STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315132	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at the Highlands	1350 Inman Avenue Edison, NJ 08820

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. 40823 Complaint # NJ 00174172 Based on interview, medical records (MR) review, and review of pertinent facility documents on 8/8/24 and 8/12/24, it was determined that the facility failed to report an injury of unknown origin to the New Jersey Department of Health (NJDOH) and follow their facility policy on Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating for 2 of 5 sampled residents (Resident #2 and Resident #4) reviewed for investigation and reporting. This deficient practice was evidenced by the following: 1. According to the Admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to unspecified Dementia, Difficulty in Walking, and Muscle Weakness. The Minimum Data Set (MDS), an assessment tool dated 12/5/2023, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) of 0/15 which indicated the resident's cognition was severely impaired. Review of the Care Plan (CP), initiated on 12/13/2023 and revised on 4/2/2024, indicated that Resident #2 had cognitive loss related to Dementia. The CP noted that the Resident had actual skin breakdown related to pressure ulcer to sacral area. The CP further indicated the following, On 3/10/2024: Resident right thumb posterior aspect noted with skin tear .3/23/24 skin tear to Left forearm . Initiated on 12/05/2023 and revised and canceled on 04/02/2024 (which is dated after the discharge of the Resident from the facility). On 1/15/24 at 10:00 a.m., the Incident Report (IR) completed by a Licensed Practical Nurse (LPN #1) revealed that the assigned CNA (unidentified) observed skin tears during morning care to the Resident's right arm and right upper arm. The IR did not indicate that the Resident was able to explain how it happened and that the Resident was confused. LPN #1 documented on the progress note (PN) dated 1/15/2024 at 4:07 p.m., which confirmed the aforementioned incident. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/24 at 12:41 p.m., the IR completed by RN #1 indicated that Resident #2 was observed to have a skin tear on her/his posterior aspect of the right thumb. The IR indicated that the Resident #2 was not able to give a description. On 3/22/24 at 6:10 a.m., the IR completed by LPN #2 indicated that the assigned unidentified CNA reported that during care, Resident #2 was observed to have a skin tear on her/his left arm. The IR indicated that the Resident was unable to give description and she/he was confused. The PN dated 3/22/2024 at 4:27 p.m., documented by LPN #4, revealed that the CNA #1 reported that the resident had border gauze on her/his left forearm. The PN indicated that the Resident had sensitive skin and tape could cause the skin tears. The facility was unable to provide a document to verify that the aforementioned injuries of unknown original was reported to the NJDOH which was not according to the facility policy. During an interview with CNA#1 on 8/8/2024 at 1:30 p.m., she stated that one morning before providing care (unable to recall date and time), she observed Resident #2's arm (unable to recall the exact location) was bandaged up and she reported to the nurse who was not aware of what happened. because the Resident did not have the bandage prior to that day. 2. According to the AR, Resident #4 was admitted to the facility with diagnoses which included but were not limited to Morbid Obesity, Muscle Weakness, and Need for Assistance with Personal Care. The Minimum Data Set (MDS), an assessment tool dated 6/2/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) of 0/15 which indicated the resident's cognition was severely impaired. In addition, her Activities of Daily Living (ADL) revealed that she was dependent for all areas of care. Review of the IR titled Injury of Unknown Cause, dated 4/24/24 at 7:21 a.m., completed by LPN #3, indicated that the unidentified CNA reported that Resident #4 had an opening to the right side of the perineal area. Resident #4 was not able to give description and it was not witnessed. Review of the facility policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 2001, under Policy Statement .All reports of resident abuse (including injuries of unknown origin) .are reported to local, state and federal agencies (as required by current regulations) .Policy Interpretation and Implementation . Reporting Allegations to the Administrator and Authorities .1. If resident .injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. 