STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315132	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT THE HIGHLANDS	**1350 INMAN AVENUE EDISON, NJ 08820**

(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 : NJ00175467 Census: 102 Sample Size: 4 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.	F 000		

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

Electronically Signed | 08/06/2024

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
	061202	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT THE HIGHLANDS	1350 INMAN AVENUE EDISON, NJ 08820

(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 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.	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 facility document review on 07/11/2024, 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 13 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 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	Nursing Leadership met and continues to meet on an on-going basis to identify staffing challenges and areas of improvement and recruitment for certified nursing assistants necessary to maintain the required minimum direct care to ratio as required. No residents were negatively impacted by this practice. All residents have the potential to be affected. To ensure the problem of staffing does not reoccur: Potential candidates are interviewed for Hospitality Aide positions. Facility will place them in the 5-week Certified Nurse	8/9/24

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

Electronically Signed | 08/06/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061202	A. BUILDING: _____ B. WING _____	C 07/11/2024

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CAREONE AT THE HIGHLANDS	1350 INMAN AVENUE EDISON, NJ 08820

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S 560	Continued From page 1 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 fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed 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 CNA and perform CNA duties. The surveyor requested staffing for the weeks of 06/23/24 to 06/29/24 and 06/30/24 to 07/06/24. The facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -06/23/24 had 7 CNAs for 113 residents on the day shift, required at least 14 CNAs. -06/24/24 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -06/25/24 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. -06/26/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -06/27/24 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. -06/28/24 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -06/29/24 had 8 CNAs for 109 residents on the day shift, required at least 13 CNAs. -06/30/24 had 6 CNAs for 108 residents on the	S 560	Aide program provided every 6 weeks by CareOne. 3 CNAs and 5 Hospitality Aides, whom of which have completed the CNA program and are pending the State written exam have been hired and retained. The facility is offering incentives for new hires, such as sign on bonuses and referral bonuses. Nursing management team is expanding their schedule to assist in coverage. DON or designee and Administrator (or designee) will review staffing practices daily and document a weekly review of the daily staff x 4 weeks, then twice monthly x 3 months. Findings will be provided to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061202	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT THE HIGHLANDS	1350 INMAN AVENUE EDISON, NJ 08820

(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 day shift, required at least 13 CNAs. -07/01/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -07/02/24 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -07/03/24 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -07/05/24 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -07/06/24 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061202		8/13/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT THE HIGHLANDS	1350 INMAN AVENUE EDISON, NJ 08820

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 08/09/2024	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	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	
7/11/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO