

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2024
NAME OF PROVIDER OR SUPPLIER Careone at the Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>39399</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to maintain dignity during mealtime for a resident who needed assistance with eating. This deficient practice was observed for 2 of 26 residents observed, Resident #27 and Resident #72 and was evidenced by the following:</p> <p>1. On 1/4/24 at 12:09 PM, the surveyor observed the Certified Nurse's Aide (CNA) on the [NAME] Unit, standing and holding a supplement in her right hand while Resident #27 was drinking the supplement via a straw. The surveyor also observed the CNA observing and holding her personal cellphone in her left hand while assisting the resident during feeding.</p> <p>The surveyor interviewed the CNA on 1/4/23 at 12:14 PM, who stated that she normally stands while feeding the resident because she was also assisting another resident (Resident #27's roommate) at the same time in the same room.</p> <p>A review of the Admission Record for Resident #27 reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Fracture part of right clavicle; Nontraumatic intracerebral hemorrhage; Cognitive Communication Deficit, Dementia and Dysphagia.</p> <p>A review of the resident's Minimum Data Set, an assessment tool used to facilitate the management of care dated 12/21/23, reflected that Resident #27 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating severe cognitive impairment.</p> <p>A review of the facility's policy and procedure titled, Assistance with Meals revealed under Dining Room Residents #3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example a. not standing over residents while assisting them with meals.</p> <p>On 1/9/24 at 1:48 PM, the Administrator, and the Clinical Lead RN were made aware of the surveyor's observation, and both agreed that the CNA should be attentive and seated next to the resident when feeding.</p> <p>46049</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 1/4/24 at 12:07 PM, the surveyor observed lunch being served on the [NAME] Unit. The surveyor observed CNA #2 sitting at the end of Resident #72's bed in their room. The resident was lying in bed with the head of the bed elevated, eating their lunch set up on the tray table, positioned in front of the resident. The surveyor observed CNA #2 not looking, talking, or attending to Resident #72. CNA #2 was looking down at an electronic device in her hand.</p> <p>On 1/4/24 at 12:08 PM, the surveyor called the Assistant Director of Nursing (ADON) to the doorway of Resident #72's room. The ADON observed CNA #2 sitting at the foot of the resident's bed looking at the electronic device in her hands. The ADON entered the room and called CNA #2 to the hallway to speak with the surveyor. The ADON stated that the device held by CNA#2 was a facility tablet which the CNAs used to complete their resident documentation.</p> <p>The surveyor interviewed CNA #2, in the presence of the ADON. CNA #2 acknowledged that she should not have been sitting on the resident's bed. CNA #2 stated she was supervising the resident to provide help with their meal if needed and that the documentation she was completing on the tablet included the resident's intake.</p> <p>The ADON acknowledged that CNA #2 should not have been seated on the resident's bed and that it was not an appropriate time for the CNA to complete documentation. The ADON acknowledged that CNA #2 should have been interacting with Resident #72.</p> <p>According to the Admission Record (an admission summary), Resident #72 had diagnoses that included but were not limited to traumatic subdural hemorrhage, encephalopathy, and cognitive communication deficit.</p> <p>A Comprehensive MDS assessment, dated 11/27/23, indicated the facility assessed the resident's cognition using a BIMS test. Resident #72 scored 4 out of 15, which indicated the resident had severe cognitive impairment. The MDS further documented the resident required set up or clean-up assistance for meals.</p> <p>On 1/9/24 at 1:47 PM, the surveyor informed the regional Registered Nurse [NAME] President of Special Clinical Project (VPSCP) and the Licensed Nursing Home Administrator (LNHA) of the above concerns during dining observation.</p> <p>On 1/11/24 at 10:52 AM, the VPSCP and the LNHA met with the survey team. The VPSCP acknowledged CNA #2 should not have been sitting on Resident #72's bed and should not have used a work tablet at the resident's bedside. The VPSCP further explained CNA #2 should have been interacting with the resident and not on an electronic device.</p> <p>A review of the facility's policy titled Resident, last revised in April 2022, under Policy Statement it read: Employees shall treat all residents with kindness, respect, and dignity. Under Policy Interpretation and Implementation, it read: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity including being addressed by the resident's chosen name and pronouns .</p> <p>N.J.A.C. 8:39-4.1(a)12</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>39399</p> <p>Based on observation, interview and record review, it was determined that the facility failed to maintain the confidentiality of the resident information on the Electronic Health Records system. This deficient practice was observed during unit observation and was evidenced by the following:</p> <p>On 1/8/24 at 1:11 PM, the surveyor observed a paper documenting written information placed on top of the medication cart showing resident's photos, resident's names, resident's room numbers, vital signs including blood pressure, heart rate, blood glucose level, and temperature associated with each resident. Further observation revealed other documented notes about the residents next to their names.</p> <p>The surveyor observed two family members passed by the medication cart where the paper was placed having documented information available for viewing by anyone passing by.</p> <p>On 1/8/24 at 1:20 PM, the surveyor observed the Registered Nurse (RN) walking towards the medication cart. The RN stated to the surveyor that she was assigned to the medication cart. The RN further stated that the piece of paper was referred to as roster. The RN explained that the roster was a sheet of paper that allows her to document important information about the residents assigned to her.</p> <p>During the interview, the surveyor informed the RN that the paper documented resident's personal medical information. The RN responded that there were no HIPPA (Health Insurance Portability and Accountability Act, a 1996 Federal law that restricts individual's private medical information) violations that referred to this because it only listed the resident's names and room numbers.</p> <p>On 1/9/24 at 1:48 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administrator and [NAME] President of Special Clinical Projects (VPSCP) who both agreed that the nurse revealed private medical information that should have been covered from view.</p> <p>NJAC 8:39-4.1 (a) 18</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39399</p> <p>Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) - Discharge Assessment in accordance with federal guidelines. This deficient practice was identified for 1 of 26 residents reviewed for resident assessment, Resident #84.</p> <p>This deficient practice was evidenced by:</p> <p>On 1/9/24 at 11:22 AM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments.</p> <p>The MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. After transition of the MDS, a quality measure will be transmitted to enable a facility to monitor the residents decline or progress.</p> <p>On 1/9/24 at 11:30 AM, the surveyor reviewed Resident #84's electronic medical record Review of the record revealed that the resident was discharged to the community on 11/22/23.</p> <p>The surveyor reviewed the resident's MDS 3.0 Assessment History assessment tool, including all the completed MDS's. The MDS assessment history revealed that there was no Discharge Assessment MDS completed for the resident's discharge date of [DATE].</p> <p>According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) page 2-11 Discharge refers to the date a resident leaves the facility . There are two types of OBRA required discharges: return anticipated and return not anticipated. A Discharge assessment is required with all types of discharges. The manual revealed on Page 2-17 A Discharge Assessment - return not anticipated MDS must be completed not later than discharge date + 14 days. The assessment must also be transmitted to the QIES ASAP system not later than the MDS completion + 14 days.</p> <p>On 1/10/24 at 12:33 PM, the surveyor interviewed the facility's MDS Coordinator responsible for completing MDS assessments, who stated to the surveyor that the Discharge MDS for Resident #84's assessment was missed.</p> <p>On 1/11/24 at 11:07 AM, the facility's Licensed Nursing Home Administrator and [NAME] President of Clinical Special Project was informed regarding the above concern. There was no further information provided.</p> <p>NJAC 8:39 - 11.2</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>44605</p> <p>Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 2 of 26 residents, Resident #105 and Resident #47, reviewed for accuracy of MDS coding.</p> <p>This deficient practice was evidenced by the following:</p> <p>1. On 1/11/24 at 2:18 PM, the surveyor reviewed the closed hybrid (paper and electronic) medical records for Resident #105.</p> <p>A review of the Admission Record (a summary of important information about the resident) documented Resident #105 with diagnoses that included but were not limited to Chronic Kidney Disease, Hematuria, Anemia, and Muscle Weakness.</p> <p>A review of a discharge MDS for the resident, dated 11/4/23, under section A documented it was a Discharge assessment-return not anticipated .Planned discharge . to a Short-Term General Hospital.</p> <p>A review of the Patient Discharge Summary/Instructions form dated 11/3/23 documented that Resident #105 was discharged home.</p> <p>On 1/11/24 at 10:51 AM, the surveyor informed the [NAME] President of Special Clinical Projects (VPSCP) and Licensed Nursing Home Administrator (LNHA) about the above concerns. The VPSCP stated all MDS coding should be accurate. There was no further information provided.</p> <p>On 1/12/24 at 8:47 AM, the surveyor reviewed the Discharge MDS of Resident #105 with the MDS Coordinator. The MDS Coordinator stated that the identified coding on the Discharge MDS was an error. The MDS Coordinator confirmed that the resident was discharged home and not to a short-term general hospital.</p> <p>39399</p> <p>2. On 1/8/24 at 1:04 PM, the surveyor observed Resident #47 in the day room seated in their recliner wheelchair in the dayroom.</p> <p>The surveyor reviewed Resident #47's hybrid medical records.</p> <p>The admission record (AR) reflected that Resident #47 was admitted to the facility with medical diagnoses that included but were not limited to Metabolic Encephalopathy, Urinary Tract Infection, Unspecified Severe Protein-Calorie Malnutrition and Dysphagia.</p> <p>A review of the Significant Change in Status Assessment Minimum Data Set (SCSA/MDS), an assessment tool used to facilitate the management of care, dated 11/29/23 documented that the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 indicating that the resident had severely impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the SCSA/MDS under Section J1900 documenting the number of falls since admission/entry or reentry to the facility revealed that Resident #47 had one fall with no injury and another fall with a major injury.</p> <p>The surveyor interviewed the facility's MDS Coordinator (MDS-C) who was responsible of completing the MDS assessments. The MDS-C stated that the MDS section J1900 for falls was coded in error. The MDS-C further stated that Resident #47 did not have a fall with major injury, only the one fall with no injury.</p> <p>On 1/9/24 at 1:48 PM, the surveyor discussed the above concern with the facility's LNHA and VPSCP. There was no further information provided.</p> <p>NJAC 8:39-11.1, 11.2(e)(1)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31656</p> <p>Complaint #NJ00154940</p> <p>Complaint #NJ 00153394</p> <p>Based on observation, interview, and record review it was determined that the facility failed to accurately document and clarify the administration of medication for 3 of 36 residents, Resident #39, #43 and #21.</p> <p>This deficient practice was evidenced by the following:</p> <p>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.</p> <p>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.</p> <p>1. On 1/4/24 at 11:47 AM, the surveyor observed Resident #39 seated in their Geri Chair in their personal gown in their room. Resident #39 was noted with hand splints on both hands as well as foam protectors on their feet. Resident #39 was not alert or oriented and did not respond to the surveyor when gesturing by waving or saying hello to the resident.</p> <p>On 1/9/24 at 11:10 AM, the surveyor observed Resident #39 seated in their Geri Chair in their personal gown in their room. Resident #39 had hand splints on both hands as well as foam protectors on their feet.</p> <p>On 1/10/24 at 12:15 PM, the surveyor observed Resident #39 seated in their Geri Chair in their personal gown in their room. Resident #39 had hand splints on both hands as well as foam protectors on their feet.</p> <p>On 1/11/24 at 11:56 AM, the surveyor observed Resident #39 seated in their Geri Chair in their personal gown in their room. Resident #39 had hand splints on both hands as well as foam protectors on their feet.</p> <p>At this time, the surveyor noted the Registered Nurse (RN) in the room. The surveyor interviewed the RN who informed the surveyor that the hand splints are applied to Resident #39 between 11:30 and 12:00 PM.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #39's electronic health record (EHR) revealed the following:</p> <p>According to Resident #39's Admission Record (an admission summary), Resident #39 was admitted with diagnoses that included but were not limited to Contracture to left hand, Contracture to right hand, Dysphagia, and Dementia.</p> <p>Review of the resident's Quarterly Minimum Data Set (QDS) assessment, a tool used to facilitate management of care, dated 11/22/23, indicated that the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #39 scored a 0 out of 15, which indicated the resident had a severely impaired cognition.