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	05/16/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Complaint: NJ00180728 Based on interviews, medical record reviews, and review of pertinent facility documents on 05/14/2025 and 05/16/2025, it was determined that the facility failed to follow their, Accidents and Incidents - Investigating and Reporting policy, and conduct a thorough investigation after a resident was found on the floor after a fire alarm for 1 of 3 residents (Resident #6) reviewed for accidents and incidents. This deficient practice was evidenced by the following: Review of the admission Record revealed that Resident #6 was admitted to the facility with diagnoses that included but were not limited to unspecified atrial flutter (rapid pumping in the heart's upper chambers resulting in palpitations, shortness of breath, and fatigue); anemia (unspecified); Type 2 diabetes mellitus without complications; muscle weakness (generalized); difficulty walking, not elsewhere classified; and cognitive communication deficit. Review of the Minimum Data Set (MDS), an assessment tool, dated 11/08/2024, revealed that Resident #6 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the resident had severely impaired cognition. The MDS revealed that Resident #6 required substantial or maximal assistance from a helper to move from sitting to standing, and to walk ten feet once standing. Review of a progress note (PN) written by Licensed Practical Nurse (LPN) #1 dated 11/28/2024 at 3:46 P.M., revealed that at 11:57 A.M. the facility fire alarm sounded, and all doors were closed per the facility's protocol. At 12:20 P.M., after the alarm was cleared LPN #1 was called to Resident #6's room by a Certified Nursing Assistant (CNA). LPN #1 then observed Resident #6 lying on the floor, unresponsive, with a pillow under her/his head. The PN revealed that Resident #6 had a blood oxygen level of 74% on room air which increased to 82% with the application of a non-rebreather oxygen mask. Resident #6's blood pressure was 97/57 and she/he had a faint pulse. The PN further revealed that the resident had sluggish responses to verbal and painful stimuli. 911 was called at 12:30 P.M., and Resident #6 was transported out of the facility at 12:40 P.M. Review of the facility document, Nurse Fall Investigation, completed by LPN #1 and dated 11/28/2024 was conducted. The document revealed that Resident #6's fall was not witnessed. The Nurse Statement/Resident description of fall, section of the document confirmed the information contained in the PN on 11/28/2024, at 3:46 P.M. Review of the facility document, Witness Statement, dated 11/28/2024 and signed by CNA #2 was conducted. The witness statement revealed that at on 11/28/2024 at 12:20 P.M., after a fire alarm, CNA #2 found Resident #6 laying on the floor on her/his back with a pillow under her/his head. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was not able to provide additional witness statements or facility documentation regarding Resident #6 being found on the floor after the fire alarm on 11/28/2024. An interview was conducted with CNA #2 on 05/16/2025 at 1:00 P.M. CNA #2 stated that on 11/28/2024 just before the alarm sounded, Resident #6 ate, got dressed, and drank water. CNA #2 stated that when the fire alarm sounded, she observed Resident #6 in her/his bed prior to closing the room door. The CNA stated that after the alarm, she returned to Resident #6's room and found the resident on the floor with a pillow under her/his head. CNA #2 stated that the resident appeared short of breath or nervous and did not explain how she got to the floor. Review of the facility Fall Report document revealed that on 11/29/2024 The Interdisciplinary Team convened to discuss the incident that involved Resident #6. Review of the facility assignment sheet revealed that CNA #3, CNA #4, CNA #5, CNA #6, and Registered Nurse (RN) #1 worked on the same unit with LPN #1 and CNA #2 during the 7:00 A.M., to 3:00 P.M., shift on 11/28/2024. Interviews were conducted with CNA #3, CNA #4, CNA #5, and CNA #6 on 05/16/2024 from 12:09 P.M., to 1:20 P.M. CNAs #3, #4, #5, and #6 did not recall being interviewed or providing statements about the incident involving Resident #6 on 11/28/2024. An interview was conducted with Registered Nurse (RN) #1 on 05/16/2025 at 12:44 P.M. RN #1 did not recall being interviewed or providing a statement about the incident involving Resident #6 on 11/28/2024. An interview was conducted with the Director of Nursing (DON) on 05/16/2025 at 2:04 P.M. The DON stated that after review of Resident #6's hospital record she determined that Resident #6's fall was due to a cardiac event. An interview was conducted with the facility's Licensed Nursing Home Administrator (LNHA) on 05/16/2025 at 2:24 P.M. The LNHA stated that the LNHA and DON are responsible for determining what investigations are required. The LNHA stated that the 11/28/2024 incident involving Resident #6 was a fall. The LNHA further stated that the DON determined that the fall was cardiac in origin after she reviewed the resident's hospital records. The facility policy titled Accidents and Incidents- Investigating and Reporting, revised on 7/2017, revealed Policy Statement All accidents or incidents involving residents, employees, visitors, etc., occurring on our premises shall be investigated and reported to the administrator. Policy Interpretation and Implementation. 1. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/Accident form: . e. The name(s) of witnesses and their accounts of the accident or incident; . m. Other pertinent data as necessary or required; NJAC 8:39-27.1 (b)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint: NJ00180728 Based on interviews, record review, and review of pertinent facility documents on 05/14/2025 and 05/16/2025 it was determined that the facility failed to follow the facility policy Weight Assessment and Intervention and follow physician orders (POs) for weekly weights. This deficient practice was identified for 1 of 3 residents (Resident #6) reviewed for nutrition. The deficient practice was evidenced by the following: The admission Record revealed that Resident #6 was admitted to the facility with diagnoses that included but were not limited to anemia (unspecified); Type 2 diabetes mellitus without complications; unspecified severe protein-calorie malnutrition; muscle weakness (generalized); dysphagia, oral phase; and cognitive communication deficit. Review of Resident #6's Minimum Data Set (MDS), an assessment tool, dated 11/08/2024, was conducted. The MDS revealed that Resident #6 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the resident had severely impaired cognition. The MDS further revealed that Resident #6 was 64 inches tall and weighed 113 pounds (lbs.), had not experienced weight loss in the past six months, and was on a therapeutic diet. Review of the Order Summary Report for November of 2024 revealed that Resident #6 had a PO for weights every seven days for four weeks. The PO had a start date of 11/02/2024 and an end date of 11/30/2024. Review of Resident #6's care plan (CP), initiated and revised on 11/04/2024 revealed that the resident was at risk for malnutrition related to anemia, diabetes, limited mobility, and advanced age. The CP included an intervention for the resident to be weighed as ordered. Review of Resident #6's Weight Summary (WS), revealed that on 11/02/2024 Resident #6 weighed 113 lbs. No additional weights were reflected on the resident's WS. Review of the facility document Weekly Weights (WW), revealed at the top, Reminder: All new admissions and readmissions should be weighed upon admission, then weekly x 4 weeks. The WW further revealed that Resident #6 had to be weighed between 11/10/2024 to 11/16/2024, 11/17/2024 to 11/23/2024, and 11/24/2024 to 11/30/2024. The WW did not indicate that Resident #6 was weighed during the aforementioned periods. Review of Resident #6's weights documented in the facility's electronic medical record (EMR) revealed that Resident #6 weighed 113 lbs. on 11/02/2024. The EMR revealed that no additional weights documented through the resident's discharge on [DATE]. The facility was unable to provide evidence that Resident #6 was weighed weekly according to POs. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 05/14/2025 at 11:45 A.M. CNA #1 stated that CNAs obtained resident weights according to an established schedule, or as instructed by nurses. CNA #1 stated that nurses were verbally informed of resident's weights and CNAs recorded weights in the facility's electronic documentation system. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 05/14/2025 at 2:40 P.M. The DON stated that residents were weighed on admission, the day after admission, then weekly and then monthly. The DON confirmed that the only documented weight for Resident #6 was on 11/02/2024. An interview was conducted with the Registered Dietician (RD) 05/16/2025 at 1:29 P.M. The RD stated that she obtained residents' weights from either weight books on the unit or from the EMR. The RD confirmed that the Weekly Weights sheet contained no weight information for Resident #6 from 11/10/2024 through the resident's discharge. The RD further stated that it was important for residents to be weighed as ordered because weight was a measure of the resident's nutritional status. A review of the facility policy Weight Assessment and Intervention, revised March 2022 was conducted. Under Policy Statement, the policy revealed Resident weights are monitored for undesirable or unintended weight loss or gain. Under Weight Assessment, the policy revealed 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team such as: weekly for four weeks, then monthly unless otherwise indicated [.], or as ordered. [.], 2. Weights are recorded in each individual's medical record. NJAC 8:39-27.1(a)