STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315087	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Middletown	1040 State Route 36 Atlantic Highlands, NJ 07716

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on observation, interview and record review it was determined that the facility failed to update resident Care Plans for Activities for 2 of 2 residents reviewed for activities (Resident #26 and Resident #2). The deficient practice was evidenced by the following: a) On 01/06/25 10:46 AM, Resident #26 was observed in bed and was alert. The surveyor tried to engage the resident in conversation and the resident spoke Spanish. There were no activities observed in progress in the room, or any Spanish language materials for the resident. On 01/06/25 at 12:24 PM, the surveyor interviewed the Certified Nurse Aide (CNA) assigned to resident #26. There was a sheet observed with boxes in Spanish and Pictures to help communicate with the resident and was located on the bedside table. The surveyor asked if that was how she communicated with the Resident and the CNA stated, not everything was on there and stated no CNAs speak Spanish. The surveyor asked what the resident liked to do and the CNA stated she didn't know what the resident like to do. On 01/06/25 at 2:00 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #26 which revealed: the Adminssion Record documented diagnoses which included, but were not limit to Sepsis, Metabolic Encephalopathy and Acute Kidney Failure. The Admission Minimum Data Set, dated dated dated [DATE], revealed that the Resident's preferred language was Spanish, and Yes was checked for needing or wanting an interpreter to communicate with the doctor of health care staff. Section F0800 revealed that the Staff Assessment of Daily and Activity Preferences were left blank. The Brief Interview for Mental Status section revealed the resident scored 3/15 which indicated the resident was severely cognitively impaired. A Care Plan Focus for Activities initiated 12/30/24 revealed, Enjoys activities such as music, crafts and television. The Goal is Will actively participate in independent activities of choice daily, Date Initiated: 12/30/2024, Target Date: 01/12/2025. The Interventions included, Assist to transport to and from activities of choice, Date Initiated: 12/30/2024, Provide supplies/materials for leisure activities as needed/requested, Date Initiated: 12/30/2024. The Activity Evaluation, singed by the AD on 12/30/24 documented that the the Language Spoken was English, and speech was Clear. The Activity Evaluation revealed the following; Current Interests: Crafts/Arts/Hobbies, Music, TV Program Viewing Radio, Talking and Conversing, Spending Time Outdoors, Watching Movies and Favorie Movie section was left blank, and Parties and Social Events. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/08/25 at 11:45 AM, the surveyor interviewed the AD regarding if there was any documentation regarding attendance in activities. The AD stated that only for the Long Term Care Residents, and it was not for the activity program attendance. The AD stated Resident #26 was considered sub-acute and she did not include the sub-acute residents. The surveyor asked were there any programs developed for cognitively impaired residents including sensory programs. The AD could not provide the survey team with any sensory programs or activities that were scheduled for the residents. The surveyor asked the AD about Resident #26 activities since the resident only spoke Spanish and the Care Plan did not speak to any Spanish activities and the Activity Evaluation indicated the resident spoke English. The AD stated that she must have gotten the information from somewhere else. The AD was unable to provide any information on Resident #26 being provided activities in their native language and related to their cognitive status. 38079 b) On 01/05/25 at 7:26 AM, Surveyor #2 toured the Station 3 nursing unit and observed a large Activity calendar by the unit day room. The activity calendar failed to include all times and locations of activities. Also during tour, Surveyor #2 observed Resident #24 sleeping in their room. On 01/06/25 at 11:49 AM, Resident #24 was observed in their room watching television (TV), and there were also residents in the day room observed watching TV. On 01/07/25 at 9:27 AM, the resident's direct care CNA stated that the resident was independent but needed prompting. He stated Resident #24 would come out of their room and liked to watch TV and sports. A review of the Admission Record revealed Resident #24 had been admitted in 2017 and readmitted in 2021. Resident #24 had diagnoses which included but were not limited to; Bipolar (a mental illness with extreme mood swings); dementia, and muscle weakness. A review of the annual MDS dated [DATE], included a BIMS of 04 out of 15 indicating severe cognitive impairment; Section D Mood revealed 0 never for social isolation; Section F Preferences for Customary Routine and Activities documented it was 1 Very Important to go outside, participate in religious services and 2 Somewhat Important to listen to music, be around animals, keep up with the news. A review of the resident-centered care plan included but was not limited to; Focus area initiated 12/22/2020 and revised 12/22/2020, Prefers not to attend group activities prefers independent activities. A Goal initiated 12/22/2020 and revised 11/20/24, Will sometimes be a passive observer. Goal: will participate in activities of choice such as watching television, wheeling around facility, and engaging in conversation with staff and residents. Intervention dated 8/7/21, encourage participation in activities of interest, and dated 12/22/20, provide information on activity programs on a regular basis and to respect choice in regard to limited/no activity participation. No interventions were revised after 12/22/2020. A review of the facility provided