</p> <p>On 1/11/24 at 12:10 PM, the surveyor reviewed the January 2024 Emar for Resident #39. The surveyor reviewed two physician's orders on the January 2024 Emar. The first physician's order with a start date of 9/30/23 read, Apply Bilateral resting splints in the afternoon for contracture. Please do skin check before donning and doffing splint and remove per schedule. The Emar had documentations that the splints were being donned (applying) the splints at 12:00 PM and Doffed (removing) at 4:00 PM daily.</p> <p>The second physician's order with a start date of 1/5/24, found on the January 2024 Emar for Resident #39 documented, Wear bilateral splints for 6 hours during day don at afternoon, doff in evening. The documentation on the Emar revealed that it was applied daily at 4:00 PM and removed at 10:00 PM from 1/5/24 to 1/10/24.</p> <p>On 1/11/24 at 1:56 PM, the surveyor informed the Regional Director of Education and Development of the conflicting orders for the Splints.</p> <p>On 1/12/24 at 11:56 AM, the Regional Director of Education and Development could not explain why there were two orders for the hand splint application. He did clarify that the hand splints should be applied on Resident #39 for only 6 hours per day, on at 4:00 and off at 10:00 PM.</p> <p>On 1/12/24 at 11:58 AM, the surveyor along with the Regional Director of Education and Development observed Resident #39 seated in their Geri Chair in their personal gown in their room. Resident #39 had hand splints on both hands as well as foam protectors on their feet.</p> <p>2. On 1/5/24 at 12:33 PM, the surveyor interviewed Resident #43 who was seated in a wheelchair in their room. The resident was alert, oriented and conversant. Resident #43 informed the surveyor that Lidocaine 5% Patch was supposed to be applied every morning, but the nurses have informed the resident that it was not available.</p> <p>A review of Resident #43's electronic health record (EHR) revealed the following:</p> <p>According to Resident #43's Admission Record (an admission summary), Resident #43 was admitted with diagnoses that included but were not limited to, Polyneuropathy, Bilateral Primary Osteoarthritis of knee, Disease of Spinal Cord, and Muscle Weakness.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Quarterly Minimum Data Set (QDS) assessment, a tool used to facilitate management of care, dated 10/16/23, indicated that the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #43 scored a 15 out of 15, which indicated the resident had an intact cognition.</p> <p>A physician's order dated 12/27/23 and noted on the electronic medical administration record (Emar) read: Lidocaine Patch 5% Apply to legs lower topically one time a day for Pain Management. Apply for only 12 hours in a 24 hour period. External use only. And remove per schedule. The documentation on the Emar for January 2024 revealed application at 9:00 AM and removal at 9:00 PM.</p> <p>Review of the application documentation by nursing for Lidocaine 5% Patch was documented as applied at 9:00 AM and removed at 9:00 PM from 1/1/24 to 1/5/24.</p> <p>On 1/5/24 at 1:21 PM, the surveyor discussed Resident #43's Lidocaine 5% Patch with the Licensed Practical Nurse (LPN) responsible for administering the resident's medication. The LPN stated that the patch was applied in the morning.</p> <p>The surveyor along with the LPN approached Resident #43 and with their permission, inspected the resident's lower legs. There was no evidence that Lidocaine 5% patch was applied to the legs of Resident #43.</p> <p>The LPN could not explain why the Lidocaine 5% Patch was documented as applied when there was no evidence that it was applied on Resident #43.</p> <p>On 1/5/24 at 1:24 PM, the LPN in the presence of the surveyor inspected her medication cart where there was no Lidocaine 5% Patch available.</p> <p>On 1/9/24 at 11:41 AM, the surveyor called the provider pharmacy and spoke with the pharmacy technician who stated that the Lidocaine 5% Patch was never sent by the pharmacy. It was ordered as a profile medication only and therefore was only printed on the Emar.</p> <p>3. On 1/9/24 at 11:41 PM, the surveyor interviewed Resident #43 who was seated in a wheelchair in their room. The resident was alert, oriented and conversant. Resident #43 informed the surveyor that Zeasorb (Miconazole Antifungal Powder) AF was another medication that was supposed to be applied every morning, but the nurses informed the resident that it was not available until today. Resident #43 presented the bottle of Miconazole Nitrate 2% Antifungal powder with a delivery date of 1/9/24. Resident #43 stated that it was delivered this morning and lasts about 3 weeks.