STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40042 Complaint # NJ 169012 Based on observation, interviews, review of medical records (MR) and other pertinent facility documentation, it was determined that the facility failed to report an injury of unknown origin which resulted in serious bodily injury to the New Jersey Department of Health (NJ DOH) within 2 hours for 1 of 3 sampled residents, (Resident #20). This deficient practice was evidenced by the following: On 3/04/24 at 11:49 AM, the surveyor observed the resident in their room sitting in chair. The resident was wearing a short sleeve shirt, long sweatpants and skid proof socks. Resident #20 was pleasant and offered no concerns. Review of the residents Admission Record (an admission summary) reflected that the resident had diagnoses which included but were not limited to; bipolar disorder, peripheral vascular disease (PVD), recurrent depressive disorder, anxiety disorder and laceration to the left lower leg. Review of the residents Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/29/23 indicated the resident had a Brief Interview for Mental Status (BIMS) of 8 which indicated the resident had a moderately impaired cognition. Review of the resident's care plan (CP) initiated on 2/15/23 and revised on 11/8/23, included: Actual skin breakdown related to cellulitis, PVD, vascular/circulation condition, loose dresser drawer handles. The CP also included left lower extremity laceration. Review of the residents Progress Notes included the following: On 11/5/23 at 9:00 PM, Resident observed ambulating down hall bleeding profusely from left lower leg, large laceration noted on outer calf approximately 15 x 10 CM [centimeters]. Blood loss approximately 1 pint. Pressure dressing applied, 911 called. Ambulance arrived at 8:15 PM, taken to [name redacted] hospital. On 11/5/23 at 10:27 PM, Resident found ambulating in the hallway toward the nurse's station with large laceration to left lower leg. Noted to be bleeding excessively . direct pressure applied to laceration . 911 called and direct pressure maintained on wound. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2024
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/23 at 12:25 AM, Writer spoke to ER [emergency room] nurse . who stated that the resident was treated for a laceration to the left leg and received 20 stitches in the ER. Review of a wound care report dated 11/8/23, included the resident was treated for a left lower leg - trauma wound which was 12 cm long, 9 cm wide and 0.2 cm deep. Further review of additional wound care reports indicated that the resident received treatment to the left lower leg through 3/8/24. On 3/6/24 at 10:24 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a completed wound investigation for Resident #20 who sustained an unwitnessed injury, dated 11/5/23 at 8:14 PM. On 3/7/24 at 9:27 AM, the Director of Nursing (DON) provided the surveyor with a Reportable Event Record / Report which was sent to the NJDOH dated 11/9/23. It reflected the incident was called in to the NJDOH on 11/6/23 at 7:00 PM by the DON. On 3/11/24 at 11:23 AM, the surveyor interviewed the Infection Preventionist (IP) who was Resident #20's Registered Nurse/Unit Manager until 2/18/24. She stated that approximately two to three months ago the resident had an incident which resulted in a laceration to the left lower leg. She stated that the resident came out of the room and had already sustained the wound and was bleeding heavily. She stated she was not on duty at that time, but staff reported that they applied pressure with a dressing, but the bleeding was too heavy, and he/she was sent to the hospital where the resident required stitches. She stated that the laceration was significant and acknowledged that it required more care than the facility could provide. The IP stated that the resident was a poor historian and was unable to report what happened. She also acknowledged that the incident was unwitnessed by any staff members. She further stated that the resident continued to be evaluated and treated by the wound care company and that the wound was almost healed. On 3/11/24 at 2:08 PM, the surveyor interviewed the DON about the incident and the reporting process to the NJDOH. She acknowledged that the resident sustained a laceration to the left lower leg, was bleeding badly and had to be sent to the hospital. She also acknowledged that the resident required 20 sutures. The DON stated that she reported the incident to the NJDOH and the Ombudsman's office since it was a serious injury which required medical care unable to be provide at the facility. In addition, she stated that she reported the incident in less than 24 hours and was not familiar with requirements for other reporting time frames. On 3/13/24 at 11:38 AM, the surveyor interviewed the DON and LNHA in the presence of the survey team. The DON stated after she spoke with the surveyor the other day I could have reported it a lot sooner, and that my focus was related to patient care and staff interviews making sure when I did report it, it was accurate. She further stated, I should have reported it as soon as I was notified. She stated that at that time she was