most recent. Activity Evaluation was dated 01/28/2024 and not filled out. The Activity Evaluation included but was not limited to; background, Spiritual involvement, Preferences, 22 categories of activity preferences, adaptions required (i.e.: reminders, assistance, leisure cart visits, sensory, one to one, dementia programs), and mode of transportation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided Care Conference Notes effective 12/17/24, revealed recreation department did not attend and there was no summary or update of Resident #24's activity preferences. A review of the facility provided Care Conference Notes effective date 10/30/23, included but was not limited to; enjoys time outdoors, family call often, enjoys watching TV, passive observer and sometimes participates in activities, and has been attending more programs in the main dining room. A review of the January 2025 Individual Participation Record revealed codes to be used to record resident activity. The form included A=active, P=passive, R=refused, W=leaves and returns, I=individual, and O=off unit. The form included 21 categories of activities and noted that Resident #24 was marked A in four categories inconsistently and no other codes were entered to indicate if the resident was a passive observer or was invited and refused. On 01/08/25 at 11:49 AM, the Activities Director stated that Resident #24 enjoyed music events and live music. The Activities Director further indicated there was no documentation regarding Resident #24's activity attendance or preferences. A review of the facility provided policy, Care Plans, Comprehensive Person-Centered edited 04/25/22, included but was not limited to; Statement . includes measurable objective and timetables . 2. interventions are derived from a thorough analysis of the information gathered as part of a comprehensive assessment. 7. The process will: . b. includes an assessment of strengths and needs and c. personal and cultural preferences . 8. The . care plan will: b. describes services to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being . 13. Assessments are ongoing and care plans are revised as information about the resident and residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: . b. when the desired outcome has not been met, c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly in conjunction with the required quarterly MDS assessment. A review of the facility provided Activity Director job description signed and dated 06/12/2020, included but was not limited to; Purpose . to assure an ongoing program of activities is designed to meeting in accordance with the comprehensive assessment, the interests . mental and psychosocial well-being of each resident. Ensure all activity notes are informative and descriptive of the services provided and the resident's response to the service. On 01/08/25 at 1:43 PM, the above concerns were addressed with the facility administration and the Director of Nursing acknowledged Resident #24's care plan should have been reviewed and revised since 2020. The facility had no additional information to provide. NJAC 8:39-11.2; 27.1

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48423 Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to follow the physician orders for medications (meds) that required parameters. This deficient practice occurred for 1 of 18 residents (Residents #62) reviewed for medications and was evidenced by the following: This deficient practice 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 and 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 regimens 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 1/5/25 at 8:49 AM, the surveyor observed Resident #62 eating breakfast in their wheelchair and the resident informed the surveyor that they had received all their medications. The surveyor reviewed Resident # 62's electric medical records (EMR) that revealed the following: The Admission Record (AR; admission summary) revealed that Resident #62 had diagnoses that included but were not limited to, acute kidney failure (a condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few days), repeated falls, and muscle weakness. A quarterly Minimum Data Set (qMDS) an assessment tool used to facilitate management of care, with an Assessment Reference Date (ARD) of 12/3/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #62 scored a 11 out of 15, which indicated the resident was moderately cognitively impaired. A review of the Order Summary Report (OSR) reflected that Resident #62 had an active Physician Order (PO) dated 6/27/24 for a med: Midodrine HCL (hydrocholoride) Oral Tab 10 mg- Give 1 tablet by mouth every 8 hours for Hypotension (low blood pressure [BP]); HOLD if SBP [systolic BP] > 120, with a start date of 6/27/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The corresponding PO was transcribed into the September 2024 through January 2025 electronic Medication Administration Record (eMAR). Further review of the September 2024 - January 2025 eMARs for Resident #62 revealed that nurses signed and reflected a checkmark which means that the med was administered when the med should have been held for a SBP that was greater than 120 according to the PO, for the following dates and times: Date Time SBP 9/4/24 2:00 PM 125/89 9/7/24 2:00 PM 128/73 9/19/24 10:00 PM 129/69 9/20/24 10:00 PM 129/76 10/30/24 6:00 AM 122/67 10/30/24 10:00 PM 127/72 10/31/24 10:00 PM 124/65 11/11/24 6:00 AM 122/60 12/7/24 2:00 PM 121/68 12/16/24 2:00 PM 121/69 12/16/24 10:00 PM 140/71 1/1/25 10:00 PM 121/67 During an interview with the surveyor on 1/7/25 at 10:32 AM, the Licensed Practical Nurse (LPN#1) stated, Midodrine was for hypotension (for low BP) and if the BP was higher than 120, then we would hold the medication because it would bring the BP higher. The LPN further stated, we would check BP before administering the medication. During an interview with the surveyor on 1/7/25 at 10:48 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #1) stated, Midodrine is used to raise the BP. The LPN/UM #1 stated the process was to check Vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure) first and if the BP >120, then the medication would be held. The surveyor informed the LPN/UM #1 of the above concerns for Resident #62. The LPN acknowledged that the medication should have held when the BP> 120. On 1/8/25 1:44 PM, the survey team met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The surveyor notified of the above-mentioned concerns for Resident #62. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided Job Responsibilities for Licensed Practical (Vocational) Nurse (LPN)/ (LVN) under Duties and Responsibilities included: Administer medications within the scope of practice and according to practitioner orders. Report adverse consequences, side effects or any medication errors. A review of the facility policy titled Administering Medications revised 4/19 included under Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Under section Policy Interpretation and Implementations- 4.) Medications are administered in accordance with prescriber orders, including any required time frame. On 1/9/25 at 10:41 AM, the survey team met with the LNHA, and DON for the Exit Conference, and facility management did not provide any additional information and did not refute the findings. NJAC 8:39-11.2(b), 27.1 (a), 29.2(d)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Based on observation, interview, and record review, it was determined that the facility failed to provide the necessary services to maintain adequate grooming for a resident who was dependent on the staff for activities of daily living. This deficient practice was observed for 1 of 19 residents reviewed for care (Resident #125) and was evidenced by the following: On 01/05/25 at 9:07 AM, the surveyor observed Resident #125 lying in bed. Resident #125's facial area was covered with long thick facial hair. Resident #125 was positioned on the left side and the head of the bed was slightly elevated. On 01/05/25 at 11:30 AM, the surveyor observed the resident still laying on the left side as observed at 9:07 AM. The surveyor left the room and reviewed the assignment sheet. The surveyor located the Certified Nursing Assistant (CNA #1) assigned to Resident #125. CNA #1 entered the room with the surveyor and stated that she was caring for another resident and had not provided care yet to Resident #125. On 01/05/25 at 11:45 AM, in the presence of the surveyor, CNA #1 provided incontinence care to the resident, adjusted the bed linen and exited the room. The surveyor returned to the room at 12:45 PM, Resident #125 was still in bed. On 01/05/25 at 1:00 PM, the surveyor interviewed CNA #1 who stated that Resident #125 was dependent on staff for all activities of daily living. CNA #1 stated that Resident #125 had been at the facility for a few days, refused to eat and had not been out of the bed. On 01/06/25 at 8:15 AM, the surveyor observed Resident #125 in bed, positioned on the backside with the head of the bed slightly elevated. The surveyor observed the resident still with long thick facial hair. On 01/06/25 from 10:15 AM to 11:30 AM, the surveyor sat in the room, the resident was still in bed as observed at 8:15 AM, no staff entered the room during the observation. On 01/06/25 at 11:30 AM, the surveyor reviewed the Admission Record which indicated that Resident #125 was admitted to the facility with diagnoses which included but were not limited to: frontal lobe and executive function deficit following non traumatic intracerebral hemorrhage, hypertension, unspecified dementia without behavioral disturbances, and muscle weakness. The Admission Minimum Data Set (MDS) dated [DATE], an assessment tool use by the facility to prioritize care, reflected that Resident #125 had a Brief Interview for Mental Status (BIMS) of 03 indicative of severe cognitive impairment. The MDS further assessed that Resident #125 required total staff assistance for personal hygiene, including combing hair, brushing teeth and eating. On 01/07/25 at 8:20 AM, the surveyor observed that Resident #125 was in bed, and still observed with thick facial hair. The resident could not answer any questions when approached. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/07/25 at 8:48 AM, the surveyor observed Resident #125 in bed and the face was still covered with thick facial hair. On 01/07/25 at 9:44 AM, the surveyor inquired through the Unit Manager (UM) regarding who supervised the care. The UM stated, that the nurses and the UM were to make rounds and ensure that the the CNAs cared for the residents. The UM stated that she did not notice the facial hair on Resident #125. On 01/07/25 at 11:45 AM, the surveyor interviewed again CNA#1 who cared for Resident #125 on 1/5/25 and 1/6/25. The CNA confirmed that Resident #125 was totally dependent on staff for care. When inquired regarding the facial hair observed for the last 3 days even after she had provided care to Resident #125, CNA #1 stated that she observed the facial hair and was not aware that she could shave the resident. The CNA added that she had been working at the facility and had never shaved or assisted a resident with shaving. On 01/07/25 at 12:30 PM, the surveyor observed another CNA transferring Resident #125 to the Dayroom. Resident #125 was neatly dressed, and their grooming was tending to. There was no facial hair. Resident #125 had their eyes open and was smiling. On 01/08/25 at 8:46 AM, during a second interview with the UM, she stated that the CNAs were responsible for shaving the residents. The UM further added, that any staff can supervise the care. She was not aware that Resident #125 had facial hair. On 01/08/25 at 9:49 AM, the surveyor interviewed CNA #2 who cared for Resident #125 on 01/07/25. The CNA stated, When she entered the room on 01/07/25 at 8:40 AM, she observed the resident with thick facial hair, she thought that the resident was a [a different gender], and she went to the nurse's station and informed the Unit Manager. CNA #2 stated that she had to use four razors and asked another CNA to assist with the shaving. The CNA stated, I could not believe that the resident had been here and had not been shaved. I had to do it. On 01/08/25 at 11:06 AM, the above concerns were discussed with the the Licensed Nursing Home Administrator (LNHA), who provided the policy for shaving and stated that the CNA should know that she can shave the residents. On 01/08/25 at 12:05 PM, the surveyor reviewed the CNA assignment/computer tablet which reflected the resident had a self-care performance deficit and required staff assistance for personal hygiene. On 01/08/25 at 2:15 PM, the surveyor discussed the above observations and concerns with the Administrator and the Interim DON and required the policy for ADL and shaving. On 01/09/25 at 9:45 AM, the LNHA provided the policy titled, Shaving the Resident last revised 2/2018. The following were noted: Purpose: The purpose of this procedure is to promote cleanliness and to provide skin care. The Activities of Daily Living (ADL) Supporting contained the following: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/24 at 11:10 AM the surveyor reviewed the yearly competency evaluation for the CNA and verified that all CNAs received competency evaluation on Shaving. NJAC 8:39-27.1 (a)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to a.) ensure activity assessments accurately reflected the needs of all residents and appropriate activities were provided for a non-English speaking resident (Resident #26), and b.) complete a yearly activity assessment and activity monitoring to determine the meaninful interests of a resident (Resident #24), hobbies, and cultural preferences. This deficient practice occurred for 2 of 2 residents reviewed for resident activities and was evidenced by the following: a) On 01/05/24 at 12:47 PM, the surveyor observed Resident #26 sitting in the wheelchair in the Day Room of Station 1. Resident #26 was at a table by themselves, next to a wall, awake and alert with no activities observed in front of the resident, and no activity staff were present. Three other residents were observed in front of a television at another table. At that time, three staff were observed at the nursing desk and there was no resident activity in progress. On 01/06/24 at 11:30 AM, the Liscensed Nursing Home Administrator (LNHA) provided six months of activity calendars and included a weekly January nativity sheet. The scheduled activities for 01/06/24 were Morning Trivia at 10:15 AM on Statio 2 and 3, Bingo and Lunch 11:30 AM in the Dining Room and the Gab [NAME] at 2:15 PM There was nothing scheduled for the entire day for Station #1. On 01/06/25 10:46 AM, Resident #26 was observed in bed and was alert. The surveyor tried to engage the resident in conversation and the resident spoke Spanish. There were no activities observed in the room, or any Spanish language materials for the resident. On 01/06/25 at 10:52 AM, the surveyor observed the three residents in front of the television on Station #1 Day Room. The Activity Director asked if any residents wanted to play Bingo and one resident agreed to go to Bingo. The other two Residents remained in the Station 1 Day Room in front of the television with no other activities planned for Station 1. On 01/06/25 at 12:24 PM, the surveyor interviewed the Certified Nurse Aide (CNA) assigned to resident #26. There was a sheet observed with boxes in Spanish and Pictures to help communicate with the resident and was located on the bedside table. The surveyor asked if that is how she communicated with the Resident and the CNA stated, not everything was on there, and stated no CNAs speak Spanish. The surveyor asked what the resident liked to do and the CNA stated she didn't know what the resident like to do. On 01/06/25 at 1:41 PM, Resident #26 observed in the Station 1 day room, at the end of the table by the television, sitting at a table with other residents and Resident #26 was sleeping while the television was on and no activities were in progress. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/06/25 at 2:00 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #26 which revealed: the Adminssion Record documented diagnoses which included, but were not limit to Sepsis, Metabolic Encephalopathy and Acute Kidney Failure. The Admission Minimum Data Set, dated dated dated [DATE] revealed that the Resident's preferred language was Spanish, and Yes was checked for needing or wanting an interpreter to communicate with the doctor of health care staff. Section F0800 revealed that the Staff Assessment of Daily and Activity Preferences was left blank. The Brief Interview for Mental Status section revealed the resident scored 03 out of 15 which indicated the resident was severely cognitively impaired. A Care Plan Focus for Activities initiated 12/30/24 revealed, Enjoys activities such as music, crafts and television. The Goal is Will actively participate in independent activities of choice daily, Date Initiated: 12/30/2024, Target Date: 01/12/2025. The Interventions included, Assist to transport to and from activities of choice, Date Initiated: 12/30/2024, Provide supplies/materials for leisure activities as needed/requested, Date Initiated: 12/30/2024. The Activity Evaluation, singed by the AD on 12/30/24 documented that the the Language Spoken was English, and speech was Clear. The Activity Evaluation revealed;ed the following Current Interests: Crafts/Arts/Hobbies, Music, TV Program Viewing Radio, Talking and Conversing, Spending Time Outdoors, Watching Movies and Favorie Movie section was left blank, and Parties and Social Events. On 01/08/25 at 11:45 AM, the surveyor interviewed the AD regarding if there was any documentation