PRINTED: 12/17/2025 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315472		- 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER CAREONE AT EAST BRUNSWICK			STREET ADDRESS, CITY, STATE, ZIP CODE 599 CRANBURY ROAD , EAST BRUNSWICK, New Jersey, 08816				
PRÉFIX (EACI	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
The NJ The sull COMPI CENSU SAMPU THE FA REQUI	rvey was officially con _AINT #: 2633411 JS: 100 .E SIZE: 5 ACILITY IS IN SUBST REMENTS OF 42 CF	ANTIAL COMPLIANCE WITH THE R PART 483, SUBPART B, FOR LCASED ON THIS COMPLAINT VISIT.		000			

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: NJNDFH9U				(X3) DATE SUR\ 11/20/2025	(X3) DATE SURVEY COMPLETED 11/20/2025			
NAME OF PROVIDER OR SUPPLIER CAREONE AT EAST BRUNSWICK			STREET ADDRESS, CITY, STATE, ZIP CODE 599 CRANBURY ROAD , EAST BRUNSWICK, New Jersey, 08816					
(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		
S0000	Initial Comments		S0000					
S0560	REGULATORY OR LSC IDENTIFYING INFORMATION)		S0560	The Administrator and the Director of N immediately reviewed the daily staffing minimum direct care staff-to-resident ra (1) One certified nurse aid to every eight for the day shift. (2) One direct care staff member to every for the evening shift, provided that no fee of all staff members shall be certified nurse aide of One direct care staff member to every the night shift provided that each direct member shall sign in to work as a certification and shall perform certified nurse. 2. All residents have the potential to be 3. On 10/07/25, the Administrator and Design of the Nursing provided education to the staffithat included but was not limited to the	to ensure the tios: Int residents Int residents	11/26/2025		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: NJNDFH9U NAME OF PROVIDER OR SUPPLIER CAREONE AT EAST BRUNSWICK		_IA	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SU 11/20/2025			RVEY COMPLETED	
				REET ADDRESS, CITY, STATE, ZIP COD CRANBURY ROAD, EAST BRUNSWIC		6	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0560	Continued from page 1 codified as N.J.S.A. 30:13-18 established minimum staffing homes. The following ratio (s 02/01/2021: One Certified Nurse Aide (Cl for the day shift. One direct devery 10 residents for the ewno fewer of all staff members direct staff member shall be certified nurse aide and shall duties: and One direct care is residents for the night shift, predirect care staff member shall and perform CNA duties. For the 2 weeks of staffing presidents on follows: On 09/21/2025 to 10/04/2025, the CNA staffing for residents on follows: On 09/21/25 had 9 CNAs for shift, required at least 12 CN on 09/23/25 had 11 CNAs for shift, required at least 12 CN on 09/24/25 had 11 CNAs for shift, required at least 12 CN on 09/25/25 had 11 CNAs for shift, required at least 12 CN on 09/27/25 had 9 CNAs for shift, required at least 12 CN on 09/27/25 had 9 CNAs for shift, required at least 12 CN on 09/27/25 had 11 CNAs for shift, required at least 12 CN on 09/28/25 had 7 CNAs for shift, required at least 12 CN on 10/01/25 had 11 CNAs for shift, required at least 12 CN on 10/01/25 had 11 CNAs for shift, required at least 12 CN	requirements in nursing were effective on NA) to every eight residents are staff member to ening shift, provided that shall be CNAs and each signed into work as a perform nurse aide taff member to every 14 rovided that each ill sign in to work as a CNA for to survey from e facility was deficient in 7 of 14 day shifts as 101 residents on the day As. 109 residents on the day As. 100 residents on the day As. 100 residents on the day As.	Si	0560	Continued from page 1 regulations for CNA staffing: 1:8 for 7-3 3-11 pm, 1:14 for 11-7 am. The facility in media, employment sites and recruitme new staff members. The facility has impincentive program including shift pick up referral bonuses for employees referring appropriate. The facility utilized an ager with setting up interview and qualified of the staffing daily to ensure Certified Nursing staffing meets the minimum staff to result and the staffing of staff-to-resident ratios to Administrator and the Quality Assurance Improvement Committee (QAPI) at the an on-going basis. The QAPI committed determine the need for further follow up to the staff-to-resident ratios to the staff-to-resident ratios to the staff-to-resident ratios to administrator and the Quality Assurance Improvement Committee (QAPI) at the an on-going basis. The QAPI committed determine the need for further follow up to the staff-to-resident ratios to the staff-to-resident r	utilized social ent efforts to hire blemented an p bonuses, and g staff where ncy to assist candidates. will review g Assistant ident ratios. n on-going nee will report the ex Performance monthly meetings on e will review and	

PRINTED: 12/17/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315472		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025		
NAME OF PROVIDER OR SUPPLIER CAREONE AT EAST BRUNSWICK			STREET ADDRESS, CITY, STATE, ZIP CODE 599 CRANBURY ROAD , EAST BRUNSWICK, New Jersey, 08816				
PRÉFIX (EACH I	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PF		ID PREFI TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
An offsite Correction the 10/07 to be in confor Long To	/2025 Complaint su ompliance with 42 (Term Care Facilities	n 12/11/2025 in relation to arvey. The facility was found CFR Part 483, Requirements .	F0000	stitution may be excused from correcting p		12/11/2025	

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

(X6) DATE

New Jersey State Department of Health

		(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: NJNDFH9U	Α	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 12/11/2025 B. WING		RVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER CAREONE AT EAST BRUNSWICK			STREET ADDRESS, CITY, STATE, ZIP CODE 599 CRANBURY ROAD , EAST BRUNSWICK, New Jersey, 08816					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL F		ID PREFI TAG	(EACH CORRECTIVE ACTION SHOULD BE COMP		(X5) COMPLETION DATE		
S0000	Initial Comments An offsite/desk review of the Correction was conducted or the 10/07/2025 State of New The facility was found to be in Standards in the New Jersey Chapter 8:39, Standards for Facilities.	facility's Plan of n 12/11/2025 in relation to Jersey Complaint survey. n compliance with the	\$0000			12/11/2025		
Office of Primary Care and Health Systems Management								

STATE FORM Event ID: 1D8DC6-H2 Facility ID: NJNDFH9U If continuation sheet Page 1 of 1

TITLE

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