STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315488	A. BUILDING **01** B. WING ______	**04/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MADISON AVENUE	**151 MADISON AVENUE** **MORRISTOWN, NJ 07960**

(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 4/16/21 . Care One at Madison 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 Occupancies. Care One at Madison is a 4 story mutltiphase constructed building that was built in 1905 and 2004 and composed of Type V and Type II construction. The facility is divided into 12 smoke zones.	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered	K 161		5/8/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/01/2023

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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K 161	Continued From page 1 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/11/2023, it was determined that the facility's building did not comply with the height requirements for a wood frame construction type as evidenced by: During the survey entrance at 9:00 AM, a request was made to the Administrator (Admin) if the facility had any waivers. The Admin told the surveyor, yes it is for the type of construction of the original building. At 9:33 AM, the surveyor observed in the presence of the facility's Maintenance Director, the front section of the building was a 2-1/2 story wood frame construction type thus exceeding the	K 161	K161 How the corrective action for those residents found to have been affected by the practice: Care One Madison Avenue was granted a Time Limited Waiver (TLW) approved by the State and CMS. Staff who utilize the dining room and residents who utilize therapy areas have the potential to be affected. How the facility will identify other residents having the potential to be affected by the	

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K 161	Continued From page 2 1-story height requirement per NFPA 101:2012 - 19.1.6.1. This finding was verified by the facility's Maintenance Director in an interview during the observation. NFPA 101:2012 - 19.1.6.1 NJAC 8:39-31.1(c) Note: The waiver about the historic wooden structure at Care One at Madison Avenue, under K-161 was approved by CMS for a 5-year-time limited period of 7/19/18-10/18/23 to make modifications due to not passing their 9/20/18 FSES. The limited waiver expires on 10/18/23.	K 161	same deficient practice an what corrective action will be taken: Staff who utilize the dining room and residents who utilize therapy areas have the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur. The Leadership Team including the Administrator, Director of Environmental Services, and Care One Construction Department staff, conduct calls to monitor compliance with the TLW. KOFFEL Compliance has retained by Care One Madison in Morristown to conduct a fire safety evaluation system (FSES) analysis. To determine if Mansion portion of the facility may continue to house resident services despite a non compliant type of construction and deficient egress conditions. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. Care One at Madison along with Care one construction has addressed the compliance analysis and corrected items of the report to make the facility compliant. Monthly rounds to be conducted for environmental audit x 3 months the results from monthly rounds to report to	

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K 161	Continued From page 3	K 161	environmental Audit tool Quality Assurance Performance Improvement Committee	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 4/11/2023, 4/12/2023 and 4/13/2023 in the presence of facility management, it was determined that the facility failed to: To provide four (4) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously	K 293	K 293 How the corrective action will be accomplished for those residents affected by the deficient practice? (4) Illuminated exit lights were installed and made readily visible to reach the exit and is now apparent to all occupants to comply code 21127.10.1.5.1 (1) Lower level corridor by room LL29 exit stairwell (2) First floor corridor by room 102 exit stairwell (3) first floor room 114 exit access route (4) first floor corridor near salon exit stairwell How the facility will identify other residents having the potential to e affected by the	5/1/23

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K 293	Continued From page 4 illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 4/11/2023 (day one of survey) during the survey entrance at approximately 9:00 AM, a request was made to the Administrator (Admin) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a four-story building. Starting at approximately 9:33 AM on 4/11/2023 and continued on 4/12/2023, 04/13/2023 in the presence of the facility's MD a tour of the facility	K 293	same deficient practice and what corrective action will be taken? Tour building to ensure that all exit lights are illuminated and all arrows facing means of nearest exit door. What measures will be put in place or what systemic changes will be made to ensure the deficient practice will not recur? Maintenance Director and Assistant have been educated. Maintenance director to do weekly rounds. Monthly rounds to be done by regional director to ensure Exit Lights are maintained. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. Results from weekly and monthly rounds to be reported to QA. Time frame: 4/28/2023	

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K 293	Continued From page 5	K 293		

was conducted.

Along the three (3) day tour of the facility, the surveyor observed four (4) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations,

1) On 4/12/2023 at approximately 10:03 AM, one (1) illuminated exit sign with a directional arrow in the [redacted] corridor next to resident room [redacted] identify the exit stairwell.

A review of an emergency evacuation diagram posted in the [redacted] corridor corridor identifies the stairwell as the primary and/ or secondary exit access route to reach an exit

2) On 4/13/2023 at approximately 9:18 AM, one (1) illuminated exit sign with a directional arrow in the [redacted] floor corridor next to resident room#102 to identify the exit stairwell.