not looking at the incident as a major injury in terms of reporting times. The DON stated that she should have reported the incident in a more timely manner. The LNHA stated it should have been reported within 2 hours. Review of the facility policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 9/2022, included the following: (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. - The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. the state licensing/certification agency responsible for surveying/licensing the facility . - Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury . - NJAC 8:39-13.4(2)(v)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49173 Complaint NJ# 164959 Based on observation, interviews, record review and review of pertinent facility documentation, it was determined that the facility failed to (a) document the measurement of a pressure ulcer (an injury to the skin and underlying tissue resulting from prolonged pressure on the skin), and (b) obtain a physician's order for wound care for a resident admitted with a community-acquired pressure ulcer in accordance with professional standards of practice. This deficient practice was identified for 1 of 3 resident's (Resident #70) reviewed for pressure ulcers. This deficient practice was evidenced by the following: On 3/4/24 at 11:33 AM, the surveyor observed Resident #70 lying in bed. The resident was awake and alert and stated that he/she had a pressure ulcer on their feet, but it did not occur at the facility. A review of the resident's medical record revealed the following: The Admission Record (an admission summary) indicated that Resident #70 was admitted to the facility with diagnoses including, but not limited to, venous insufficiency (improper functioning of the vein), an unstageable pressure ulcer on the right heel (full-thickness pressure injury in which the base is not visible due to slough or eschar tissue), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of the form titled Resident Evaluation dated 1/18/24, section H identified that Resident #70 had a stage 3 (full thickness tissue loss) pressure ulcer to the sacrum and right buttock. However, there were no measurements documented on the resident evaluation form for the sacrum or right buttock. Review of the comprehensive admission Minimum Data Set (MDS), a tool to facilitate the management of care, included a Brief Interview for Mental Status (BIMS) score of 15 which indicated an intact cognition. It also reflected that the resident was admitted to the facility with one or more unhealed pressure ulcers/injuries. Interventions coded as being in place included pressure-reducing devices for chair and bed, as well as pressure ulcer/injury care. Review of the care plan initiated on 1/19/24, included a focus of actual skin breakdown, with a goal to show signs of healing. Interventions included but were not limited to Administering treatment per physician orders. Review of the January 2024 Order Summary Report revealed a physician's order (PO) dated 1/25/24, for Phytoplex Z-Guard External Paste 57-17% to be applied topically every shift for wound care to the sacrum and bilateral buttocks. There was no PO for wound treatment prior to 1/25/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January 2024 Treatment Administration Record (TAR) reflected that the order for Phytoplex Z-Guard External Paste 57-17% was being administered effective January 25, 2024, on the night shift, as documented by licensed nursing staff. On 3/12/24 at 8:52 AM, the surveyor interviewed the wound care Licensed Practical Nurse (LPN) regarding the protocol when wounds are identified on admission. The nurse stated that on admission, a full-body assessment should be completed, wounds should be measured and documented as the baseline assessment. She further stated that hospital records should be reviewed for wound treatment, the doctor should be notified to obtain PO's, and the treatment should occur immediately. The wound then should be assessed and measured weekly to ensure appropriate treatment and healing. The wound care LPN reviewed the initial skin assessment dated [DATE], in the presence of the surveyor and acknowledged that the resident was admitted with wounds from the hospital. She stated that interventions should have been implemented immediately and acknowledged that wound care treatment did not occur until January 25, 2024. On 3/12/24 at 12:07 PM, the surveyor interviewed the LPN/Unit Manager (UM) regarding the protocol when wounds are identified on admission. The LPN/UM stated that wounds should be assessed and measured upon admission, the nurse in charge should notify the physician for treatment orders, and the treatment should occur immediately. On 3/12/24 at 12:17 PM, the surveyor interviewed the Director of Nursing (DON) regarding the protocol when wounds are identified on admission. The DON stated the following should be completed and documented: a skin assessment, wounds measured, and treatments initiated. She further stated that admissions were reviewed during clinical meetings, and the nurse/unit manager was responsible to ensure that the treatment was initiated. Review of the facility policy Admission Assessment and Follow-Up: Role of the Nurse dated 4/25/22, Under the section titled Steps in the Procedure, 11. Conduct a physical assessment including, the following systems . j. the skin. 15. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information, obtaining admission orders based on these findings. Review of the facility policy Pressure Ulcer/Skin Breakdown-Clinical Protocol dated 4/2018, included that in addition, the nurse shall describe and document/report the full assessment of pressure sores, including location, stage, length, width, depth, and presence of exudates or necrotic tissue. N.J.A.C 8:39-27.1 (a)(e)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49173 Based on observation, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to obtain, record and monitor weights on admission, readmission and weekly in accordance with professional standards of practice. This deficient practice was identified for 1 of 6 residents (Resident #82) reviewed for nutrition. The deficient practice was evidenced as follows: On 03/11/24 at 12:30 PM, the surveyor observed Resident #82 in bed, awake, and alert. The resident was observed independently feeding themselves and had eaten 75% of lunch. A review of the electronic medical record (EMR) revealed that the resident was admitted to the facility on [DATE], discharged on [DATE], and readmitted back to the facility on [DATE]. A review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but not limited to; dysphagia (difficulty or discomfort in swallowing), depression (a mood disorder that causes persistent feelings of sadness and a loss of interest), and gastro-esophageal reflux disease (GERD) - a digestive disease in which stomach acid or bile irritates the lining of the stomach. A review of the comprehensive admission Minimum Data Set (MDS), a tool which facilitates the management of care, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which reflected a severely impaired cognition. A review of the Care Plan initiated on 2/12/24 revealed a focus for nutritional status as evidenced by therapeutic diet and interventions included, but were not limited to, weights as ordered. A review of the Physician's Order's (PO) for January 2024 and February 2024 did not reflect a PO to obtain weights. A review of a Nutrition Evaluation dated 2/12/24, included a weight of 135 pounds (lbs.) which was based on a previous hospital weight. It further included that the Registered Dietitian (RD) was unable to determine the resident's estimated nutritional needs since a current weight was not available. A review of the Resident Evaluation's dated 1/30/24 and 2/7/24, which is completed by nursing on admission did not include documentation of the resident's Most Recent Weight (the section was blank). A review of the resident's weights recorded in the EMR revealed the following: -03/05/2024 16:40 130.2 lbs. (sitting) -03/06/2024 21:05 132.1 lbs. (sitting) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/06/24 at 09:17 AM, the surveyor interviewed the Licensed Practical Nurse (LPN)/Unit Manager (UM) regarding the facility's protocol for obtaining weights on new admissions and re-admissions. The LPN/UM stated that weights should be obtained on admission, re-admission, and then weekly for four weeks, and monthly thereafter. She stated that a new admission/re-admission weight should be obtained on the same day of admission/re-admission, and if the weight was not obtained, another attempt should be made on the next day. She stated that it was her and the RD's responsibility to ensure that the weights are obtained. She stated that if someone refused to be weighed, it should be documented in the assessment or on a separate note. On 03/06/24 at 12:23 PM, the surveyor interviewed the RD regarding the facility's protocol of obtaining weights and assessing the resident's nutritional status if a weight was not available. The RD stated that weights should be obtained on admission and re-admission. She further stated that the UM was responsible for ensuring that weights were obtained on admission or re-admission. She stated that if a weight was not obtained, she made a list of missing weights and emailed the list to the UM and cc'd (carbon copy) the administrator and Director of Nursing (DON). She stated that the Certified Nursing Assistant (CNA) was responsible for obtaining the resident's weight. In the event that a weight was not recorded, she would remind the CNA to obtain a weight. In addition, she stated if a weight was not available, she would contact the family for a weight history and if need be, she used the hospital weight to assess the resident's nutritional status. During this same interview, the surveyor inquired what delayed the staff from obtaining a weight on admission, re-admission and weekly for Resident #82. The RD stated that the resident was discharged to the hospital on 2/2/24 and readmitted back to the facility on [DATE]. She stated that the resident refused to be weighed because he/she was not feeling well. The surveyor also inquired if a resident refused to be weighed, should it be documented? The RD stated, it should be and it (the refusal) would be care planned. The surveyor inquired why weekly weights were not obtained and documented, and she stated, they didn't do it. On 03/07/24 at 02:02 PM, the surveyor interviewed the DON regarding the protocol for obtaining weights. The DON stated that the practice was that weights were obtained on admission, re-admission, and weekly for four weeks. She stated that her expectation was that a weight should be obtained within 48 hours of admission or re-admission. She also stated that it was a team effort to obtain a weight. She acknowledged that if a resident refused to be weighed, it should be documented, and care planned. A review of the facility policy Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol dated 9/2017, reflected under the section Assessment and Recognition 1. the nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time. N.J.A.C 8:39-27.1(a);27.2(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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49173 Based on observation, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to (a) obtain a physician order to maintain peripheral intravenous (IV) access and, (b) discontinue peripheral IV access after completion of an IV antibiotic in accordance with professional standards of practice. This deficient practice was identified for 1 of 1 resident (Resident #70) reviewed for antibiotic use. The deficient practice was evidenced by the following: On 03/04/24 at 11:26 AM, Resident #70 was observed lying in bed with a heparin lock (IV peripheral line) in the left antecubital space (region of the arm in front of the elbow). A transparent dressing was covering the peripheral site. On 03/05/24 at 10:28 AM, Resident #70 was observed in bed awake and alert, after having received morning care from the certified nursing assistant (CNA). The surveyor observed a heparin lock in the left arm (antecubital space) with a transparent dressing covering the peripheral site. A review of the admission record (an admission summary) revealed that Resident #70 was admitted to the facility with the following diagnoses, which included but not limited to: sepsis (inflammation throughout the body), cellulitis of the right lower limb (bacterial skin infection), urinary tract infection (infection of any part of the urinary tract), and pneumonia (infection that inflames air sacs in one or both lungs). A review of the comprehensive Minimum Data Set (MDS), a tool used to facilitate the management of care, revealed that the Brief Interview for Mental Status (BIMS) score was 15 which indicated an intact cognition. It also reflected that resident was on IV medications while at the facility. A review of the February 2024 Order Summary Report (summary of physician orders [PO]) revealed a PO dated 2/14/24 for the following: Invanz solution reconstituted 1gm/100ml (Ertapenem Sodium) to be used at 100 ml/hr intravenously once a day for infection for 5 days, and a PO dated 2/18/24 for Ceftazidime Intravenous Solution Reconstituted 1GM (Ceftazidime) to be used at 1 gram intravenously every 12 hours for UTI for days. Further review of the Order Summary Report did not reflect a PO to flush (maintain patency) the heparin lock. A review of the February 2024 Medication Administration Record (MAR) revealed that Resident #70 had received IV Invanz from 2/15/24 to 2/18/24 for an infection and IV Ceftazidime from 2/18/24 to 2/23/24 for a urinary tract infection . A review of the Care Plan initiated on 2/8/24, reflected a focus for the potential for complications at the IV insertion site and a goal that the IV site would be free of signs and symptoms of infiltration (IV fluid leakage to surrounding tissue), and interventions which included but were not limited to flushing IV lines per physician orders. A review of the Progress Notes revealed the following: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/25/2024 14:56 Nursing/Clinical Note Text: Patient alert and oriented with times of confusion. No s/s [signs and symptoms] of distress or SOB [shortness of breathe] noted. Breathing is easy and unlabor. Afebrile. Peripheral line intact and easy to flush. Due medications given and tolerated well. Call bell within reach. 2/26/2024 14:18 Nursing/Clinical Note Text: Patient alert and oriented, able to make needs know. am care and OOB [out of bed] provided by staff with maximal assistance. Unlabored breathing. Afebrile [no fever]. Due medications give and tolerated well. Patient foley intact and clean. Peripheral line intact and clean with easy to flush. Patient denies pain. Appetite is good. Provided wound care treatment. Call bell within reach. 2/28/2024 15:13 Nursing/Clinical Note Text: Patient alert and oriented, able to make needs know. Am care and OOB provided by staff with partial assistance. Breathing is easy and unlabor. Afebrile. Due medications give and tolerated well. Patient foley intact and clean. Peripheral line intact and clean with easy to flush. Called MD to make aware of patient refusing nebulizer treatment during this shift, no at this time. Patient denies pain. Call bell within reach. 