector is installed in lounge on second floor. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in facility have the potential to be affected. Residents, staff and visitors safety will be maintained due	1/15/24

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K 347	Continued From page 3 lounge. NJAC 8:39-31.2(e) NFPA 70, 72	K 347	to several smoke detectors located in the immediate vicinity. A battery operated smoke detector was installed on 12/7/23 and was checked for operation daily until the project was complete. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not reoccur A battery operated smoke detector was installed and was monitored daily until the project completion of the hard wired detector was completed. 4. How the facility will monitor its corrective action to ensure that the deficient practice will not recur Director of Maintenance or Designee monitored the battery operated smoke detector daily until project completion. Results of the monitoring presented at QA monthly. Upon completion of the wired smoke detector it was tested and added to the regular inspection list. Maintenance director reports all inspection results at quarterly QAPI meeting. Completion Date: 01/15/2024	
K 525 SS=F	HVAC - Solid Fuel-Burning Fireplaces CFR(s): NFPA 101 HVAC - Solid Fuel-Burning Fireplaces Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: * Areas are separated by 1-hour fire resistance construction * Fireplace complies with 9.2.2	K 525		1/15/24

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K 525	Continued From page 4 * Fireplace enclosure resists breakage up to 650 degrees Fahrenheit and has heat-tempered glass * Room has supervised CO detection per 9.8 18.5.2.3(3) and 19.5.2.3(3) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the carbon monoxide detectors were electrically supervised and the glass doors were closed on the solid fuel-burning fireplace in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.5.2.3. This deficient practice had the potential to affect all 85 residents. Findings include: An observation on 10/17/23 at 2:35 PM revealed that the carbon monoxide detectors were battery operated and not electrically supervised. Continued observation revealed the glass doors on the solid fuel-burning fireplace were open with solid fuel burning in the fireplace. During an interview at the time of the observations, the Maintenance Director confirmed that the carbon monoxide detectors were not electrically supervised and that the glass doors were open. NJAC 8:39-31.2(e)	K 525	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by this deficient practice. Glass doors on the solid fuel-burning fireplace were immediately closed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in facility have the potential to be affected. During the project residents, staff and visitors were kept safe from any hazards as directed from the vendor installing the electric. Director of Maintenance was present during install to ensure safety is observed. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not reoccur Director of Maintenance and Administrator educated facility team on the importance of the glass doors being closed at all times on the fireplace.	

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K 525	Continued From page 5	K 525	Director of maintenance or designee will perform daily checks to ensure glass is closed on the fuel burning fireplace. Director of Maintenance or designee performed daily checks to ensure battery operated carbon monoxide detector device was functioning until the project is completed and they were hard-wired. How the facility will monitor its corrective action to ensure that the deficient practice will not recur The carbon monoxide detectors are now monitored via the main fire system and are on the regualar inspection schedule. Results of the audit of the glass doors will be presented to the Quality Assurance Committee monthly X3 and then quarterly X3 by the Maintenance Director. Adjustments to the plan will be determined by the results of the audit and updates will be submitted as necessary to the QA committee. Results of the Completion Date: 01/15/2024	

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)
315485	A. Building 01 - MAIN BUILDING B. Wing	2/23/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WALL	2621 HIGHWAY 138 WALL, NJ 07719

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 K0345	Correction Completed 11/30/2023	ID Prefix Reg. # NFPA 101 LSC K0347	Correction Completed 01/15/2024	ID Prefix Reg. # NFPA 101 LSC K0525	Correction Completed 01/15/2024
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
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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 10/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO	