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	07/31/2025

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

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy, the facility failed to promote the dignity of one (Resident (R) 63) of 13 residents reviewed with indwelling catheters from a sample of 24 residents when R63 was observed with urinary drainage bag without a privacy covering. This had the potential for the residents to have a diminished quality of life. Findings include: Review of the facility policy titled Dignity with a review date of February 2021 revealed. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example, helping the resident to keep urinary catheter bags covered. Review of R63's admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included acute cystitis without hematuria and chronic kidney disease. Review of R63's Physician Orders for the month of July 2025 located in the resident's EMR tab titled Orders revealed the resident had an indwelling catheter. During an observation on 07/27/25 at 12:26 PM revealed R63 sitting in his wheelchair in the doorway of his room. The resident was wearing short pants which revealed a leg urinary drainage bag positioned on his upper right thigh. The collection bag had yellow urine. The drainage bag did not have a privacy covering. At 2:20 PM R63 was observed in the day room with several other residents watching television. The resident was wearing short pants with leg urinary drainage bag exposed to view without a privacy covering. During an observation on 07/28/25 at 1:15 PM, revealed R63 returning from the dining room with other residents and staff. The resident was again wearing short pants with the leg urinary drainage bag exposed to view without a privacy covering. During an observation on 07/29/25 at 10:10 AM revealed R63 being pushed in a wheelchair down the hallway in front of other residents, visitors, and staff members. The resident was wearing short pants with his leg urinary drainage bag fastened to his upper right thigh, the drainage bag contained a moderate amount of yellow urine. The drainage bag did not have a privacy covering and was exposed to the view of the public. During an interview on 07/30/25 at 9:30 AM with Certified Nursing Assistant (CNA) 2 revealed that the resident wore the leg drainage bag during the day while he is in the wheelchair; and at night the resident's catheter is connected to larger drainage bag that has a privacy covering, however confirmed the leg drainage bad did not have a covering. CNA2 stated that he did not know if the leg drainage bag had privacy coverings. During an interview on 07/31/25 at 10:30 AM with the North Manager (MGRN) it revealed she was aware the resident wore a urinary drainage bag on his thigh. However, she was unaware of the leg drainage bags came with privacy coverings. The MGRN admitted it could be a concern for the resident's dignity to be observed in public with a urinary drainage bag. NJAC 8:39-4.1(a)12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure the monitoring of target behaviors for the use of Seroquel (an antipsychotic medication) for one of five sampled residents (Resident (R) 28) reviewed for unnecessary medications out of a total sample of 24. This had the potential for the resident to be administered unnecessary or the incorrect does medication due to not knowing if the medication was effective.Findings include:Review of the facility's policy titled, Psychopharmacologic Medication revised 09/06/18 revealed, MONITORING: Monitor residents for targeted behaviors and medication side effects, who are receiving the following classes: Antipsychotic, Anxiolytic (or Antianxiety), Sedative/Hypnotic & Specific Mood stabilizers and Anticonvulsants (also called Other Psychopharmacologic Agents.)Review of R28's undated Resident Face Sheet, found in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE] with a diagnosis including dementia.Review of R28's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/09/25 and located in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of four out of 15, which indicated R28 was severely cognitively impaired. The assessment indicated that the resident was not exhibiting any behavioral symptoms during the assessment period, however, was taking an antipsychotic medication.Review of R28's Physician Order Report, dated 07/09/25 and found in the EMR under the Orders tab, indicated R28 was to receive Seroquel 0.25 milligrams (mg), one tablet by mouth daily for psychosis.Review of R28's Medication Administration Record (MAR), dated July 2025 and found in the EMR under the Orders tab, revealed no documented evidence to show which specific behaviors were associated with the administration of the resident's antipsychotic medication and routine monitoring.Review of the Consultant Pharmacist Medication Regime Review provided by the facility, dated 07/18/25, revealed to update the target behavior for Seroquel.During an interview on 07/31/25 at 9:12 AM Licensed Practical Nurse (LPN) 3 said side effects of antipsychotic medications were located on the MAR, but she was unsure what specific behaviors they should be tracking for the antipsychotic medications such as Seroquel. She said she was unsure what the target behaviors were for the dementia or psychosis related to the Seroquel and agreed they would be unsure if the medication was effective of not.During an interview on 07/31/25 at 3:03 PM the Director of Nursing (DON) stated the side effect monitoring and behavior monitoring was on the MAR and that nursing staff should monitor for each shift. She stated the pharmacy review that was completed 07/18/25 requested that target behaviors be updated for R28 related to the Seroquel. But she stated it was not completed until today (07/31/25). She stated nursing staff should be monitoring target behaviors related to antipsychotic use each shift. NJAC 8:39-27.1(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure one of 24 sample residents (Resident (R) 3) had an accurate Minimum Data Set (MDS) reviewed for accuracy of assessments. Failure to code the MDS correctly could potentially lead to inaccurate assessment and care planning of the residents. Findings include: Review of the RAI Manual dated 10/01/19 indicated, .information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. Review of R3's admission Record located in the resident's electronic medical records (EMR) tab titled Profile revealed the resident was admitted to the facility on [DATE] with a diagnosis that included end stage renal disease with dialysis. Review of R3's Physicians Orders for the month of July 2025 located in the resident's EMR tab titled Orders revealed the resident received hemodialysis on Tuesdays, Thursdays, and Saturdays. Review of R3's admission MDS with an Assessment Reference Date (ARD) of 03/18/25 located in the resident's EMR tab titled MDS revealed the facility failed to document the resident was receiving hemodialysis. During an interview on 07/31/25 at 1:05 PM, MDS Coordinator (MDSC) 1 and MDSC2 confirmed that R3's MDS was not accurate as it did not indicate the resident was receiving dialysis. NJAC 8:39-33.2(d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to develop a care plan with interventions for one of one resident (Resident (R) 9) with a diagnosis of post-traumatic stress disorder (PTSD) from a sample of 24 residents. This failure has the potential for R9 not to receive adequate services for their diagnosis.Findings include: Review of the facility's policy titled, Care Plans, Comprehensive Person Center with a revision date of March 2021, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.A comprehensive person center care plan is informed by a resident's physical and psychosocial needs including those related to . past traumatic events.When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Review of R9's admission Record located in the electronic medical records (EMR) tab titled Profile revealed the resident was admitted to the facility on [DATE] with a diagnosis of PTSD. Review of R9's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/03/25 located in the EMR tab titled MDS revealed the resident had an active diagnosis for PTSD. Review of R9's Psychotherapy Progress Notes, dated 07/14/25, located in the EMR tab titled Miscellaneous, revealed the resident was receiving therapy for diagnosis that included PTSD. The evaluation documented the resident's symptoms including fatigue, insomnia, and psychomotor retardation. Review of R9's Care Plan with a revision date of 07/16/25, located in the EMR tab titled Care Plan revealed the facility did not identify the resident's diagnosis of PTSD with triggers. During an interview on 07/30/25 at 9:00 AM with R9 revealed the resident was a veteran served in the Vietnam for two tours. The resident stated he was diagnosed with PTSD after serving. The resident stated that he had received treatment at different facilities; and symptoms came and went. R9 stated that he had symptoms as recently as this week. The resident stated the triggers usually consist of flashbacks to the war, night terrors in which he will wake up screaming, or he will have difficulty sleeping. During an interview on 07/30/25 at 9:30 AM with Registered Nurse (RN) 1 revealed she was unaware R9 had a diagnosis of PTSD. The nurse reviewed the resident's EMR and confirmed the PTSD diagnosis and that the resident was being seen by a psychiatrist. The RN stated that given the diagnosis and the resident still had triggers, a care plan for PTSD should have been developed. During an interview with the Administrative Unit Manager (AUM) on 07/30/25 at 9:45AM, it was revealed she was unaware of the resident's PSTD diagnoses and stated they usually care plan residents with mental health issues but was not sure about developing a care plan for PTSD; however, he/she would investigate the matter. During an interview on 07/30/25 at 11:00 AM, the Director of Nursing (DON) stated a PTSD care plan should have been developed for R9. In addition to the PTSD interventions the care plan should include the triggers for the resident's PTSD. NJAC 8:39-11.2(e)NJAC 8:39-27.1(a)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents received alternative measures prior to the installation of bedrails and that assessments were completed for the risk of entrapment for two of two residents (Resident (R) 57 and R8) reviewed for side rails out of 24 sampled