STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Somerset Valley	1621 Route 22 West Bound Brook, NJ 08805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ 169236, 173607 Based on observation, interview, and record review it was determined that the facility failed to ensure the resident's bedside table and the call light was accessible. The deficient practice was identified for 1 of 15 residents reviewed (#112) for accommodation of need and was evidenced by the following: On 10/30/24 at 9:53 AM, the surveyor observed Resident #112 in bed. The resident appeared upset and informed the surveyor that they were admitted to the facility on [DATE] at 4:00 PM. Resident #112 stated they had diarrhea at that time, their lips were dry and could not get a sip of water all night. The Resident stated that they activated the call light and no one entered the room to inquire regarding their concerns. The surveyor then observed two cups of water were on the bedside table in the far right corner of the room, along with the breakfast tray and were both out of direct reach of the resident. Resident #112 stated that the tray was delivered around 8:00 AM in the morning, and they had surgery and were unable to get out of the bed to reach the meal tray and the water. The resident stated, please get someone. At 10:15 AM, the surveyor exited the room and observed the Assistant Director of Nursing (ADON) sitting at the nurse's station. The surveyor accompanied the ADON to the room and Resident #112 expressed concerns over not being able to reach the water on the bedside table during the night, and staff not answering the call light. Resident #112 was able to inform the ADON that their mouth was dry and they could not get out of the bed and could not reach the breakfast tray left on the bedside table. The ADON apologized for the concerns, moved the bedside table next to the bed, then informed the resident that she would warm the breakfast meal in a few minutes. On 10/30/24 at 10:38 AM, the surveyor interviewed Certified Nurse Aide (CNA #1) who confirmed the breakfast tray was delivered around 8:00 AM this morning, and stated that she did not deliver the breakfast tray to the resident's room. On 10/30/24 at 11:39 AM, the surveyor interviewed CNA #2 who was the regular assigned CNA for Resident #112. The CNA informed the surveyor that she was not familiar with the resident's routine. On 10/31/24 at 10:40 AM, the surveyor reviewed the medical record for Resident #112 which revealed the following: (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Record indicated the resident had diagnoses which included, but were not limited to: Dilated cardiomyopathy, Paroxysmal Atrial Fibrillation and unspecified Falls. Resident #112 was awake, alert, oriented, and able to make their needs known. On 11/06/24 at 8:37 AM, the surveyor interviewed Resident #112 with the ADON present. Resident #112 stated that staff failed to answer the call light in a timely manner. Resident #112 stated they watched the clock, they activated the call light, someone came turned off the light and left the room. They activated the call light 10 minutes later, and staff took almost one hour to answer the call light. The Resident stated in the presence of the ADON, I watched the clock, I was up watching the election. On 11/06/24 at 12:20 PM, the surveyor discussed the inaccessibility of the bedside table, with the water and the breakfast tray for Resident #112 with the Director of Nursing (DON) and the Liscensed Nursing Home Administrator (LNHA). On 11/07/24 at 9:45 AM, the surveyor inquired to the DON regarding residents concerns with the delay in answering the call bell during the 11:00 PM -7:00 AM shift. The DON stated the call bell concerns were addressed under grievance and she will provide the grievance forms for review. A review of the grievance forms revealed that the concerns with the call bell dated back from July. The DON informed the surveyor that she met with the residents and addressed their concerns. The DON stated that the call bell issue was related to staffing and the facility was aware and working on it. On 11/7/24 at 10:30 AM, during a telephone interview with CNA #3, who was assigned to the 11:00 PM-7:00 AM shift, regarding the delay in answering the call bell, the CNA stated, I had 22 residents during the night, I tried to manage but it is difficult. NJAC 8:39-27.1(a); 4.1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to follow professional standards of practice by administering Midodrine (medication to increase blood pressure) outside of the physician parameters. This deficient practice was identified for 1 of 15 residents (Resident #40) reviewed for medications and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 11/01/2024 at 9:42 AM, the surveyor observed the resident sitting in a wheelchair in the unit common area. On 11/01/2024 at 9:45 AM, the surveyor reviewed the medical records for Resident #40. The Admission Record revealed diagnoses which included but were not limited to; transient ischemic attack, and [NAME] encephalopathy. A review of the Order Summary Report included a physician order dated 09/16/2024, for Midodrine 5 mg (milligrams) give 1 tablet every 8 hours for orthostatic hypotension and hold if the SBP (systolic blood pressure) is greater than 130. A review of the resident-centered care plan included a focus area cardiac disease related to . hypotension initiated 09/08/2024 with interventions that included administer medications according to physician's orders. A review of the Medication Administration Record (MAR) for September 2024, revealed 36 opportunities to administer Midodrine. Three doses of Midodrine were administered outside of the parameter: 9/18/24, SBP 138; 9/20/24, 135; and 9/28/24, 146. A review of the October 2024 MAR revealed 87 opportunities to administer Midodrine. Ten doses of Midodrine were administered outside of the parameter: 10/4/24, 135; 10/13/24, 139; 10/14/24, 135; 10/17/24, 135; 10/18/24, 152 and 139; 10/23/24, 150 and 135, 10/26/24, 138; 10/31/24, 139. On 11/01/24 at 9:46 AM, the Registered Nurse stated that if Midodrine was administered outside the physician's ordered parameter, it could cause the resident's blood pressure, to go very high and that was why, we must hold it. On 11/01/24 at 10:02 AM, the surveyor interviewed the Director of Nursing (DON) about Midodrine and the DON stated that if Midodrine was administered outside the parameters, the resident might have an adverse reaction. She further stated that, there is a reason to hold medication. