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

PRINTED: 06/07/2024 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315313	B. WING _			C 04/15/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, C 221 COUNTY ROAD CRESSKILL, NJ 0	1 04/10/2024		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	INITIAL COMMENTS		F	000			
	Complaint #: NJ0017	2714					
	Census: 79						
	Sample Size: 3						
	42 CFR PART 483, S	THE REQUIREMENTS OF UBPART B, FOR LONG FIES BASED ON THIS					
ABORATORY	I DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUI	RF		TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

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

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

05/05/2024

New Jersey Department of Health

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
060208			B. WING			
ROVIDER OR SUPPLIER		DDRESS CITY ST	ATE ZIP CODE	04/15/2024		
			, 332			
E AT CRESSKILL						
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
Initial Comments		S 000				
Complaint #: NJ0017	2714					
standards in the New Chapter 8:39, Standa Term Care Facilities. Plan of Correction, in for each deficiency ar implemented. Failure result in enforcement the provisions of the Code, Title 8, chapter	Jersey Administrative Code, and for Licensure of Long The facility must submit a cluding a completion date and ensure that the plan is to correct deficiencies may action in accordance with New Jersey Administrative 43E, Enforcement of					
8:39-5.1(a) Mandator	y Access to Care	S 560		5/5/24		
by: Based on facility docuit was determined that staffing ratios were minimum staff-to-resist the State of New Jers. This deficient practice following: Reference: New Jers (NJDOH) memo, date with N.J.S.A. (New Jers 30:13-18, new minimursing homes," indicate.	ument review on 4/15/2024, at the facility failed to ensure set to maintain the required dent ratio as mandated by sey for 14 of 14 day shifts. The was evidenced by the set of the degree of the deg		How the corrective action will be accomplished for those residents four have been affected by the deficient practice The facility leadership team has met congoing basis and continued to identificate staffing challenges and areas of improvement for licensed and certified staffing needs. How the facility will identify other residuating the potential to be affected by same deficient practice All residents have the potential to be	on an fy d dents		
	ROVIDER OR SUPPLIER EAT CRESSKILL SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Initial Comments Complaint #: NJ0017. The facility was not in standards in the New Chapter 8:39, Standa Term Care Facilities. Plan of Correction, in for each deficiency arimplemented. Failure result in enforcement the provisions of the I Code, Title 8, chapter Licensure Regulation 8:39-5.1(a) Mandator (a) The facility shall of Federal, State, and loregulations. This REQUIREMENT by: Based on facility docuit was determined that staffing ratios were minimum staff-to-resit the State of New Jerst This deficient practice following: Reference: New Jerst (NJDOH) memo, date with N.J.S.A. (New Jerst (NJDOH) memo, date with NJDOH) memo, date with NJDOH (NJDOH) memo, date with NJDOH (N	DENTIFICATION NUMBER: 060208 ROVIDER OR SUPPLIER E AT CRESSKILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments Complaint #: NJ00172714 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. 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 facility document review on 4/15/2024, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 14 of 14 day shifts. This deficient practice was evidenced by the	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST. 221 COUNTY ROAD CRESSKILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments Complaint #: NJ00172714 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. 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 facility document review on 4/15/2024, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 14 of 14 day shifts. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE_ZIP CODE EAT CRESSKILL SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments Complaint #: NJ00172714 The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Terr 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, Itle 8, chapter 43E, Enforcement of Licensure Regulations. Signature 1: Security 1: Security 1: Security 2: Security 3: Secu		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE **Electronically Signed** 05/05/24