residents. The lack of alternate side rail measures and proper assessment/consent could lead to potential restraint or side rail entrapment.Findings include:Review of the facility's policy titled, Bed Safety and Bed Rails, dated 2001, revealed that the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.1.Review of R57's admission Record located in the Profile tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE] with diagnoses including lack of coordination, dementia, and cognitive communication deficit. Review of R57's quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 05/21/25, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated the resident was moderately cognitively impaired. Review of R57's Care Plan located under the Care Plan tab of the EMR and dated 11/20/24, revealed The resident was at risk for ADL [activities of daily living] deficit related to physical limitations. Interventions in place were bilateral 1/4 bedrails. Review of R57's Physician Orders, located under the Orders tab in the EMR and dated 07/30/25, revealed no evidence of an order for bedrail use. Review of R57's Resident Evaluation/Bedrail Assist Device, located under the Observations tab in the EMR and dated 11/20/24, revealed no evidence of alternates explored and it indicated that bedrails were not indicated for use. During an interview on 07/30/25 at 1:35 PM Licensed Practical Nurse (LPN) 5 stated all residents sign consent forms for bedrails. She stated all residents are asked if they want bedrails and many of them say, yes. She said all the beds in the facility have bedrails, but the facility only uses partial bedrails. She was unsure what other alternatives could be explored prior to bedrail use, and that all residents who want bedrails get them. She stated they are not exploring alternates prior to using bedrails for residents.During an interview on 07/31/25 at 2:47 PM the Director of Nursing (DON) said on admission staff go over bedrail consents with every resident and have them signed. Staff went over risk and benefits, but a lot of the residents liked to use them. Many of the families wanted to use the bedrails. She stated it was hard for them to look at what alternatives would be beneficial before using bedrails. She stated there was no time to explore alternatives prior to using bedrails since all the beds already had bedrails attached. She said the assessment was completed and she would expect that staff followed the recommendations and residents should not use bedrails if the assessment indicated they should not be using them. 2. Review of R8's EMR under the Clinical Census tab revealed the resident was admitted to the facility on [DATE].Review of R8's Medical Diagnosis tab in the EMR revealed diagnoses that included cerebral infarction (stroke), hemiplegia (paralysis) of the right side, and palliative care (Hospice).Review of R8's significant change MDS located in the EMR under the MDS tab with an ARD of 07/21/25 revealed her Brief Interview for BIMS score of three out of 15 which indicated severe cognitive impairment.Review of R8's admission Evaluation found in the EMR under the Tasks tab completed on 03/04/25 revealed she had expressed a desire to have the bed rails raised while in bed for safety and/or comfort. Medical indications for use of the bed rails included weakness and balance deficit. Security reasons for use included requested to have bed rails, stated it provided a sense of security and a history of rolling out of bed, fear of rolling out of bed, and history of sliding to the floor. Reasons the bed rails would assist the resident included turning from side to (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side, moving up and down in bed, holding self to one side, pulling self from lying to sitting position, improving balance, supporting self, exiting, entering the bed, and transferring more safely. Alternatives to bed rails were discussed with the resident. Consent was obtained from the resident.Review of R8's Care Plan located under the Care Plan tab of the EMR, revealed a focus area At risk for falls due to impaired balance/poor coordination, medication side effects, unsteady gait, impaired cognition, poor safety awareness, attempting to transfer/ambulate without staff assistance, initiated on 03/04/25 with a revision on 06/16/25. Interventions included bed rails placement, and bed rail type 1/4.Review of R8's Informed Consent for Use of Bed Rails, dated 03/04/25 and found in her paper medical record, revealed there was no documentation for the questions; What assessed medical needs would be addressed by the use of bed rails for this resident? What are the possible benefits of bed rail use for this resident and what is the likelihood of these benefits? What are the possible risks of bed rail use for this resident and how will these risks be mitigated? and What alternatives to bed rails have been attempted, but failed to meet this resident's needs, or were not attempted because they were considered to be inappropriate? There was no signature by the facility representative who reviewed this consent.During an observation of R8 on 07/28/25 at 2:00 PM, the resident was in bed laying on her side. She had bilateral one-half bedrails