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided policy, Administering Medications revised April 2019, included but was not limited to; 4. Medications are administered in accordance with prescriber orders . NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ 169236, 173607 Based on observation, interview, review of records, and review of pertinent documents, it was determined that the facility failed to provide appropriate incontinence care for 2 of 13 residents reviewed for Activities of Daily Living (ADL), Resident # 110 and #112. The deficient practice was evidenced by the following: a. On 10/30/24 at 8:45 AM, the surveyor entered Resident #110's room and the resident stated they were soiled and staff would not answer the call light. At 9:00 AM, the surveyor observed incontinence care with Certified Nurse Aide (CNA) #1. Resident #110's incontinence brief was observed saturated with urine. The surveyor exited the room and returned at 9:40 AM. Resident #110 informed the surveyor again that they had not yet been provided with incontinence care. On 10/30/24 at 9:50 AM, the surveyor interviewed CNA #1 who performed the incontinence observation with the surveyor at 8:45 AM. CNA #1 informed the surveyor that Resident #110 stated that they could wait, and CNA #1 confirmed that incontinence care was not provided when both the surveyor and CNA #1 observed the incontinence brief saturated with urine. CNA #1 informed CNA #2 who had Resident #110 on their assignment that Resident #110 needed to be changed. The surveyor then asked CNA #1 regarding the process for incontinence care in regards to dependent residents. CNA #1 stated that all staff were able to assist residents with care. On 10/30/24 at 10:45 AM, the surveyor interviewed CNA #2 who had Resident #110 on her assignment. CNA #2 revealed that she had been informed by CNA #1 that Resident #110 needed to be changed. On 10/31/24 at 11:30 AM, the surveyor reviewed Resident #110's Electronic Medical Record (EMR) which revealed the following: The admission face sheet (an admission summary) reflected that Resident #110 had diagnoses which included but were not limited to; wedge compression fracture of T11-T12, [Thoracic vertebrae 11-12] and unspecified severe protein caloric malnutrition. Resident #110 had a care plan in place for ADL Self Care Deficit related to physical limitations. The Goal, initiated 10/22/24, indicated Resident #110 was to receive assistance necessary to meet ADL needs. Interventions included: Assist with hygiene and grooming and oral hygiene. b. On 11/04/24 at 8:30 AM, the surveyor observed Resident #112 in bed. Resident #112 stated that they were last changed last night at 10:00 PM. The surveyor alerted the CNA assigned to the resident of the resident's concerns. The surveyor observed the CNA perform incontinence care. Resident#112's incontinence brief was satureated with urine and and covered with feces. In the presence of the CNA, the resident stated that they were not provided with incontinence care on the 11:00-7:00 AM shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/06/24 at 8:26 AM, the surveyor observed Resident #112 in bed. Resident #112 expressed concerns over the delay in answering the call light specifically on the 11-7 shift. Then at 8:37 AM, in the presence of the Assistant Director of Nursing (ADON), Resident #112 stated that last night they were soiled and needed to be changed. They activated the call light, then someone came in and turned the light off, but did not provide care. Resident #112 stated that they activated the call light again after 10 minutes and it took almost one hour to receive incontinence care, the wait was too long, and with a bedsore, it hurts. The surveyor asked the resident, how do you know it was over an hour to wait for staff to provide care. The resident stated, I looked at the clock. I was up and watching the election. On 11/06/24 at 10:30 AM, the surveyor reviewed the EMR which revealed: Resident #112 was admitted to the facility with diagnoses which included but were not limited to; Dilated cardiomyopathy, Paroxysmal Atrial Fibrillation and unspecified Falls. On 11/06/24 at 12:20 PM, the facility was made aware of the above concerns with incontinence care. On 11/07/24 at 8:48 AM, during a telephone interview with the CNA #3 who cared for the resident on the 11:00 PM-7:00 AM shift, the CNA revealed that she had 22 residents, she try to manage. On 11/07/24 at 11:30 AM, the facility stated staff was educated regarding incontinence care, and no further information was provided. A review of the facility's policy for ADLs, last revised 2018, revealed under policy interpretation and implementation the following: Appropriate care and services will be provided for residents who are unable to carry out ADLs. independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene, toileting, mobility and dining. The Facility Assessment Tool, dated 06-17-24 revealed Part 2: Services and care we offer based on our residents' needs; General Care: Activities of Daily Living; Specific Care of Services Provided: Bathing, showers, oral/[NAME] care,dressing, eating, support with needs related to hearing/vision/sensory impairment, supporting resident independence in doing as much of these activities independently; General