regarding resident attendance in activities. The AD stated that only for the Long Term Care Residents, and not for the activity program attendance for the sub-acute residents and Resident #26 was considered sub-acute. The surveyor asked were there any sensory type programs developed for cognitively impaired residents. The AD could not provide the survey team with any sensory type activity programs or activities that were scheduled for the residents who were cognitively impaired. The surveyor asked the AD about Resident #26 activities since the resident only spoke Spanish and the Care Plan did not document any Spanish activities and the Activity Evaluation indicated the resident spoke English. The AD stated that she must have gotten the information from somewhere else. The AD was unable to provide any information on Resident #26 being provided activities in their native language or related to their cognitive status. 38079 b) On 01/05/25 at 7:26 AM, Surveyor #2 was touring Section 3 unit and observed Resident #24 sleeping on their right side in bed. Surveyor #2 observed a very large activities calendar by the unit day room and a large television in the unit day room. The large activities calendar failed to include the times or locations of the activities. On 01/06/25 at 11:49 AM, Surveyor #2 observed Resident #24 in their room watching television. On 01/07/25 at 9:26 AM, Resident #24 was observed in bed sleeping on their right side. On 01/07/25 at 9:27 AM, the direct care Certified Nursing Assistant (CNA) stated that often Resident #24 was independent but needed prompting. He stated Resident #24 did come of the room and liked to watch television and sports. On 01/08/25 at 9:45 AM, Resident #24 was observed in the unit day room watching television with other residents. There were no activities going on at that time. Resident #24 next self-propelled off the unit. (continued on next page)

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	315087	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Middletown	1040 State Route 36 Atlantic Highlands, NJ 07716

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Admission Record revealed that Resident #24 was admitted to the facility with diagnoses which included but were not limited to; bipolar (a mental illness characterized by extreme mood swings), dementia, and muscle weakness. A review of the annual Minimum Data Set (MDS) an assessment tool used to facilitate care dated 10/26/24, included but was not limited to; a Brief Interview for Mental Status (BIMS) of 04 out of 15 indicating severe cognitive impairment; Section D Mood revealed 0 never for social isolation; Section F Preferences for Customary Routine and Activities documented it was 1 Very Important to go outside, participate in religious services and 2 Somewhat Important to listen to music, be around animals, keep up with the news; a review of the resident-centered care plan included but was not limited to; wandering through facility - attempts to minimize excess stimulation and provide supervision during recreation programs, indicators of depression/sadness - attempt to involve in activities respecting choice and preferences dated 12/22/20, and Prefers not to attend group activities prefers independent activities such as watching television, wheeling around facility and engaging in conversation with staff and residents - encourage participation in activities of interest dated 08/07/21. A review of the facility provided most recent Activity Evaluation was dated 01/28/2024 and not filled out. A review of the January 2025 Individual Participation Record revealed codes to be used to record resident activity. The form included A=active, P=passive, R=refused, W=leaves and returns, I=individual, and O=off unit. The form included 21 categories of activities and noted that Resident #24 was marked A in four categories inconsistently. There were no other codes entered to indicate if the resident was a passive observer or was invited and refused activities. On 01/08/25 at 11:49 AM, the Activities Director (AD) was in the conference room with two surveyors and stated that if a resident participated in an activity, there would not be documentation. She further stated there was no documentation if a resident was offered or refused to participate. When asked if the resident was offered should their form include an R for refused, the AD stated you are right, it is not done. I don't have an answer for that. The AD stated Resident #24 liked to go to music events and live music, but it was not documented anywhere that the resident was invited to any of those types of activities. A review of the facility provided policy, Activity Programs revised 2018, included but was not limited to; a. to support the well-being of residents and to encourage independence and community interaction; 5. designed to encourage maximum individual participation and . individual resident's needs; 9. All activities are documented in the resident's medical record. 13. residents are encouraged . to participate in scheduled activities. A review of the facility provided policy, Group Programs and Activities Calendar revised June 2018, included but was not limited to; 3. Residents are encouraged to participate in all group activities, especially those best suited for their interests and physical, mental, and emotional needs. The Activity Director Job Descrtiption revealed: The primary purpose of your job description is to plan, organize, develop and direct the overall operation of the Activity Department in accordance with current federal, state, and local standards, guidelines and regulations, our established polices and procedures, and as may be directed by the Aedministrator an d/or Activit Consultant, to assure that on on-going program of activities is designed to meet in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. The above concerns were discussed with the facility administration on 01/08/2025, and the facility had no additional information to provide. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-7.2; 7.3

