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	10/23/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(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 - Few	Complaint Survey Complaint # NJ00187927F686 D Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to maintain infection control standards and procedures during wound care treatment for 1 of 2 Residents (Resident #2) reviewed for care and services for pressure ulcers. 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 10/23/25 at 10:00 AM, during the incontinence tour with the Certified Nursing Assistant (CNA) the surveyor observed Resident #2 in bed on a specialty mattress in a supine position. The surveyor observed signage on the door, which indicated the resident was on Enhanced Barrier Precautions. The surveyor reviewed the medical record for Resident # 2. A review of the admission Record reflected the resident was admitted to the facility with diagnoses that included but were not limited to; cognitive communication deficit, peripheral vascular disease, depression, and anxiety disorders. A review of the admission Minimum Data Set, an assessment tool dated September 9, 2025, reflected that Resident #2 had a Brief Interview for Mental Status score of 6 of 15, indicating severe cognitive impairment. Section M documented that Resident #2 was admitted to the facility with an unstageable pressure ulcer.A review of the 9/2/25 Skin Evaluation reflected that the resident was admitted with an unstageable pressure ulcer (a wound that involves severe tissue damage) of their sacrum (lower back).On 10/23/25 at 10:00 AM, the surveyor observed the Registered Nurse (RN) perform the treatment to Resident #2's sacral wound and observed the following:The RN gathered the supplies, which included 4x4 gauze pads, two bottles of betadine, 2 100cc bottles of Normal Saline Solution (NSS), a tube of Santyl ointment, (3) 2x2 Calcium Alginate dressings, (3) 6x6 Calcium Alginate dressings, and (1) Foam border dressing. The RN donned (put on) a disposable gown and gloves, entered the Resident's room, and placed all supplies on top of the overbed table without first cleaning or placing a clean barrier on the table. The RN removed the soiled foam dressing, which had a moderate amount of brownish-red purulent drainage. The RN, with the same gloves (now considered soiled) cleansed the wound with Normal Saline (NSS). The RN cleaned the wound from the outside to the inside (causing possible contamination from the skin into the open wound.) The RN, with the same contaminated gloves, applied Santyl directly on to the gauze pad, placed the gauze onto the wound bed, opened the Calcium Alginate and packed the wound. The RN, with the same contaminated gloves, reached into her pocket, removed a pen, dated the foam dressing and applied it to the wound. The RN did not sanitize the over bed table after the wound treatment was completed.The RN removed her gloves and, with no observed hand hygiene, brought the unused supplies out of the room and placed them back into the treatment cart. On 10/23/25 at 10:55 AM, in the presence of the Director of Nursing (DON), the surveyor discussed the infection control breaches with the RN, who confirmed that she should have removed her gloves and sanitized her hands after she removed the soiled dressing and should have performed hand hygiene before leaving the resident's room. The RN acknowledged that she should have cleansed the wound from the inside out to prevent possible bacteria from contaminating the wound bed, should have only brought supplies that would be used for the treatment into the room, should not have placed the unused supplies back into the treatment cart, and should have sanitized the treatment cart after the treatment was completed. The DON confirmed the breaches in infection control. On 10/23/25 at 3:13 PM, the surveyor discussed the above observations and concerns with the License Nursing Home Administrator and DON. A review of the facility's Dressings, Dry/Clean revised 9/2013 reflected.The purpose of this procedure is to provide guidelines for the application of dry, clean dressings.Steps in the procedure: Clean bedside stand, establish a clean field Place supplies on a clean field Wash and dry your hands thoroughly Put on clean gloves, remove soiled dressing, pull glove

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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 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. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	COMPLAINT #NJ00187927Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards by ensuring two medications (Breo Ellipta Aerosol (a combination inhaler used to prevent and control symptoms of asthma) and Triamcinolone topical cream (a steroid cream)) were obtained in a timely manner and administered as per prescribed physician's orders for one (1) of four (4) residents sampled. The 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 10/23/25 at 10:00 AM, the surveyor reviewed the closed medical records for Resident #1.A review of the resident's admission Record reflected that the resident had diagnoses, which included but not limited to, chronic obstructive pulmonary disease (chronic lung disease causing inflammation and narrowing of the airways) (COPD). A review of the resident's electronic medication administration record (EMAR) for June 2025 revealed a physician's order (PO) dated 6/20/25 for Breo Ellipta Aerosol Powder Breath Activated 200-25 MCG (micrograms)/INH (inhalation) (Fluticasone Furoate-Vilanterol) Give 1 puff by mouth one time a day for Asthma (condition which causes airway narrowing and swelling) Rinse mouth after use, wait 5 minutes between different inhalers, discard 6 weeks after opening. The 9:00 AM dose of Breo Ellipta was not administered on 6/20/25, 6/21, 6/22, 6/23 and 6/25/25 and coded with the number 9 which corresponded to Hold/see progress notes documented by a Licensed Practical Nurse (LPN #1). In addition, the EMAR indicated on 6/24/25 the Breo Ellipta was not administered and coded with the number 13 which corresponded to absence of condition/not applicable documented by a Registered Nurse #1. A review of the resident's electronic progress notes (EPN) revealed there was corresponding progress notes to correlate with the number 9 for Breo Ellipta not being administered on the above dates indicating on order will f/u (follow up) with pharmacy documented by LPN #1. There was no corresponding EPN for 6/24/25. Further review of the June 2025 EMAR revealed a PO dated 6/20/25 for Triamcinolone Acetonide External Cream 0. 5% (Triamcinolone Acetonide (Topical) Apply to skin topically one time a day for Skin Inflammation. The 9:00 AM dose was not administered on 6/20/25, 6/21, and 6/22/25 and coded with the number 9 which corresponded to Hold/see progress notes documented by LPN #1. A review of the resident's EPN revealed there was corresponding progress notes to correlate with the number 9 for Triamcinolone topical not being administered on the above dates indicating on order will f/u (follow up) with pharmacy documented by LPN #1. On 10/23/25 at 2:25 PM, the surveyor interviewed LPN #1 who stated that when a medication was not available, she would call the pharmacy and document in the progress notes. LPN #1 added that when a medication was out of stock for more than 3 days, she would call the physician and ask for a different medication and would document in the progress notes. At that time, the surveyor and LPN #1 reviewed the EMAR for Resident #1. LPN #1 stated that the Breo Ellipta was never sent by the pharmacy, and the Triamcinolone took a while. LPN #1 added that she thought she called the pharmacy and the physician when the medications were not available. LPN #1 added that she was supposed to document in the progress notes when she spoke with the physician. LPN #1 was unable to speak to what follow up the physician had said to do. LPN #1 stated that there was no back up medications available in the facility and had to wait until the pharmacy sent the medications. LPN #1 acknowledged that there was no documentation in the progress notes that she had contacted the pharmacy. On 10/23/25 at 2:37 PM, the surveyor interviewed the Director of Nursing (DON) who stated that there was back up medications available in the facility but there was no inhalers or steroid creams available. The DON added that if a medication was not available, the nurses should call the physician for follow up orders such as ordering another similar medication that was available