</p> <p>A review of Resident #43's electronic health record (EHR) revealed the following:</p> <p>Review of the Emar dated 1/2024 documented a physician's order for Antifungal External Powder 2% (Miconazole Nitrate (Topical) Apply to groin topically every shift for fungal with a start date of 6/26/23.</p> <p>Review of the documentation on the 1/2024 Emar showed that the Miconazole was applied from 1/1/24 to 1/9/24 every shift (3 times daily).</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/9/24 at 11:41 AM, the surveyor called the provider pharmacy and spoke with the pharmacy technician who stated that the Miconazole 2% Powder was last delivered to the facility on [DATE].</p> <p>44605</p> <p>4. On 1/4/24 at 11:16 AM, the surveyor interviewed Resident #21 in the resident's room. The resident stated that they suffer with anxiety and take Sertraline (Zoloft) to treat the anxiety. Resident #21 informed the surveyor that previous to their admission to the facility they were treated with Sertraline 75 milligrams (mg) but have been receiving 50 mg daily since admission to the facility. The resident stated they noticed this about a week ago, alerted a staff member, but has not heard anything since.</p> <p>A review of Resident #21's Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to Muscle Weakness, Difficulty in Walking, Sepsis, and Anxiety.</p> <p>The Comprehensive Minimum Data Set (MDS), an assessment tool used for the management of care dated 11/24/24, revealed a BIMS score of 15 out of 15 which indicated that the resident had an intact cognition intact.</p> <p>The surveyor reviewed the January 2023 Physician Orders (PO), which revealed an order dated 11/17/23 for Sertraline HCL Tablet 50 mg, Give 1 tablet by mouth one time a day for Anxiety. May cause drowsiness.</p> <p>The surveyor reviewed the hospital After Visit Summary, a summary of medication administered to Resident #21 during the resident's hospital stay from 11/9/23-11/17/23. The After Visit Summary (AVS) documented that Resident #21 was treated with Sertraline 50 mg tablet, dose: 75mg daily for Generalized Anxiety Disorder.</p> <p>The surveyor reviewed the Nursing Admission Assessment and Physician Initial Assessment for documentation related to a reduction in dosage from Sertraline 75 mg to 50 mg. Neither the Nursing Admission Assessment or the Physician Initial Assessment addressed a change in Sertraline dosage.</p> <p>Multiple attempts were made by the surveyor to interview the Physician and nurse who documented Resident #21's medication orders from the hospital. Both were unable to be reached. Voicemail messages were left by the surveyor.</p> <p>On 1/5/24 at 1:00 PM, the [NAME] President of Special Clinical Projects provided the surveyor with facility policies titled, Psychotropic Medication Use with an edited date 2/2/2023 and Medication and Treatment Orders with a revised date of July 2016. The Psychotropic Medication Use policy states under the Policy Interpretation and Implementation, 3. Residents, families and/or representative are involved in the medication management process .Psychotropic medication management includes .b. dose. The Medication and Treatment Orders policy states under the Policy Interpretation and Implementation, 3. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Careone at the Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Inman Avenue Edison, NJ 08820	
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/11/24 at 10:53 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and [NAME] President of Special Clinical Projects (VPSCP). The VPSCP stated, with regards to the process for new admission and medication review, upon admission, orders are reconciled with the resident and physician. Transcribed as physician's orders on Point Click Care. VPSCP unable to state why the medication dosage occurred. No further comments were provided.</p> <p>NJAC 8:39-11.2 (b); 29.2(d)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>44605</p> <p>Based on observation, interview, and review of pertinent medical records, it was determined that the facility failed to follow physician orders related to the use of continuous oxygen (O2) for 1 of 1 resident, Resident #15, reviewed for O2 therapy.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 1/4/24 at 11:00 AM, the surveyor observed Resident #15 seated in a wheelchair in their room. Resident #15 was receiving O2 delivered through a nasal cannula (NC) (plastic prongs attached to a tube, inserted into the nostrils that oxygen flows through) utilizing a concentrator (an oxygen delivery system) at 4 Liters per minute (LPM).</p> <p>The surveyor reviewed the resident's paper and electronic medical chart.