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 38079 Based on observation, interview, and review of pertinent documents it was determined that the facility failed to ensure a system was in place to inspect the emergency crash carts (ECC) for expiration dates and placement. This deficient practice was identified on 3 of 3 Resident Sections (1,2,3) and was evidenced by the following: On [DATE] at 12:17 PM, Surveyor #1 and Surveyor #2 were on Section 1 unit. The Automatic External Defibrillator (AED) was located in a cabinet on the wall. Across from the AED, the ECC was located. At that time, the Licensed Practical Nurse Infection Preventionist (LPN IP) was on the unit. Surveyor #2 inspected the ECC and found it was locked. There were items on top of the ECC which included the checklist. A review of the ECC checklist revealed the following items were not documented as having been checked: AED, suction machine, suction canister, Intravenous (IV) kit, back board, flashlight with batteries, extension cord, oxygen tank, gloves, [name redacted] suction tube, oral airway, and isolation gowns. Surveyor #2 observed a resuscitation bag hanging on the ECC which was not included in the checklist and there were no instructions on the checklist. The LPN IP stated that the checklist should be checked and signed daily and that there was no reason why it was not. He further stated the facility did not have a policy or procedure for inspecting the ECC. On [DATE] at 7:48 AM, Surveyor #2 observed the ECC and checklist on Section 3. The LPN stated the process was for the staff to make sure everything is there. She stated the pharmacy replaces supplies but did not know who was responsible to check expiration dates. A review of the ECC checklist revealed a lock number for the lock on the cart and lines through the rest of the items. There were no instructions on the checklist. On [DATE] at 9:02 AM, the Licensed Nursing Home Administrator (LNHA) stated there was no policy and procedure for staff to use to check the ECC. The LNHA acknowledged that the staff were signing the bottom of the checklist but there was no procedure for them to follow regarding what to check for. On [DATE] at 9:18 AM, Surveyor #2 was on Section 1 and observed the Registered Nurse (RN) Supervisor by the ECC. The RN Supervisor stated that there was no policy, and she could not inform the surveyor what the staff would be checking for. The RN Supervisor further stated without a policy there was no way for sure to know who was responsible. She lastly stated that the ECC should be checked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:30 AM, Surveyor #3 was on Section 1 and observed the RN opening the ECC. Surveyor #3 inspected the ECC along with the RN. It was noted that the resuscitation bag hanging on the top of the cart was dated [DATE] and had expired [DATE]. Inside the ECC, it was noted that two IV insertion kits had expired [DATE]. The RN revealed that the facility had to check and ensure the emergency cart was locked only and that once a month the 11 PM - 7 PM shift staff would open and check the items inside the emergency cart. On [DATE] at 11:00 AM, Surveyor #2 inspected the ECC on Section 2. The ECC was locked, and the checklist was on top. There were no instructions on what to inspect for on the checklist. The checklist had a lock number and line through all items and did not include inspection of the resuscitation bag. On [DATE] at 1:43 PM, the facility administration was made aware of the concerns. On [DATE] at 10:00 AM, the facility administration informed the survey team that they were still waiting on a policy and procedure for the ECC. The facility informed the survey team that they did create a new ECC checklist. When reviewed, it was noted that the new list did not include inspection of the resuscitation bag. NJAC 8:,d+[DATE].1; 29.4

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31654 Based on observation, interview and document review it was determined that the facility failed to failed to maintain the kitchen environment and equipment in a sanitary and properly functioning manner to prevent potential contamination and or the spread of potential food borne illness. This deficient practice was evidenced by the following: On 01/07/25 at 9:51 AM, the surveyor conducted a tour of the kitchen with the Food Service Director (FSD) and observed the following: 1. The metal baffles that were inside of the exhaust hood, and above the cooking battery, were visibly soiled with black debris in the slats of the baffles. There was visible grease and grime located on the bottom of the baffles and there was grease type droplets affixed to the opposite inside of the hood. At that time the surveyor interviewed the FSD who confirmed the findings and the surveyor asked the FSD if there was a cleaning schedule to remove and clean the baffles. The FSD state I am working on a cleaning schedule. The nozzles of the fire suppression system in the hood was also observed covered in a grease like substance. 2. The surveyor proceeded to wash hands in the only hand washing sink in the kitchen. The sink water out of the hot faucet felt cold. The surveyor asked the FSD to take the temperature with the facility's calibrated thermometer. The FSD held a thermometer under the running hot water and the thermometer was 74 degrees Fahrenheit. There was a sign affixed above the hand washing sink that revealed: All Employees Must Wash Hands Before Returning to Work, and Wet hands with hot water with a temperature between 90 and 110 degrees Fahrenheit. The surveyor asked the FSD if it was okay if the water was below the required temperature to wash the hands. The FSD stated the cold water won't take off bacteria. 