Care: Bowel and Bladder; Specific Care of Sercies Provided: Bowel/bladder toileting programs, incontinence prevention and care, intermmittent or indwelling or other urinarycatheter, ostomy, responding to requests for assistance to the bathroom promptly. NJAC 8:39- 27.2(h)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint #'s: NJ 169236, 173607 Based on observation, interview, record review, and document review, it was determined that the facility failed to provide sufficient nursing staff to ensure all residents reached their highest practical wellbeing by failing to: a) provide timely incontinence care, b) provide consistent timely call bell response for resident assistance, c) ensure meals and water were in reach for residents who were deemed dependent with care needs , d) maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey and had the potential to affect all residents who resided at the facility. The deficient practice was evidenced by the following: Refer to F558, F677, S560 and S1680 Surveyor #1: On 10/30/24 at 8:45 AM, the surveyor entered Resident #110's room and the resident stated they were soiled and staff would not answer the call light. At 9:00 AM the surveyor observed incontinence care with Certified Nurse Aide (CNA) #1. Resident #110's incontinence brief was observed saturated with urine. The surveyor exited the room and returned at 9:40 AM. Resident #110 informed the surveyor again that they had not yet been provided with incontinence care. On 10/30/24 at 9:13 AM, Surveyor #1 interviewed a Certified Nurse Aide (CNA #1) regarding the amount of staff, who stated that staffing is not great now. CNA #1 stated that on average she had 10-12 residents in her care and CNA #1 added that today was a lucky day she had 9 residents. On 10/30/24 at 9:50 AM, the surveyor interviewed CNA #1 who performed the incontinence observation with the surveyor at 8:45 AM. CNA #1 informed the surveyor that Resident #110 stated that they could wait, and CNA #1 confirmed that incontinence care was not provided when both the surveyor and CNA #1 observed the incontinence brief saturated with urine. CNA #1 informed CNA #2 who had Resident #110 on their assignment that Resident #110 needed to be changed. The surveyor then asked CNA #1 regarding the process for incontinence care in regards to dependent residents. CNA #1 stated that all staff were able to assist residents with care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/30/24 at 9:53 AM, the surveyor observed Resident #112 in bed. The resident was visibly upset and informed the surveyor that they were admitted to the facility on [DATE] at 4:00 PM. Resident #112 stated they had diarrhea at that time, their lips were dry and could not get a sip of water all night. The Resident stated that they activated the call light and no one entered the room to inquire regarding their concerns. The surveyor then observed two cups of water were on the bedside table in the far right corner of the room, along with the breakfast tray and were both out of direct reach of the resident. Resident #112 stated that the tray was delivered around 8:00 AM in the morning, and they had surgery and were unable to get out of the bed to reach the meal tray and the water. The resident stated, please get someone. At 10:15 AM, the surveyor exited the room and observed the Assistant Director of Nursing (ADON) sitting at the nurse's station. The surveyor accompanied the ADON to the room and Resident #112 expressed concerns over not being able to reach the water on the bedside table during the night, and staff not answering the call light. Resident #112 was able to inform the ADON that their mouth was dry and they could not get out of the bed and could not reach the breakfast tray left on the bedside table. The ADON apologized for the concerns, moved the bedside table next to the bed, then informed the resident that she would warm the breakfast meal in a few minutes. On 10/30/24 at 12:53 PM, the surveyor interviewed CNA #2 regarding staffing. CNA #2 stated that she could have between 10-13 residents in her care during the day and weekends are about the same. On 11/06/24 at 8:37 AM, in the presence of the Assistant Director of Nursing (ADON) Resident #112, an awake and alert resident, informed Surveyor #1 that on 11/5/24 they activated the call light. Staff entered the room and turned the light off and then left the room. Resident #112 stated that they activated the call light again after 10 minutes, and it took almost one hour for staff to provide incontinence care. On 11/7/24 at 9:15 AM, Surveyor #1 interviewed the Director of Nursing (DON) regarding the concerns with staffing. The DON informed the surveyor that the facility was aware of the staffing issues. The surveyor then inquired regarding the acuity. [level of care required by the residents to be performed by Registered Nurse (RN)]. The DON stated she was aware of the staffing ratio set forth by the regulations for the CNAs, however, she could not comment on any staffing process related to the acuity of the residents and the required RN hours that were based on the acuity. The 2 weeks of AAS-12 [acuity based staffing] staffing from 10/13/2024 to 10/26/2024, the facility was deficient in RN staffing as follows: For the week of 10/13/24 Required RN Staffing Hours: 177 -10/13/24 had 168 actual staffing hours, for a difference of -9 hours. -10/14/24 had 168 actual staffing hours, for a difference of -9 hours. -10/16/24 had 176 actual staffing hours, for a difference of -1 hours. -10/17/24 had 152 actual staffing hours, for a difference of -25 hours. -10/19/24 had 168 actual staffing hours, for a difference of -9 hours. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	For the week of 10/20/24 Required RN Staffing Hours: 197.25 -10/20/24 had 168 actual staffing hours, for a difference of -29.25 hours. -10/21/24 had 176 actual staffing hours, for a difference of -21/25 hours. -10/22/24 had 184 actual staffing hours, for a difference of -13.25 hours. -10/24/24 had 160 actual staffing hours, for a difference of -37.25 hours. -10/25/24 had 160 actual staffing hours, for a difference of -37.25 hours. -10/25/24 had 152 actual staffing hours, for a difference of -45.25 hours. 48781 Surveyor #2: On 10/30/24 at 9:39 AM, the surveyor #2 interviewed the Resident #15 who stated, My only concern is they're short on staffing here. I prefer to go on my diaper in bed and when I call them at night, they don't come. They tell me I don't need to be changed because I didn't move my bowels, so I lay there wet for hours this happens every night. On 10/30/24 at 10:06 AM, the surveyor #2 interviewed the Resident #60 who stated, My issue is the night shift, getting changed at night is very long. Last night I waited for half an hour, they left me in the toilet for half an hour, I can't stay too long on the toilet. They tell me they have other patients to attend to. On 10/31/24 at 2:43 PM, Surveyor #3, in the presence of the Life Safety surveyor, and the Maintenance Director (MD) and staff, interviewed the Director of Nursing (DON) regarding how the facility assesses the time from when a call bell is activated until care is rendered. The DON stated, there are no system to assess time for call bell responses, no computerized time audits. The MD confirmed there was no electronic system to monitor call bell response for time. The DON stated they would just talk to the residents to find out concerns related to call bells. On 11/6/24 at 9:51 AM, the surveyor #2, in the presence of the survey team, interviewed the Staffing Coordinator. The SC stated, I'll staff CNAs according to the census, I know the ratio of CNA to patient on day shift 1/8, evening shift 1/10, and night shift 1/14. We use agency but there's never enough, and the 7:00 AM-3:00 PM and 11:00 PM-7:00 AM shifts are the hardest to staff. A review of the 5 weeks of AAS-11 [certified nurse aide minimum staffing levels] revealed the facility was deficient as follows: 1. For the 2 weeks of complaint staffing from 10/01/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-10/01/23 had 4 CNAs for 48 residents on the day shift, required at least 6 CNAs. -10/02/23 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs. -10/03/23 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs. -10/04/23 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs. -10/05/23 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs. -10/06/23 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/07/23 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/08/23 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/09/23 had 4 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/10/23 had 4 CNAs for 54 residents on the day shift, required at least 7 CNAs. -10/11/23 had 4 CNAs for 52 residents on the day shift, required at least 6 CNAs. -10/12/23 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs. -10/13/23 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -10/14/23 had 4 CNAs for 49 residents on the day shift, required at least 6 CNAs. 2. For the week of Complaint staffing from 05/05/2024 to 05/11/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -05/05/24 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -05/06/24 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs. -05/07/24 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs. -05/08/24 had 3 CNAs for 47 residents on the day shift, required at least 6 CNAs. -05/09/24 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs. -05/10/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. -05/11/24 had 4 CNAs for 48 residents on the day shift, required at least 6 CNAs. 3. For the 2 weeks of staffing prior to survey from 10/13/2024 to 10/26/2024, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows: (continued on next page)

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	315002	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Somerset Valley	1621 Route 22 West Bound Brook, NJ 08805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-10/13/24 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/14/24 had 4 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/15/24 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/16/24 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/17/24 had 4 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/18/24 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/19/24 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/20/24 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/21/24 had 4 CNAs for 59 residents on the day shift, required at least 7 CNAs. -10/22/24 had 7 CNAs for 59 residents on the day shift, required at least 7 CNAs. -10/22/24 had 3 total staff for 59 residents on the overnight shift, required at least 4 total staff. -10/23/24 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/24/24 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs. -10/24/'24 had 3 total staff for 55 residents on the overnight shift, required at least 4 total staff. -10/25/24 had 4 CNAs for 55 residents on the day shift, required at least 7 CNAs. -10/26/24 had 4 CNAs for 53 residents on the day shift, required at least 7 CNAs. On 11/7/24 at 9:15 AM, the surveyor #1, in the presence of the survey team interviewed the DON regarding the concerns with staffing. The DON informed the surveyor that the facility was aware of the staffing issues. The DON was aware of the staffing ratio set forth by the regulations for the CNAs. A review of the facility's most current policy and procedure titled, Answering the Call Light, revised in September 2022 revealed, Answer the resident call system immediately If the resident's request is something you can fulfill, complete the task within five minutes if possible. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the FacilityAssessment Tool, dated 06/17/2024 revealed: Part 3: Facility resources needed to provide competent support and care for our resident population every day and during emergencies. 3.1 . a staffing plan has been developed to meet the professional, technical, and administrative needs of the center. The plan is informed by historical experience, current resident population and business plans, and projected changes. The approach takes into consideration both the type of staff (licensure or other credential) and number of staff required for each unit, including nights and weekends. The plan is customizable and updated with changes in staffing, census, occupancy, and specialty needs . NJAC 8:39-25.2(b), 27.1(a), 27.2(h)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38079 Based on observation, interview, and record review, it was determined that the facility failed to maintain a medication error rate below 5%. The surveyors observed three nurse administer 30 doses of medication to four residents and there were 3 errors which resulted in a medication error rate of 7.6%. On 10/31/2024 at 7:24 AM, the surveyor observed the Licensed Practical Nurse (LPN) administer medication to a resident on her assignment. The unsampled resident was administered Metoprolol Succinate ER (extended release) Tablet Extended Release 24 Hour 100 MG (milligram) Give 1 tablet by mouth one time a day for HTN (hypertension) Take with or immediately following meals. At the time of the medication administration, the facility breakfast trays were not delivered, and the LPN had not provided, offered, or instructed the resident to take the medication with food. On 10/31/2024 at 7:59 AM, the surveyor observed the LPN administer medication to another resident on her assignment. The unsampled resident was administered Metformin Tablet 1000 MG Give 1 tablet by mouth two times a day for DM (diabetes mellitus) Give with meals. The unsampled resident was also administered Metoprolol Succinate ER Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth one time a day for HTN Take with or immediately following meals. At the time of the medication administration, the facility breakfast trays were not delivered, and the LPN had not provided, offered, or instructed the resident to take the medications with food. On 10/31/2024 at 8:37 AM, the LPN acknowledged she gave the medication too early and without food. She stated it should have been given with food per the physician's orders. A review of the facility provided, Medication Pass Observation dated 05/15/2024, conducted by the facility pharmacy representative, included but was not limited to; 9. Medication Administration . C. Aware of and follows cautionary messages e.g. give with food . The competency was signed by the LPN and the pharmacy representative as having been performed correctly. A review of the facility provided policy, Administering Medication revised April 2019, included but was not limited to; 4. Medications are administered in accordance with prescriber orders . NJAC 8:39-29.2(d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 27193 Based on observation, interview and review of facility documents, it was determined that the facility failed to ensure that medications were labeled and dated upon opening, expired medications were removed from active inventory upon expiration: This deficient practice was identified on 1 of 3 medications carts inspected and was evidenced by the following: On 10/30/24 at 12:15 PM, in the presence of the Licensed Practical Nurse (LPN) the surveyor inspected the low hall medication cart on the sub-acute unit. The surveyor observed a Humalog insulin pen (a medication used to treat high blood sugar) with an expiration date of 10/27/24. An other insulin pen which was delivered on 10/22/24. The Insulin pen was opened and not dated. On 10/30/24 at 12:45 PM, the surveyor interviewed the LPN responsible for the medication cart. The LPN stated that the Humalog insulin should have been dated upon opening. The LPN did not provide any rationale for the expired Insulin dated 10/27/24 still in the medication cart. On 11/06/24 at 11:35 AM, the surveyor interviewed again the LPN regarding the expired Insulin observed in the medication cart on 10/30/24. The LPN stated that the insulin was discontinued and should have been removed from the medication cart. According to the manufacturer recommendations, Humalog insulin needs to be discarded 28 days after opening. NJAC-8:39-29.4

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Based on observation, interview, and record review, it was determined that the facility failed to maintain an environment and resident care to limit the spread of potential infection by failing to: a) adhere to acceptable standards of infection control practices for the cleaning and storage of shared glucometer after each resident use. This deficient practice was observed during medication administration and for 1 of 3 medication carts (Cart #2), b) ensure that respiratory masks and tubing were properly stored to prevent the spread of potential infection. This deficient practice was identified for 2 of 2 residents reviewed for respiratory care, Resident #22 and #61, c) mitigate the spread of infection by using a contaminated disinfectant wipe to wipe a clean surface and perform adequate hand hygiene per facility policy. This deficient practice was identified for 1 of 3 nurses observed during the medication administration pass, d) ensure a process was in place to identify residents who were on Enhanced Barrier Precautions (EBP) (an infection control intervention designed to reduce transmission of resistant organism for all residents, staff and visitors in accordance with the Centers for Disease Control and Prevention), by failing to post clear signage outside of resident rooms indicating the type of Protective Personal Equipment (PPE) required and defining high risk resident care activities, and to have the PPE and alcohol-based hand