2/29/2024 15:59 Nursing/Clinical Note Text: Patient received in bed. Patient alert and oriented, able to make needs known. No s/s of distress or SOB noted. Unlabored breathing. Patient continues on oxygen via nc with SPO2 [saturation of oxygen in the blood] of 99%. Afebrile. Encouraged PO [by mouth]fluids. Appetite is good. Peripheral line intact and clean. Due medications given and tolerated well. Denies pain. Call bell within reach. 3/1/2024 14:32 Nursing/Clinical Note Text: Patient received in bed. Patient A&O [awake and oriented], able to make needs known. AM care and OOB provided by staff with max assistance. Breathing is easy and unlabored. Patient continues with oxygen via nc with SPO2 of 91%. Lung sounds noted to be clear. Afebrile. Due medications given and tolerated well. Appetite is good. Patient had a BM [bowel movement] for this shift. Foley intact and clean with an output of 800 with slight redness in the urine. Called MD [NAME] and aware of above. Peripheral line intact and clean with easy to flush. Denies pain. Call bell withing reach. 3/1/2024 21:01 Nursing/Clinical Note Text: Resident refused for left peripheral line to be taken off despite several attempts. This was seven days after the residents last dose of IV antibiotics. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/24 at 10:31 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the resident's IV use. The LPN stated that Resident #70 had a peripheral line and was no longer receiving IV antibiotics. She stated that the peripheral line remained in place because sometimes the resident's blood pressure would run low, and the physician would order IV fluids. The surveyor inquired how long should a peripheral line remain in place, and she stated she was unsure. The surveyor also inquired about the maintenance of the peripheral line, and she stated that the peripheral line was flushed every shift. After surveyor inquiry, the LPN stated she would attempt to remove the peripheral line since the resident's family was present and he/she was calmer during visits. A review of the Progress Note dated 03/05/24 at 11:37 AM, reflected that the peripheral line was removed. On 03/06/24 at 09:17 AM, the surveyor interviewed the LPN/Unit Manager (UM) regarding the protocol for peripheral lines. The LPN/UM stated that Resident #70 had a heparin lock and was unsure how long the peripheral line was in place. She further stated that a heparin lock should not remain at the same site for more than 72 hours and stated that if the heparin lock was not being used, it should be removed immediately. The surveyor inquired as to why Resident #70's peripheral access remained in place after the completion of IV antibiotic treatment. The LPN/UM stated that the resident had behavioral issues. She acknowledged that if the resident refused to allow the nurse to remove the peripheral line, it should have been documented. The LPN/UM reviewed the Order Summary Report for February 2024 and acknowledged that there was no order to flush the peripheral line. On 03/11/24 at 11:55 AM, the surveyor interviewed the Director of Nursing (DON) and the Registered Nurse Infection Preventionist in the presence of Licensed Nursing Home Administrator (LNHA). The surveyor inquired about the protocol for peripheral line use. The DON stated that a peripheral line would be inserted once there was a PO. The peripheral line would then be secured in the vein and the date and time should be noted on the dressing. The DON further stated that after placement, nursing should have documented at least every shift to include assessment of the line and monitor for any signs of infection (i.e., redness and swelling). The DON stated that the peripheral line should be removed after IV antibiotics were completed and per PO. The DON stated that if IV antibiotics were completed on 2/23/24 that the peripheral line should have been removed the same day. In addition, she stated that if a resident refused to allow the nurse to remove the peripheral line the physician should have been notified and this should have been documented. The DON stated that there should have been a PO for flushes to the peripheral line before and after antibiotic administration and every shift intermittently, when antibiotics were not being infused. She also stated that it was important to remove the peripheral line after IV antibiotics were completed to decrease the risk for infection and the IV site. The DON provided the surveyor with a policy with a review date of 1/8/2024, from their pharmacy [name redacted] and stated that the facility adopted this policy. The policy was titled Short Peripheral Venous Catheter Standard of Care, and did not include protocol for peripheral line flushes and discontinuation. N.J.A.C 8:39-25.2(c)5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37791 Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to follow a Physician Orders (PO) for the administration of blood pressure medication for 1 of 1 residents (Resident #25) reviewed for blood pressure medication management. 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 03/04/24 at 10:00 AM, the surveyor observed Resident #25 in the room. The resident was in bed watching television. The resident was alert but unable to answer surveyor's questions. The surveyor reviewed Resident #25's medical records. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to limbs) and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). A review of the Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for daily decision-making score was 3 out of 15, which indicated that the resident's cognition was severely impaired. A review of the Order Summary Report (OSR) revealed a PO dated 2/10/24, for Midodrine 5 mg (milligrams), give 1 tablet by mouth three times a day for hypotension. Do not administer after the evening meal or 4 hours from bedtime to avoid supine hypertension. Hold for SBP (systolic blood pressure-top number of blood pressure) greater than 100. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the February 2024 electronic Medication Administration Record (eMAR) revealed a PO dated 2/10/24, for Midodrine 5 mg tablet, give 1 tablet by mouth three times a day. Do not administer after the evening meal or 4 hours from bedtime to avoid supine hypertension. Hold for SBP greater than 100. Further review of eMAR revealed that the Midodrine was signed as administered (2) two times when the resident's SBP was above 100 on the following dates: 2/15/24 at 9 AM (B/P: 144/87) and 2/19/24 at 9 AM (B/P: 143/78). A review of the March 2024 eMAR revealed a PO dated 2/10/24, for Midodrine 5 mg tablet, give 1 tablet by mouth three times a day. Do not administer after the evening meal or 4 hours from bedtime to avoid supine hypertension. Hold for SBP greater than 100. The eMAR revealed that the Midodrine was signed as administered (2) two times when the resident's SBP was above 100 on the following dates: 3/1/24 at 9 AM (B/P:110/67) and 3/2/24 at 1 PM (B/P:140/74). On 3/06/24 at 11:45 AM, the Licensed Practical Nurse (LPN) reviewed Resident #25's PO for Midodrine in the presence of the surveyor. The LPN stated that according to the PO that Midodrine should be held when the SBP was above 100. The LPN reviewed Resident #25's February and March 2024 eMARs in the presence of the surveyor. The LPN acknowledged that on (4) four occasions, Resident #25 was administered Midodrine when the resident's SBP was above 100. She stated that on those occasions that Midodrine should have been held. On 3/12/24 at 2:00 PM, the surveyor presented the above concerns to the Licensed Nursing Home Administrator and the Director of Nursing (DON). There was no additional information provided. A review of the facility's policy for Administering Medications dated 5/21/19, which was provided by the DON included the following: 4. Medications are administered in accordance with prescriber orders, including any required time frame. 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary. NJAC 8:39-11.2 (b), 29.2 (d)

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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 - Few	Provide and implement an infection prevention and control program.

41858

Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to ensure staff wear the appropriate personal protective equipment (PPE) to prevent the potential spread of COVID-19 (a contagious disease caused by the virus SARS-CoV-2) observed on 1 of 2 units observed, (North unit).

This deficient practice was evidenced as follows:

On 03/05/24 at 10:30 AM, the surveyor observed a Certified Nursing Assistant (CNA) exiting Resident #342's room. The CNA was not wearing goggles, or a face shield. She was wearing glasses that did not have protective shields to protect her eyes from exposure to splashes, sprays, splatter, and respiratory secretions. The surveyor observed a STOP: ISOLATION DROPLET/CONTACT PRECAUTIONS sign on the outside of the resident's door. The sign read Everyone Must: including visitors, doctors, and staff; Clean hands: when entering and exiting, gown, N 95 Respirator (a mask that filters out particulates) Eye Protection (face shield or goggles), gloves. A PPE bin was hanging outside of the door which contained the following items: gown, surgical masks and N 95 masks. The surveyor interviewed the CNA, who stated that the resident was on isolation for COVID-19. The surveyor reviewed the sign with the CNA. The surveyor inquired why she wasn't wearing eye protection, she stated, I thought my glasses were enough.

A review of Resident #342's Admission Record revealed the resident had diagnoses that included but were not limited to: Heart Failure and COVID-19.

A review of Resident #342's Order Summary Report revealed a physician's order for Droplet precautions for COVID-19 every shift for covid + dated 2/25/24.

On 03/11/24 at 11:55 AM, the surveyor interviewed the Director of Nursing (DON) and the Infection Preventionist Nurse (IPN) in the presence of the Licensed Nursing Home Administrator (LNHA). The IPN stated that droplet precautions required an N 95 mask, goggles, gloves, and gown worn upon entry to the room. She stated that the expectation was that staff follow the signage posted on the resident's door. The IPN confirmed that eyeglasses were not adequate eye protection to protect the eyes because particles could get around the glasses. The IPN confirmed that the CNA observed exiting Resident #342's room was wearing regular eyeglasses. The IPN stated that the purpose of wearing the appropriate PPE was to protect residents and staff from infection.