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		060208	B. WING		C 04/15/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
CAREONE	E AT CRESSKILL	221 COUN	TY ROAD			
OARLONI	- AT OREOGRIEE	CRESSKIL	L, NJ 07626			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
S 560	Continued From page	e 1	S 560			
	established minimum nursing homes. The feffective on 02/01/20 One Certified Nurse A residents for the day One direct care staff residents for the ever fewer than half of all CNAs, and each direct signed in to work as a shall perform nurse a One direct care staff residents for the night direct care staff mem CNA and perform CNA	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 rewer than half of all staff members shall be considered in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a considered considered that each direct care staff member shall sign in to work as a considered considered considered that each direct care staff member shall sign in to work as a considered considered considered considered that each direct care staff member shall sign in to work as a considered		What measures will be put into place systemic changes will be made to ensith the deficient practice will not recurrent facility census to ensure requirements per shift. The facility has implemented an incentive program including referral bonuses for employer eferring staff where appropriate, conducting job fairs, immediate intervity with contingency offers and expedited onboarding process for new hires. The DON and DOR continue to partner in addressing staffing challenges. Where appropriate, the occupational therapy assist in providing care and activities daily living to residents.	es ews the es	
	of 3/24/24 to 3/30/24 The facility was deficing residents on 14 of 14 total staff for resident as follows: -03/24/24 had the day shift, required -03/25/24 had on the day shift, required on the overnight shift staff. -03/26/24 had on the day shift, required reduced the day shift, required the day shift, required the day shift, required the day shift, required	I 10 CNAs for 87 residents ired at least 11 CNAs. I 5 total staff for 87 residents, required at least 6 total I 10 CNAs for 87 residents ired at least 11 CNAs. I 9 CNAs for 84 residents on		actions to ensure that the deficient practice is being corrected and will no recur, i.e. what QA program will be puplace to monitor the continued effectiveness of the systemic change. The DON and/or designee will meet with the staffing coordinator daily to review facility census, call outs if any, and staneeds. The DON and/or designee will monitor callouts and staffing ratios we until the requirement is met. The resu the audits will be forwarded to the fact administrator and QAPI Committee for futher review and recommendations a needed.	t into - vith viaffing ekly lts of elity r	

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	OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED			
					С		
		060208	B. WING		04/15/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE			
CAREONE	E AT CRESSKILL		NTY ROAD				
	OLIMANA DV OTA		LL, NJ 07626	DDOVIDEDIO DI ANI OF CODDECTIO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE		
S 560	Continued From page	2	S 560				
5 500	the day shift, required -03/29/24 had the day shift, required -03/30/24 had the day shift, required -03/31/24 had the day shift, required -04/01/24 had the day shift, required -04/02/24 had the day shift, required -04/03/24 had the day shift, required -04/04/24 had the day shift, required -04/05/24 had the day shift, required -04/05/24 had the day shift, required	at least 10 CNAs. 8 CNAs for 83 residents on at least 10 CNAs. 9 CNAs for 83 residents on at least 10 CNAs. 7 CNAs for 83 residents on at least 10 CNAs. 7 CNAs for 83 residents on at least 10 CNAs. 9 CNAs for 81 residents on at least 10 CNAs. 9 CNAs for 81 residents on at least 10 CNAs. 9 CNAs for 81 residents on at least 10 CNAs. 9 CNAs for 81 residents on at least 10 CNAs. 8 CNAs for 80 residents on at least 10 CNAs. 8 CNAs for 80 residents on at least 10 CNAs.	5 500				

STATE FORM: REVISIT REPORT										
PROVIDER / SUPPLIER / CLIA / MULTIPLE CONST IDENTIFICATION NUMBER A. Building			STRUCTION					DATE OF	REVISIT	
060208 _{Y1} B. Wing							Y2	5/16/202	24 _{Y3}	
NAME OF FACILITY CAREONE AT CRESSKILL					STREET ADDRESS, CIT 221 COUNTY ROAD CRESSKILL, NJ 07626	Y, STATE, ZIP CODI	E			
corrective	e action was acco	mplished	 Each deficien 	cy should be fully	, identified usi	/ reported that have bee ng either the regulation es shown to the left of e	or LSC provision r	number and t	he	
ITEI	м		DATE	ITEM		DATE	ITEM			DATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix	S0560		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	8:39-5.1(a)		Completed	Reg. #		Completed	Reg. #			Completed
LSC			05/05/2024	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
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REVIEWED BY STATE AGENCY		DATE	SIGNATUI	RE OF SURVEYOR			DATE			
REVIEWE CMS RO	D BY	REVIEW!		DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 4/15/2024					RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN			YES	i □ NO	

Page 1 of 1

EVENT ID:

6LIL12

(11/06)