3. Under a stainless steel table opposite of the cooking area the insulated tray lids were stacked with food covering side open and unprotected under a visibly soiled stainless steal table. The Cleaning Policy, undated, provided by the Liscensed Nursing Home Administrator revealed: 2. Surfaces must be cleaned with a sanitizing agent /solution . 4. Grid panels in the fire suppression hood over the stove will be removed and run through the dish machine once a month. NJAC 8:39-17.2(g)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48423 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain infection control standards and procedures to address the risk of infection transmission by failing to: a) follow Contact isolation precautions for a resident who was on Transmission Based Precautions (TBP) (Resident #42), b) ensure that resident's indwelling urinary catheter drainage bag was stored properly for 1 of 1 resident reviewed for urinary catheter (Resident #47), and c) perform hand hygiene during meals according to the facility policy. This deficient practice occurred on 2 of 3 resident units (Section 1 & 2) and was evidenced by the following: 1. On 1/5/24 at 7:19 AM, during the initial tour, the surveyor observed a Contact Precaution signage and personal protective equipment (PPE; equipment (gowns, gloves, masks, etc. worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) bin hanging on Resident #42's door. The surveyor observed that the signage indicated Everyone must: Put on gloves before room entry. Put on gown before room entry. On 1/6/25 at 12:36 PM, the surveyor observed a Certified Nursing Assistant (CNA) in Resident #42's room. The CNA was not observed wearing a gown and gloves while in the resident's room as the sign on the door indicated. At that time, the surveyor conducted an interview with the CNA upon exiting Resident #42's room. The CNA confirmed that she was not wearing a gown and gloves upon entering Resident #42's room. The CNA stated it was important to put on PPE before entering a Contact precaution room to protect oneself from what the resident had. The CNA stated, I just went to drop off the lunch tray and I did not have to put on PPE. After reading the posted signage, the CNA further stated they (the unit manager [UM]) told us we have to put on a gown and gloves when we are feeding a resident. I wasn't feeding the resident. I just went to drop off the tray and came out. Later, the CNA stated, I should have put it on as per the signage. At 1/6/25 at 12:43 PM, during an interview with the surveyor, the Licensed Practical Nurse/ Unit Manager (LPN/UM) stated the Contact precaution signage meant that gown and gloves were to be worn at all times and anytime you walked into the Contact isolation room. The LPN/UM stated it was important to put on gown and gloves to protect self and the residents. The surveyor notified the LPN/UM of the above-mentioned observations and the LPN/UM stated that the CNA should have had the gown and gloves on before she entered Resident #42's room. The surveyor reviewed the medical records for Resident #42 which revealed the following: The Admission Record (AR, admission summary) reflected that the resident was admitted to the facility, had diagnoses which included but were not limited to Crohn's disease (a chronic [long duration and generally slow progression] inflammation of the digestive tract that leads to abdominal pain, severe diarrhea, fatigue, weight loss and malnutrition), irritable bowel syndrome (a common condition that affects the stomach and intestines), ulcerative colitis (an inflammatory bowel disease, that causes irritation, inflammation, and ulcers in the lining of your large intestine (also called your colon), and major depressive disorder. The Order Summary Report (OSR) indicated a physician order Contact isolation every shift for HSV-1 (a viral infection that causes genital and oral herpes) with a start date of 12/23/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 9:37 AM, during an interview with the surveyor, the Infection Preventionist (IP) stated it was important to utilize PPE before entering the Contact precaution room for infection control. The IP acknowledged that the CNA should have worn PPE upon entry and when she delivered the lunch tray. A review of the facility provided Employee In-Service Education dated 5/1/24, Topic: Infection Control: Hand Washing, PPE, EBP, Donning & doffing revealed that above mentioned CNA attended. A review of the facility provided Job Responsibilities for Certified Nursing Assistant (CNA) under Duties and Responsibilities included: Follow established infection prevention and control procedures. A review of the facility policy titled Isolation - Categories of Transmission-Based Precautions (TBP) revised 9/22 included under Policy Statement: TBP are initiated when a resident develops signs and symptoms of a transmissible infection and is at risk of transmitting the infection to other residents. Under Policy Interpretation and Implementation 5a.) The signage informs the staff of the type of CDC (centers for disease control and prevention) precautions, instructions for use of PPE, and/or instructions to see a nurse before entering the room. 2. On 1/5/25 at 8:13 AM, during initial tour, the surveyor observed Resident #47 watching TV in their bed. Resident had a urinary drainage bag placed on bedframe to their left side of the bed. On 1/6/25 from 11:58 AM through 1:25 PM, the surveyor observed Resident #47 in bed. At that time, the surveyor observed resident's urinary drainage bag resting on the floor. The drainage bag was not secured to the bedframe. At 1:29 PM, during an interview with the surveyor, the CNA stated if a resident has a urinary catheter. The CNA stated the drainage bag would be below the bladder and secured on the frame of the bed (bedframe). The CNA stated if she observed a urinary drainage bag on the floor, she would notify resident's nurse. The surveyor then accompanied the CNA to resident #47's room and both observed resident's