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; b. The local/state ombudsman .d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials .3. 'immediately' is defined as: a. within two hours of an allegation involving abuse . NJAC 8:39-94.1 (f) NJAC 8:39-27.1 (a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40823 C# NJ00174172 Based on interviews, and record review, as well as review of pertinent facility documents on 8/8/2024 and 8/12/2024, it was determined that the facility failed to ensure that the residents' care plan (CP) was revised for 2 of 5 (Resident #2 and Resident #4) reviewed for CP revision. This deficiency is evidenced by the following: 1. According to the ADMISSION RECORD (AR), Resident #2 was admitted with diagnoses that included but were not limited to: Dementia, Muscle Weakness, Cognitive Communication Deficit, and Difficulty in Walking. The Minimum Date Set (MDS), an assessment tool dated 3/10/2024, indicated that the Resident had a Brief Interview for Mental Status (BIMS) of 0/15 which indicated the Resident's cognition was severely impaired and needed help during Activities of Daily Living (ADL). The CP initiated on 12/05/2023 and revised on 04/02/2024 indicated that Resident #2 had actual skin breakdown, on 1/14/24 at about 1:00 p.m. the Resident sustained skin tear to back of her/his right arm, on 3/10/2024 Resident's had skin tear to her/his right thumb posterior aspect, and on 3/23/24 skin tear to left forearm. The CP initiated on 02/07/2024 and revised on 04/02/2024 revealed that Resident #2 was at risk for alteration in skin integrity related to independent ambulation in room and on the unit, fragile skin, use of anti-coagulant medication. The Surveyors review of the Resident's incident reports (IR) revealed the following: - On 1/14/24 at 1:19 p.m., the IR completed by Registered Nurse (RN #1), revealed that during care, Resident #2 was observed by the assigned unidentified Certified Nursing Assistant (UCNA#1) that Resident #2 had a skin tear on her/his back of left arm. The UCNA reported to the assigned Registered Nurse (RN #1). - On 1/15/2024 at 10:00 a.m., the IR completed by Licensed Practical Nurse (LPN #1), indicated that she was alerted by UCNA #2 that Resident #2 had skin tears on his/her right arm and right upper arm. - On 3/10/2024 at 12:41 p.m., the IR completed by RN #1, Resident #2's right thumb was observed to have skin tear. - On 3/22/2024 at 6:10 a.m., the IR completed by LPN #2, indicated that she was notified by UCNA #3 that the Resident's left arm had skin tear. Resident #2's CP did not reflect that a new invention was added for the aforementioned IR to prevent reoccur of the aforementioned incidents. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the telephone interview with the Surveyors on 08/12/2024 at 11:58 a.m., RN #1 stated that when IR is completed, the CP had to be updated at the time of the incident. The RN further explained that the CP had to be revised to prevent the aforementioned incidents. The RN stated that the CP was not revised on the aforementioned IRs on 1/14/24 and 3/10/24. He explained that he forgot and it was an oversight. 2. According to the AR, Resident #4 was admitted with diagnoses which included but not limited to Muscle Weakness, Hemiplegia and Hemiparesis, and Need for Assistance with Personal Care. The MDS, dated [DATE], revealed Resident #4 had a BIMS of 0/15 which indicated the Resident's cognition was severely impaired and he/she needed help during ADL. The CP initiated on 02/24/2021 and revised on 06/18/21 indicated that Resident #4 had Urinary incontinence related to impaired mobility, physical limitations. The Surveyors review the Resident's IR revealed the following: - On 04/24/2024 at 7:21 a.m., the IR completed by LPN #3, revealed the UCNA #4 reported that the Resident an opening to the Resident's right side of the perineal area. The CP and corresponding interventions were not revised after this incident. During the interview with the Surveyors on 8/12/2024 at 3:31 p.m., the Unit Manager/LPN (UM/LPN) stated that the CP had to be updated right away when there was change in condition. During an interview with the Surveyors on 08/08/2024 at 4:30 p.m., the Director of Nursing (DON) stated that the CP should be updated by the UMs at the time of the incident. However, she was not able to explain why the CP was not updated. The policy titled Care Plans, Comprehensive Person-Centered, dated 4/25/2022, under Policy Interpretation and Implementation .13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition .b. When the desire d outcome is not met . NJAC 8:39-11.2(2)