sanitizer (ABHS) available outside or within each resident's room who required EBP. This deficient practice was identified for 18 of 19 residents reviewed for EPB and was evidenced by the following: a) On 10/30/24 at 12:15 PM, the surveyor observed a Licensed Practical Nurse (LPN) checking Resident #210's blood sugar. The LPN retrieved the uncovered glucometer (a machine that tests blood glucose level) from the medication cart, along with other supplies, and without first cleaning the glucometer, then entered Resident #210's room, then used the lancet to obtain the blood sample, and placed the blood sample on the test strip. The LPN then removed the used test strip from the glucometer, exited the resident's room and placed the glucometer directly into the medication cart without first cleaning the glucometer. On 10/30/24 at 1:30 PM, the surveyor interviewed the LPN regarding the facility process for the cleaning of shared medical equipment. The LPN stated that all medical equipment was to be disinfected after each resident use. The surveyor then inquired regarding the observed practice of the glucometer machine not being cleaned before or after being used and then stored in the medication cart. The LPN confirmed that she did not disinfect the glucometer. Upon further inquiry, the LPN stated that she had received education on infection control during her orientation. A review of the manufactures's specifications for the glucometer indicated the following: The Evencare G3 Meter should be cleaned and disinfected between each patient. To clean the meter, clean the meter surface with one of the approved disinfectant. Allow the surface of the meter to remain wet at room temperature for the contact time. on the wipe's directions for use. Wipe all external areas of the meter including both front and back surfaces until visibly wet. Avoid wetting the meter test strip port. On 11/6/24 at 1:00 PM, the facility was made aware of the above concerns. On 11/7/24 at 11:20 AM, the facility provided copies of education for all the staff involved. No further information was provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b) On 10/30/24 at 10:04 a.m., the surveyor observed Resident #22 in the bed with their eyes closed, and observed a nebulizer (used for providing aerosol breathing treatments) machine on the bedside table with the nebulizer mask placed directly on the night stand surface along with other resident and belongings. The surveyor returned to the room on 10/30/24 at 12:35 PM, and the nebulizer mask remained on the night stand. The medical record reflected Resident #22 was admitted to the facility with medical diagnoses which included, but were not limited to, acute pulmonary edema, muscle weakness, other viral pneumonia and End Stage Renal disease. The medical record also revealed that Resident #22 had an order for Ipratropium-Albuterol 0.5 -2.5 (3) milligrams /3 milliliter 1 vial inhale every 6 hours for wheezing, shortness of breath. On 11/06/24 at 10:30 AM, the surveyor observed a Bipap machine and mask (device that helps breathing) on the bedside table in Resident #61's room. The Bipap mask was placed directly on the bedside table along with other items. The surveyor exited the room and accompanied the Registered Nurse (RN) back into the room to observe the Bipap mask. The RN informed the surveyor that all respiratory equipment was to be disinfected and placed in a plastic bag after each use to prevent the spread of infection. A review of Resident #61's electronic medical record reflected an order for Bipap at bedtime with oxygen at 2 liters, and off in the morning. Resident #61 medical record revealed that Resident #61 had diagnoses of hypertension and chronic obstructive pulmonary disease. A review of the facility policy titled, Departmental (Respiratory Therapy) Prevention of infection edited 3/18/24 indicated the following: Purpose The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. The following was noted under Infection control Considerations related to medication Nebulizers/ Continuous Aerosol: After completion of therapy, remove the nebulizer container. Rinse the container with fresh tap water; and dry on a clean paper towel or gauze sponge. Store the circuit in plastic bag, marked with date and resident's name, between uses. 38079 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c) On 10/31/2024 at 7:30 AM, the surveyor conducted a medication pass observation with the Licensed Practical Nurse (LPN) was observed in the room of an unsampled resident room [ROOM NUMBER]. The LPN applied the blood pressure cuff to the resident's bare arm, a pulse oximeter to the resident's bare finger, and obtained the temperature with a no touch thermometer. Next the LPN obtained a disinfectant wipe and wiped down the blood pressure cuff, pulse oximeter, and thermometer all with the same wipe. On 10/31/2024 at 7:59 AM, the LPN was observed in an unsampled resident's room, room [ROOM NUMBER], to administer medications. The LPN had donned (put on) gloves to apply the blood pressure cuff to the resident's bare arm, applied the pulse oximeter to the resident's bare finger, and used a no touch thermometer to obtain the resident's temperature. The LPN then used a disinfectant wipe to disinfect the blood pressure cuff, pulse oximeter, and thermometer all with the same wipe. The LPN removed her gloves and entered the resident's bathroom. The LPN turned on the water, wet her hands, applied soap, applied friction for 14 seconds, rinsed her hands, dried her hands, and used a new paper towel to turn off the faucet. Next the LPN donned gloves to use a glucometer to check the resident's fasting blood sugar. After doffing (removing) her gloves, the LPN entered the resident's bathroom. The LPN turned on the water, wet her hands, applied soap, applied friction for 16 seconds, rinsed her hands, dried her hands, and used a new paper towel to turn off the faucet. On 