A review of an emergency evacuation diagram posted in the [redacted] floor corridor corridor identifies the stairwell as the primary and/ or secondary exit access route to reach an exit

3) On 4/13/2023 at approximately 9:30 AM, one (1) illuminated exit sign with two directional arrows in the [redacted] floor corridor next to resident room#[redacted] to identify the exit access route to reach an exit.

4) On 4/13/2023 at approximately 9:35 AM, one (1) illuminated exit sign with a directional arrow in the [redacted] floor corridor near the salon to identify the exit stairwell.

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K 293	Continued From page 6 A review of an emergency evacuation diagram posted in the [redacted] floor corridor corridor identifies the stairwell as the primary and/ or secondary exit access route to reach an exit. The MD confirmed the finding at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 4/13/2023 at approximately 1:00 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 311 SS=D	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. 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 observations and review of facility documentation on 4/11/2023, 4/12/2023 and 4/13/2023, in the presence of facility	K 311	K311 How the corrective action for those	5/1/23

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K 311

Continued From page 7

Management it was determined that the facility failed to ensure that 1 of 12 exit access stairwell doors tested, were capable of maintaining the 1-1/2 hour fire rated construction.

This is evidenced by the following,

On 04/11/2023 (day one of survey) during the survey entrance at approximately 9:00 AM, a request was made to the Administrator (Admin) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility is a four-story building. There are four (4) exit stairways.

Starting at approximately 9:33 AM on 4/11/2023 and continued on 4/12/2023, 04/13/2023 in the presence of the facility's MD a tour of the facility was conducted.
Along the two (2) day tour the surveyor performed a closure test of twelve (12) corridor exit access doors leading into exit stairways with the following results,

1. On 4/11/2023 at approximately 11:02 AM, during a closure test of the second (2nd.) floor stairway (next to Resident room #223) corridor exit access door, the door did not positive latch into its frame. This test was repeated two additional times with the same results.

The stairwell doors would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire.

K 311

residents found to have been affected by the practice.

On [redacted] floor by room [redacted] Corridor exit door latch was replaced.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All residents have the potential to be affected. Ensure that all weekly rounds to check the exit stairwell are completed.

What measures will be put in place or what systemic changes will be made to ensure the deficient practice will not recur.

Maintenance Director and Assistant were educated. Maintenance Director to do weekly rounds. Weekly rounds to be done by Administrator to ensure proper compliance.

How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance program will be put into place.

Maintenance department will monitor for 3 months, the results from weekly and monthly rounds to report to environmental audit tool Quality Assurance Performance Improvement Committee.

Time Frame: 4/28/23

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K 311	Continued From page 8 The MD confirmed the finding at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 4/13/2023 at approximately 1:00 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
K 351 SS=D	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 observations on 4/11/2023, it was determined that the Facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in	K 351	K351 How the corrective action for those residents found to have been affected by	5/1/23

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K 351

Continued From page 9

accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy.

The deficient practice is evidenced by the following,

On 4/11/2023 (day one of survey) during the survey entrance at approximately 9:00 AM, a request was made to the Administrator (Admin) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility is made up of two buildings (and New Building) that are connected with four floors.

Starting at approximately 9:33 AM on 4/11/2023 and continued on 4/12/2023, 4/13/2023 in the presence of the facility's MD a tour of the facility was conducted.

On 4/11/2023 at approximately 10:15 AM, the surveyor observed no evidence of fire sprinkler coverage in the 3'- 8" deep by 2'-6" wide attic dormer window. The surveyor observed a sprinkler pipe with a "T" connector that had a plug inserted in the T connector that was in the coverage area of the dormer window.

The Maintenance Director confirmed the findings at the time of observations.

K 351

the practice.

(1) new sprinkler head was installed in dormer window.

How the facility will identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

The deficient practice was not in a resident care area but could affect the staff.

What measures will be put in place or what systemic changes will be made to ensure the deficient practice will not recur.

Install sprinkler head in . Maintenance Director an Assistant were educated. Maintenance Director to do weekly rounds. Monthly rounds to be done by Regional Director to ensure sprinkler coverage.

How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, what quality assurance program will be put into place.

Maintenance Department will monitor for 3 months the results from weekly and monthly rounds to report to Environmental Audit Tool Quality Assurance Performance Improvement Committee.