urinary drainage bag on the floor. The CNA donned PPE and picked up resident's urinary drainage bag and secured on the bed frame. The CNA stated she would notify resident's nurse and change the privacy bag. On 1/6/25 at 1:57 PM, during an interview with the surveyor, the LPN stated the urinary bag would be placed on a hook on the bedframe, so it doesn't touch the floor for infection control. The LPN further stated if the urinary bag touched the floor or was on the floor, she would notify resident's physician and get an order to change the bag. On 1/6/25 at 2:07 PM, during an interview with the surveyor, the LPN/UM stated the urinary drainage bag would be placed on the bed frame and it should not touch the floor due to risk of infection. The surveyor notified of the above-mentioned observations and concern regarding resident's urinary bag between the time of 11:58 AM - 1:50 PM. The surveyor then reviewed the medical records for Resident #47 which revealed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The AR reflected that the resident was admitted to the facility, had diagnoses which included but were not limited to type 2 diabetes mellitus with other circulatory complications, history of falling, obstructive and reflux uropathy (when urine can't flow (either partially or completely) through your ureter, bladder, or urethra due to some type of obstruction [blockage]). A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/7/2024 included the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident's cognition was moderately impaired. Further review of MDS, Section H for bladder and bowel reflected Resident #47 had an indwelling catheter. A review of the OSR indicated a physician order, dated 11/08/24 for Insert #16fr (size of catheter) 10 cc (milliliters) [Name redacted] catheter. A review of Resident #47's care plan included the following focus area with an initiated date of 11/26/2024: Use of indwelling urinary catheter related to disease process secondary to obstructive uropathy. On 1/8/25 1:44 PM, the survey team met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The surveyor notified of the above-mentioned concerns. On 1/9/25 at 9:37 AM, during an interview with the surveyor, the IP stated urinary bags should be secured on the bedframe. The surveyor mentioned Resident #47's urinary bag concerns to the IP. The IP further stated, There is no excuse. It (urinary drainage bag) shouldn't be on the floor. A review of the facility provided Employee Competency Assessment for Catheter Care, Urinary, dated 7/15/24, did not reflect any comments or concerns for the CNA. A review of the facility policy titled Catheter Care, Urinary revised 8/22 included under Infection Control: 2. Be sure the catheter tubing and drainage bag are kept off the floor. 27193 3. On 01/06/25 at 11:49 AM, the surveyor reported to the subacute Unit to observe the lunch meal. The surveyor observed a Certified Nursing Assistant (CNA) approaching the dietary cart, picked up a tray, delivered the tray to Resident #58, assisted with setting up the resident. Posted signage was observed on the door to caution staff to wash hands prior to enter and exiting the room, and to wear Personal Protective Equipment during care. The CNA then exited the room without performing hand hygiene. The CNA then went to the dietary cart picked up another meal tray, delivered the tray to another resident on Enhanced Barrier Precaution without washing their hands first. On 01/06/25 at 1:30 PM, the surveyor interviewed the CNA who stated that she entered the room, delivered the tray and did not perform any care to the resident. The surveyor then showed to the CNA the signage posted at the door, and the CNA did not have any comment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time the surveyor reviewed the Electronic Medical Record (EMR) for Resident # 58 was admitted to the facility with diagnoses which included but were not limited to, muscle weakness, immunodeficiency, aftercare following joint replacement surgery. Resident #58 had a wound to the left leg and was placed on Enhanced Barrier precautions. On 01/07/25 at 1:45 PM, the surveyor interviewed the Infection Control Nurse who stated that all staff had been educated on Infection Control Prevention. On 1/9/25 at 10:41 AM, the survey team met with the LNHA, and DON for the Exit Conference, and facility management did not provide any additional information and did not refute the findings. NJAC 8:39-19.4(1,2), 27.1(a)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48782 Based on observations and interviews between 01/08/2025 and 01/10/2025 in the presence of the Maintenance Assistant (MA), Regional Director of Maintenance (RDOM) and Senior Regional Director of Maintenance (SRDOM), it was determined that the facility failed to ensure that the resident call bell system properly functioned .This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 01/09/2025 at 10:14 AM revealed, when the call bell was tested for room [ROOM NUMBER], it did not send a signal of activation to the nurse's station on unit 3. The call bell annunciator was showing an ERROR CONNECTIVITY signal at the desk. An observation at 10:22 AM revealed, when the call bell was tested for room [ROOM NUMBER], it did not send signal of activation to the nurse's station on unit 3. Upon further investigation, The SRDOM push the cord on the annunciator in and stated that the cord was not all the way in. An observation at 11:01 AM revealed, when the call bell was tested for room [ROOM NUMBER], it did not send signal of activation to the nurse's station on unit 2. Upon further investigation, the RDOM noticed that the annunciator at the nurse's station was unplugged and not powered on. The RDOM proceeded to plug the annunciator in and power it on. The facility's Administrator was informed of the deficient practices at the Life Safety Code exit conference on 01/10/25 at 12:30 PM. N.J.A.C 8:39-31.2 (e)