10/31/2024 at 8:09 AM, the LPN used a disinfectant wipe to clean the dirty glucometer and next used the same contaminated disinfectant wipe to wipe down the top of the medication cart. On 10/31/2024 at 8:37 AM, the LPN stated that when performing hand washing, she should apply friction for 20 seconds. She stated that the purpose of hand washing was to prevent the spread of infection. On 10/31/2024 at 12:57 PM, during an interview with a surveyor, the Infection Preventionist Registered Nurse stated, We use the purple and the blue wipes. We are not supposed to use the same wipes for multiple items, each item has to be cleaned separately with a different wipe, not the same wipe. A review of the facility provided, Hand Washing skill dated 08/14/2024, included but was not limited to; 4. [NAME] all surfaces of hands, wrist, and fingers producing friction, for at least 20 seconds. The skill competency was signed by the LPN and the evaluated as having been performed correctly. A review of the facility provided policy, Administering Medications revised April 2019, included but was not limited to; 25. Staff follows established facility infection control procedures . A review of the facility provided policy, Handwashing/Hand Hygiene edited 03/18/2024, included but was not limited to; Washing Hands 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. A review of the facility provided policy, Cleaning and Disinfection of Resident-Care Items and Equipment revised September 2022, included but was not limited to; Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention) and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard. 48781 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d) On 10/30/24 at 9:00 AM, during the initial tour of the sub-acute unit, the surveyor observed that their was no EBP signage on doorways for any resident rooms. There were no PPE or ABHS at the entrance to the rooms. PPE was observed at the end of the hallways. On 10/30/24 at 12:40 PM, the surveyor observed some residents rooms had an orange dot next to their name on the front of their door. room [ROOM NUMBER]-D, Resident #18 had no orange dot. The door had green dot with FR written on it. The room [ROOM NUMBER]-W, contained Resident #259, who had an orange dot by their name. On 10/31/24 at 7:47 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), working at the facility per-diem, less than a year. The surveyor asked the LPN about the green and orange dots on the door to room [ROOM NUMBER]. The LPN stated she was Not sure what the orange dot on door means. The green dot might be for EBP because 2-D is on dialysis. I've been away for three months, things might be different here. On 10/31/24 at 12:39 PM, the surveyor reviewed the Electronic Medical Record (EMR) revealed Resident #18 received dialysis treatments and Resident # 258 had an indwelling urinary catheter. On 10/31/24 at 9:01 AM, the surveyor observed two family members (FM #1 and FM #2) of Resident #259, enter the room without using ABHS. The surveyor asked the family and both residents in if they knew what the orange and green dots next to the name on the door meant, the FM #1 stated, We don't know what that means, they don't explain anything here, I didn't notice that at all. It is not brought to our attention. FM #2 stated, I've seen it but don't know what that is and no one told us. Resident #18 in the other bed stated, I didn't know what that is. On 10/31/24 at 11:00 AM, the surveyor interviewed a housekeeping staff in the hallway, the stated they been working almost two years in the facility, regarding what the green and orange dots indicated on in Resident #259's and 18's Room. She stated, I have no idea what the dots mean, orange dot has to have precautions, but I don't know what. I had in-service last month on PPE and EBP. On 10/31/24 at 12:57 PM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON)/ Infection Preventionist (IP), Registered Nurse (RN), who has been working in the facility for over two years, regarding the facility's process for EBP. She stated, If a patient comes in with tube feeding [food via tube into stomach], Foley [type of urinary catheter], dialysis, catheter, wounds, we must use precautions. Before going into the resident's room, wash hands or use Alcohol base hand sanitizer (ABHS) until it dries. PPE must be put on before entering the room if direct contact is provided. She then stated they give report every day and we also have the orange dot next to the patient's name for those who are on EBP. The ADON/IP stated we were told not to put signage on the door, but only in the inside of the patient's room., and the Social Worker (SW) then notified families via e-mail that resident is on EBP. On 10/31/24 at 1:23 PM, the Director of Nursing (DON) provided the surveyor with in-services for EBP that were conducted on 6/3/24, which revealed the per-diem LPN was not in attendance. The surveyor asked the DON if all staff should be in-serviced on EBP and the DON acknowledged, We expect that all staff including per-diems to be in-serviced on EBP as well. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/31/24 at 2:00 PM, the surveyor and the ADON/IP nurse went into Resident #259 and 18's room to check the EBP signage. The signage was noted inside the room against the wall next to the door. FM #1 of the Resident #259 was in the room at the time and the surveyor asked if they observed the sign and knew what it meant. FM #1 stated, I didn't really see the sign and I don't know what that is and no one ever told us. The surveyor asked the ADON/IP if the EBP signage should be visible to all staff and visitors and residents, and how would staff know what PPE to use before entering the room. The ADON/IP responded, I was told that the State rule said you cannot have it in front of the door. The sign also does not stick on the door good, so I put it inside the room. The ADON/IP was asked if the sign should be visible for everyone to see. The ADON/IP acknowledged that the EBP signage should be visible for everyone to see to know what type of precautions and what PPE to put on. The surveyor observed room [ROOM NUMBER]-D still had no orange dot next to the resident's name by the door. On 11/01/24 at 1:00 PM, a review of the EHR order summary for the Resident #18 and the Resident #259 had no orders for EBP. The Resident #18 order summary revealed: hemodialysis diagnosis of end stage renal dialysis; Dialysis Days M, W, F and time: 3PM chair pick up time: 2:15-2:25PM Dialysis Center. Check right upper chest site for bleeding post dialysis. The Resident #259 order summary revealed: urinary catheter: indwelling size:16 French balloon size:10cc change PRN for obstruction. as needed for Neurogenic Bladder Change. On 11/4/24 at 8:30 AM, the surveyor interviewed the ADON/IP nurse regarding who is responsible for tracking residents on EBP. She stated, I don't do the tracking for those who are on EBP. I have the tracking for those who have active infection only. On 11/4/24 at 8:32 AM, another surveyor (#2) observed dots on doors in the hallway and one PPE cart in the hallway. The surveyor observed that there was no signage on the doors. When questioned, the ADON/IP nurse stated that there were no signs to indicate what precautions the residents are on and the cart is for the whole hallway, and there is signage in the room and the dots are the process. Another surveyor asked the ADON/IP nurse what the protocol for the dots was, and how would visitors know what they represented. The ADON/IP nurse stated, the staff would look for someone who never visited here before, and educate them, it is enhanced barrier. On 11/4/24 at 10:48 AM, the ADON/IP was not able to provide information that the previous SW notified the families of 2-D and 2-W of EBP information, she stated, I asked the SW and she does not have it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/4/24 at 12:10 PM, the surveyor interviewed the ADON/IP nurse, in the presence of the survey team. The ADON/IP nurse stated, When we have admissions, if they don't have IV, Catheter, we don't initiate EBP. If they have dialysis, catheter, IVs, PICC lines, tube feedings, wounds, the nurses do it right away, they put the bins in the hallway, orange sticker on the door, the signage is put in the room. The doctors stop by the nurse's station, any of the nurses will tell them, the patient is on EBP, we see families right away, we tell them the EBP. I must ask the administrator about putting the signage on the doorway. The corporation reviews the guidance and I'm told what to do. On 11/6/24 at 8:53 AM, the surveyor interviewed the ADON/IP nurse regarding missing PPEs from EBP rooms the previous week, including orange dots and ABHS. The ADON/IP nurse stated, I don't know how many residents are on EBP right now. room [ROOM NUMBER]-D should have had an orange sticker on her door last week and should have PPEs by their door. On 11/6/24 at 9:11 AM, the surveyor observed in the presence of the ADON/IP nurse, resident rooms 20, 26 and 28 with orange dots by their names, no PPE or ABHS by the doorways. She then stated, It should be by the doorway so that it's accessible to everyone. On 11/6/24 at 9:15 AM, the surveyor was in room [ROOM NUMBER]-W in the presence of the DON. The surveyor asked the Resident #15 if he/she knew what the EBP sign on the wall near the bathroom meant, the resident stated, I don't know what that is, no one ever explained it to me. The resident was moved from 5-D to 10-W on 10/31/24 with orange dot on doorway for dialysis-EBP. The surveyor observed no PPEs or ABHS by the resident's doorway. The surveyor asked the DON why that was. The DON stated, The PPE is not by the doorway because it takes up too much room and it's further down on the hallway. On 11/6/24 at 12:37 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON regarding concerns with the facility's EBP process. The surveyor requested for the list of residents on EBP name, room numbers and what type of EBP and the facility's evidenced based guidance of their EBP policy. On 11/7/24 at 8:19 AM, the surveyor interviewed the IP nurse and she stated, The LNHA, the DON and me reviewed the CDC guidance for EBP yesterday and that is why we moved the signage of the EBP on the front of the residents' doors, including placing the PPEs and ABHS on front of doorways. The surveyor asked the ADON/IP nurse if the CDC guidance was ever reviewed prior to admitting residents on EBP in the past and the IP nurse stated, I saw a webinar before on guidelines that corporate tells us and we follow what corporate tells us to do. The ADON/IP acknowledged, we were doing it wrong as per CDC guidance. On 11/7/24 at 11:30 AM, the survey team met with LNHA and DON regarding concerns with EBP residents. A review of the most current facility policy Enhanced Barrier Precautions dated 4/10/24 revealed, Staff are trained in EBP'S and alerted to the signage to look for, prior to caring for residents on EBPs. Signage is posted indicating the type of precautions and PPE required. Discreet signage may be implemented, to maintain a homelike environment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Somerset Valley	1621 Route 22 West Bound Brook, NJ 08805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the CDC guidelines on HTTPS://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html, dated July 12, 2022, stated, Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (e.g., gowns and gloves); For EBP, signage should also clearly indicate the high-contact resident activities that require the use of gown and gloves; Make PPE, including gowns and gloves, available immediately outside of the resident room; Ensure access to ABH rub in every resident room (ideally both inside and outside of the room); Provide education to residents and visitors. NJAC 8:39-19.4(a)(c)(k)