Time Frame: 4/28/23

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K 351	Continued From page 10 The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 4/13/2023 at approximately 1:00 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 4/11/2023, 4/12/2023 and 4/13/2023 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 18 of 25 portable fire extinguishers, as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 4-3, 4- 3.1, 4- 3.3 and 4- 3.4 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire	K 355	K 355 How the corrective action for those residents found to have been affected by the practice. Conduct visual monthly fire extinguisher inspection and document month and date. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The deficient practice could possible affect everyone. Create a log with the locations of all fire extinguisher in building and confirm al have been inspected. What measures will be put in place or	5/1/23

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CAREONE AT MADISON AVENUE	**151 MADISON AVENUE** **MORRISTOWN, NJ 07960**

(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 355	Continued From page 11 extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following, On 4/11/2023 (day one of survey) during the survey entrance at approximately 9:00 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. Starting at approximately 9:33 AM on 4/11/2023 and continued on 4/12/2023, 04/13/2023 in the presence of the facility's MD a tour of the facility was conducted. Along the two day tour of the facility the surveyor observed and inspected twenty three (23) portable fire extinguishers that were last annually inspected May 2022 in various locations with the following issues identified: 1) At approximately 10:37 AM, One class "K-Wet" Chemical Type fire extinguisher in the kitchen was last annually inspected May 2022	K 355	what systemic changes will be made to ensure the deficient practice will not recur. Maintenance Director and Assistant were educated. Create a log with the locations of all fire extinguisher in building and confirm all have been inspected. Maintenance director to do monthly rounds. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. Maintenance department will monitor for 3 months the results from monthly rounds to report to Environmental Audit Tool Quality Assurance Performance Improvement Committee. Time Frame: 4/28/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315488	A. BUILDING **01** B. WING ______	**04/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MADISON AVENUE	**151 MADISON AVENUE** **MORRISTOWN, NJ 07960**

(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 355	Continued From page 12 was missing monthly visual examination performed and documented for January and February 2023. The MD confirmed the finding at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 4/13/2023 at approximately 1:00 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 4/11/2023, 4/12/2023 and 4/13/2023, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 18 electrical outlets located next to a water source (with-in 6 feet) was equipped with safe and secured Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 4/11/2023 (day one of survey) during the	K 911	K 911 How the corrective action for those residents found to have been affected by the practice. (1 [redacted] floor nourishment room install 1 ground fault circuit interrupter GFIC outlets (2 [redacted] Level nurse station install 1 ground fault circuit interrupter GFIC	5/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315488	A. BUILDING **01** B. WING	**04/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MADISON AVENUE	**151 MADISON AVENUE** **MORRISTOWN, NJ 07960**

(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 911	Continued From page 13 survey entrance at approximately 9:00 AM, a request was made to the Administrator (Admin) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the facility is a four-story building. Starting at approximately 9:33 AM on 4/11/2023 and continued on 4/12/2023, 4/13/2023, in the presence of the facility's MD a tour of the building was performed. During the three day tour , the surveyor observed and tested eighteen (18) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following, 1) On 4/11/2023 at approximately 11:11 AM, the surveyor observed at the [redacted] floor nourishment area one (1) Duplex electrical electrical outlet 18 inches to the left of the sink. When the surveyor tested the Duplex electrical outlet with a GFCI tester to de-energize, the Duplex electrical outlet did de-energize as required by code. 2) On 4/12/2023 at approximately 10:10 AM, the surveyor observed at the [redacted] level Nurses Station one (1) Duplex electrical electrical outlet 33 inches to the right of the sink. When the surveyor tested the Duplex electrical outlet with a GFCI tester to de-energize, the Duplex electrical outlet did de-energize as required by code. 3) On 4/13/2023 at approximately 9:41 AM, the surveyor the surveyor observed on the [redacted]t floor nourishment area two (2) Duplex electrical electrical outlets 44 inches to the left of the sink.	K 911	outlets (3) [redacted] floor nurse station install 2 ground fault circuit interrupters GFIC outlets. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The deficient practice was in a resident care area but could affect the staff. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur. Install new GFIC receptacles in all affected areas. Maintenance Director and assistant were educated and will monitor 4 receptacles for 2 months. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. Maintenance department will monitor for 2 months the results from monthly rounds to report to environmental Audit Tool Quality Assurance Performance Improvement Committee. Time Frame: 4/28/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315488	A. BUILDING **01** B. WING ______	**04/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MADISON AVENUE	**151 MADISON AVENUE** **MORRISTOWN, NJ 07960**

(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 911	Continued From page 14 When the surveyor tested the two Duplex electrical outlets with a GFCI tester to de-energize, the Duplex electrical outlets did de-energize as required by code. The Maintenance Director confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 4/13/2023 at approximately 1:00 PM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60921 (Y1)	A. Building B. Wing (Y2)	5/16/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MADISON AVENUE	151 MADISON AVENUE MORRISTOWN, NJ 07960

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 05/01/2023	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	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	
4/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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)
315488	A. Building 01 - MAIN BUILDING B. Wing	5/16/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT MADISON AVENUE	151 MADISON AVENUE MORRISTOWN, NJ 07960

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 K0161	Correction Completed 05/08/2023	ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 05/01/2023	ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 05/01/2023
ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 05/01/2023	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 05/01/2023	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 05/01/2023
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

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 4/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			