On 03/12/24 at 1:44 PM, during a meeting with the survey team, the LNHA and the DON were made aware of the above findings.

A review of the facility's Personal Protective Equipment (PPE) Competency Validation revealed the CNA received a check under the column marked Competent, YES, for Donning (putting on) PPE 7. Don Goggles or Face Shield: Place over face and eyes; adjust fit and Standard Precautions & Transmission Based Precautions 23. Staff correctly identifies the appropriate PPE for the following scenarios: d. Droplet Precautions on 11/15/23.

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NAME OF PROVIDER OR SUPPLIER Careone at Holmdel		STREET ADDRESS, CITY, STATE, ZIP CODE 188 Highway 34 Holmdel, NJ 07733	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Employee Education Attendance Record revealed that the CNA received an in-service for Content-COVID, Infection Control, PPE, dated 1/5/24. A review of the facility's policy, Isolation-Categories of Transmission-Based Precautions with a review date of 01/08/2024, revealed Droplet Precautions; 1. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 microns in size] that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures suctioning).; 4. Gloves, gown and goggles are worn if there is a risk of spraying respiratory secretions. NJAC 8:39-19.4(a)(1-2)(c)

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 41858 Based on facility staff interviews and review of pertinent facility documentation, it was determined that the facility failed to provide a designated qualified Infection Prevention and Control Nurse from 12/1/23 until 2/18/24. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020, revealed the following: ii. Required Core Practices for Infection Prevention and Control: Facilities are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; or b. A Physician who has completed an infectious disease fell owship; or c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of Infection Control experience. iv. Facilities with 100 or more beds or on-site hemodialysis services must: 1. Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than August 10, 2021. On 03/04/24 at 10:22 AM, during entrance conference with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the DON stated the facility had a designated full time Infection Preventionist Nurse (IPN #1). A review of IPN #1's Center for Disease Control and Prevention (CDC) certificate revealed that IPN#1 completed the Nursing Home Infection Preventionist Training Course on 02/19/2024. On 03/05/24 at 10:56 AM, during an interview with IPN #1, she stated that she had been in the Infection Preventionist (IP) position for 2 weeks. She stated prior to that she was the Registered Nurse/Unit Manager for the South Side unit. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/24 at 09:54 AM, the LNHA provided the surveyor with a timeline for the IPN. A review of the timeline revealed the following: IPN#2 left the position on November 30, 2023 and IPN#1 assumed the role on February 18,2024. At that time, the surveyor interviewed the LNHA, who stated that the DON was performing the IPN duties while IPN#1 transitioned (between IPN#2 leaving and IPN#1 assuming the position) to the IPN role. The LNHA confirmed that the DON was performing both the duties of the DON and the duties of the IPN. She then acknowledged that the IPN should be a designated fulltime position. On 03/07/24 at 10:20 AM, during an interview with the surveyor, the LNHA confirmed that the DON did not have an Infection Control certification. She stated that IPN #2 was a consultant during the transition but was not working in the building. She then stated that the facility consulted with an Infectious Disease doctor as needed. The LNHA again confirmed that there was not a designated full time IPN in the building after 11/30/23 and until 02/18/24. On 03/11/24 at 11:55 AM, the surveyor interviewed the DON and IPN#1, in the presence of the LNHA. The DON confirmed she was performing both DON and IPN duties after IPN#2 left the position on 11/30/23. The DON confirmed she was not certified in IP. She stated she was overseeing the COVID-19 (an infectious disease caused by the SARS-CoV-2 virus) Outbreak when it started on 01/02/24. A review of the facility's policy, Infection Prevention and Control Program reviewed on 1/8/24, revealed: Policy Interpretation and Implementation; 5. Coordination and Oversight: a. The infection prevention control program is coordinated and overseen by an infection prevention specialist (infection preventionist.) A review of the facility's policy, Surveillance for Infections reviewed on 1/8/24, revealed: Policy Statement: The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. 6. If a communicable disease outbreak is suspected, this information will be communicated to the Charge Nurse and Infection Preventionist immediately. 9. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the Infection Preventionist will collect data to help determine the effectiveness of such measures. A review of the facility's job description for the Infection Preventionist revealed: The primary purpose of this position is to plan, organize, develop, coordinate and direct the facility infection prevention and control program and its activities in accordance with current federal, state, and local standards, guidelines and regulations that given such programs and as directed by the Administrator and the Infection Prevention and Control Committee. NJAC 8:39-19.1 (b), 19.4(d) (e)