in the raised position. On 07/29/25 at 10:00 AM, she was in bed laying on her side. She had the bilateral one-half bedrails in the raised position.During an interview on 07/31/25 at 3:45 PM, the Director of Nursing (DON) revealed the process for side rails to be used included an initial assessment when admitted , reviewing the informed consent with the resident and/or representative on the potential risks and negative outcomes. She confirmed no alternatives to using the bedrails had been explored. She stated the beds used all had bedrails on them and she was not sure if they could be removed. The DON stated once the initial assessment was completed, the expectation was to use the information to make a decision on the use of the side rails. She agreed R8's cognitive ability was limited to make an informed decision on the use of the side rails. NJAC 8:39-27.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, review of Center for Disease Control (CDC) recommendations and guidelines, the facility failed to ensure staff followed enhanced barrier precautions (EBP) for wearing personal protective equipment (PPE) for residents on EBP for two of 18 residents (Residents (R) 73 and R63) reviewed for EBP of 24 sample residents. This failure has the potential to promote the spread of infections.Findings include:Review of CDC updates as July 12, 2022 located at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, revealed .Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities.EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO [multi-drug resistant organism] colonization status; Infection or colonization with an MDRO.Review of the facility's signage for EBP, provided by the facility and posted outside the residents' room, directed the staff to clean their hands before entering and when leaving the room. Providers and staff must wear gloves and a gown for the following high contact residents care activities dressing, bathing, showering, transferring, changing linen, providing hygiene, changing briefs, or assisting with toileting, device care or use: central lines, urinary catheter, feeding tube, or tracheostomy; wound care any skin opening requiring a dressing. 1. Review R73's admission Record located in the electronic medical record (EMR) tab titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that included methicillin resistant staphylococcus (MRSA) infection of wound and removal of internal fixation device. Review R73's Physician Orders for month of July 2025 located in the resident EMR tab titled Orders, revealed the resident had urinary catheter. Review of R73's Care Plan with an initiation date of 06/19/25 and located in the resident's EMR tab titled Care Plans, identified the resident had an indwelling catheter and was on EBP. During an observation on 07/27/25 at 12:18 PM, R73 was in bed with a urinary drainage bag attached to the side of the resident's bed. There was EBP signage posted outside the resident's room and a cart containing the needed PPE. During an observation on 07/27/25 at 12:53 PM, two Certified Nursing Assistants (CNA) 2 and CNA5 entered the resident's room and donned gloves but no gown. The two CNAs pulled back the sheet covers, repositioned the resident in bed, adjusted the resident's gown, checked the position of the resident's urinary catheter; and prepared the resident for the lunch meal. Interview on 07/27/26 at 2:30 PM with CNA5 revealed she only wore a gown with R73 when providing direct care, it was not necessary to don (put on) a gown when positioning the resident in bed for meals. During an interview on 07/30/25 at 12:22 PM, CNA2 revealed she did not don a gown when positioning R73 in bed for lunch. CNA2 stated the Infection Control Nurse reeducated the staff on 07/28/25 about wearing the appropriate PPE when in a resident's room for enhanced barrier precautions. 2. Review of R63's admission Record located in the resident's EMR tab titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnosis that included acute cystitis and chronic kidney diseases. Review of R63's Physician Orders for the month of July 2025 located in the resident's EMR tab titled Orders, revealed the resident had an indwelling catheter. Review of R63's Care Plan with initiation date of 6/22/25 located in the EMR tab titled Care Plans, identified the resident was on EBP due to the indwelling catheter. During an observation on 7/30/25 at 9:10 AM, EBP signage was posted outside the resident's room and a cabinet containing PPE. CNA6 was observed wearing gloves but not a gown. CNA6 finished assisting R63 to dress and sit in his wheelchair. CNA6 emptied the resident's urinary drainage bag into a measuring container. During an interview on 07/30/25 at 9:10 AM, CNA6 revealed R63 was on EBP and acknowledged that she did not follow the guidelines as listed for EBP. During an interview on 07/31/25 at 11:30 AM, the Infection Preventionist (IP) revealed the staff had recently received re-education on the guidelines for EBP and contact precautions. The observations of R63 and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R73 were described to the IP, and the IP confirmed that the staff were not donning appropriate PPE to provide resident care. NJAC 8:39-19.4