

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315152	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER CAREONE AT WELLINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 301 UNION STREET , HACKENSACK, New Jersey, 07601	
(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
F0000	<p>INITIAL COMMENTS</p> <p>COMPLAINT #: 2604894, 2578526</p> <p>CENSUS: 121</p> <p>SAMPLE SIZE: 4</p> <p>THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.</p>	F0000		03/20/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060205	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2026
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S0000	Initial Comments Based on review of facility documents on 02/06/2026, it was determined that the facility failed to ensure staffing ratios were met for 11 of 14 day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts reviewed. This deficient practice had the potential to affect all residents. Findings include:	S0000		03/20/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: For the 2 weeks of complaint staffing from 1/18/2026-1/31/2026, the facility was deficient in CNA staffing for 11 of 14 day shifts, and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: On 1/18/26 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. On 1/19/26 had 11CNAs for 118 residents on the day shift, required at least 15 CNAs. On 1/20/26 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. On 1/21/26 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. On 1/22/26 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. On 1/24/26 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. On 1/25/26 had 6 CNAs for 120 residents on the day shift, required at least 15 CNAs.	S0560	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - The Administrator and the Director of Nursing immediately reviewed the daily staffing to ensure the minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties. No residents were adversely affected by this practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 2/6/2026 The Administrator and Director of	03/20/2026

Office of Primary Care and Health Systems Management

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S0560		S0560	Continued from page 2 Assurance Performance Improvement Committee (QAPI) at the monthly meeting on an on-going basis. The QAPI committee will review and determine the need for further follow up.	03/20/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 3/20/26 in relation to the 2/6/26 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 3/20/26 in relation to the 2/6/26 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		

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