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40042 Based on observations, interviews, and pertinent facilty documents it was determined that the facility failed to maintain the designated emergency supply of water needed for residents in the event of a loss of normal water supply. This deficient practice was evidenced by the following: On 3/04/24 at 10:22 AM, the surveyor conducted an entrance conference with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The facility was licensed for 120 beds and the facility census was 86 (the number of residents who currently resided at the facility). On 3/04/24 at 9:30 AM, the surveyor conducted a kitchen tour with the Food Service Director (FSD), in the presence of a second surveyor. The FSD showed the emergency water supply located in the salon separate from the kitchen. The FSD counted the cases in the surveyors' presence and stated there were 22 cases, each had six one-gallon bottles (132 gallons). He further stated that it was enough emergency water for three days and that the requirement was one gallon per person per day for three days (258 gallons). On 3/07/24 at 9:00 AM, the surveyor observed the emergency food supply which was in a closet in the staff break room with the FSD and a second surveyor. At that time, the surveyors did not observe cases of water in the closet or the break room. On 3/11/24 at 2:32 PM, the surveyor interviewed the LNHA in the presence of a second surveyor. At that time, she acknowledged that 22 cases of water were not enough. On 3/12/24 at 11:36 AM, the LNHA informed the surveyor that there were additional cases of water in the staff breakroom. On 3/12/24 at 11:46 AM, the surveyor observed the water in the staff breakroom with the FSD and the LNHA. The FSD stated there was 10 cases of water, and there were 6 gallons of water per case which totaled 60 gallons. On 3/12/24 at 1:12 PM, the FSD informed the surveyor that he miscounted the number of cases of water that was stored in the salon during the initial tour. On 3/13/24 at 10:06 AM, the surveyor interviewed the FSD in the presence of a second surveyor. He stated that on the initial tour he miscounted the number of cases of emergency water in stock. He stated initially he counted 22 cases but rather it was approximately 36 cases (216 gallons). The FSD stated that water was ordered the second day of survey which now equaled 82 cases. This included the emergency water now stored in the staff breakroom. He acknowledged that the water in the staff breakroom was not there on the initial tour and that the additional water was ordered by the Director of Maintenance (DM). (continued on next page)

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/13/24 at 10:47 AM, the surveyor interviewed the DM in the presence of the survey team. He stated that he had not ordered emergency water and that it was the FSD's responsibility. He did state that the local water company dropped off water to the facility on [DATE] or 3/8/24 due to a possible local water interruption, which did not occur. He stated he did not have any documentation as to the amount of water that the water company had provided but estimated the amount to have been probably a few hundred gallons. Review of the facility's undated Emergency Supply Quantity Converter, included a three-day supply of water for the facility to include census and staff should be 70 cases, each of which had six - one-gallon bottles per case. Review of the facility' undated policy Disaster Feeding Plan, included If uncontaminated water . not available . the Food Service Department will use its three to seven day .fluid supply. Review of the facility policy Dietary Considerations for Residents dated 1/2011, included that the facility has planned for the dietary needs of the residents in the case of an emergency situation. It included emergency water which should be located in a specific location and the amount based on the number of residents, employees and visitors during a crisis or disaster situation to last for seven day's. It also included to take into consideration minimal resource availability. The facility provided a contract with a food service vendor dated 1/2/23, which included With proper notification, [name redacted] will maintain an inventory of bottled water in a variety of pack sizes to sufficiently address this potential emergency need. It also included We will do our best to meet your needs on a timely basis. In addition, the contract included that the facility should maintain an estimated need of 64 ounces of water per day for each resident, employee and/or visitors. A three-day supply is recommended should such a need arise. It also included, Depending on the severity of the storm and impacts to our fleet, buildings and potentially employees, we will do our best to recover as quickly as possible following any weather event. NJAC 8:39-31.6 (n)