</p> <p>A review of the Admission Record (a summary of important information about the resident) documented the resident's diagnoses included but were not limited to Heart Failure, Chronic Obstructive Pulmonary Disease, Essential Hypertension, and Chronic Systolic Heart Failure (CHF).</p> <p>A review of a comprehensive Minimum Data Set (an assessment tool to facilitate care) dated 10/23/23, documented the resident had a Brief Interview for Mental Status (BIMS) and scored a 15 out of 15, indicating that Resident #15 had intact cognition intact.</p> <p>A review of the Physician's Orders (PO) and electronic treatment administration record (eTAR) documented a physician's order for, Oxygen via Nasal Cannula (NC) continuous at 2 LPM with a start date of 11/3/23 at 3:00 PM.</p> <p>A review of Resident #15's Care Plan (CP) with an effective date of 10/17/23 read, .Has/At risk for respiratory impairment related to CHF. An intervention for the CP read, Administer oxygen per physician order.</p> <p>On 1/4/24 at 12:20 PM, the surveyor observed Resident #15 seated in a wheelchair in their room. The resident was receiving O2 delivered through a NC utilizing a concentrator at 4 LPM.</p> <p>On 1/4/24 at 12:25 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) caring for Resident #15. The LPN and surveyor reviewed the PO for the resident's O2 settings.</p> <p>The surveyor informed the LPN of the two observations on 1/4/23 in which the resident's O2 setting was at 4 LPM. The surveyor accompanied the LPN to Resident #15's room to check the O2 settings. The LPN acknowledged the O2 was not set at 2 LPM as ordered by the physician. The LPN could not explain why the resident's O2 was set at 4 LPM.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/10/24 at 10:30 AM, the Director of Nursing (DON) provided the surveyor with a facility policy titled, Oxygen Administration, which had a revised date of October 2010. Under the Preparation portion of the policy it read, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Under the Documentation section of the policy it read, After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record .3. The rate of oxygen flow, route, and rationale.</p> <p>On 1/11/24 at 10:53 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and [NAME] President of Special Clinical Project (VPSCP). The surveyor informed the LNHA and VPSCP about the concerns of the O2 setting for Resident #15. The VPSCP stated the O2 should be administered according to physicians' orders. There was no further information provided by the facility.</p> <p>NJAC 8:39-27.1(a)</p>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>39399</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that the residents' primary physician signed and dated monthly physician orders (PO) to ensure that the residents' current medical regimen was current and accurate. This deficient practice was observed for 4 of 46 residents reviewed, Resident #76, Resident #51, Resident #47, and Resident #27 and was evidenced by the following:</p> <p>1. On 1/4/24 at 11:27 AM, the surveyor observed Resident #76 in bed alert and responsive.</p> <p>The surveyor reviewed the Admission Record (one page summary of important information about a resident) (AR) for Resident #76. The resident was admitted to the facility with diagnoses that included but was not limited to End Stage Renal Disease; Major Depressive Disorder; Cognitive Communication Deficit and Muscle Weakness.</p> <p>A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated 11/21/23, reflected that Resident #76 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderately impaired cognition.</p> <p>On 1/9/24 at 12:35 PM, the surveyor reviewed the resident's PO in the electronic medical chart which revealed in red print indicating, Next Order Review: 11/1/23 - 70 days overdue.</p> <p>On 1/10/24 at 12:10 PM, the surveyor interviewed the Nurse Practitioner (NP) who worked in collaboration with the physician via a telephone call who stated that the PO must be reviewed and signed electronically every month. The NP further stated that she had not reviewed and signed Resident #76's PO.</p> <p>2. On 1/4/24 at 11:27 AM, the surveyor observed Resident #51 seated in the wheelchair right outside their room. The resident was alert and verbally responsive.</p> <p>The surveyor reviewed the AR for Resident #51. The resident was admitted to the facility with diagnoses that included but was not limited to Heart Failure; Alzheimer's Disease; Atherosclerotic Heart Disease, Type 2 Diabetes Mellitus and Morbid (Severe) Obesity.</p> <p>A review of the MDS, an assessment tool used to facilitate the management of care, dated 10/20/23, reflected that Resident #51 had a BIMS score of 5 out of 15, indicating severely impaired cognition.</p> <p>On 1/9/24 at 12:35 PM, the surveyor reviewed the resident's PO in the electronic medical chart which revealed in red print indicating, Next Order Review: 11/1/23 - 70 days overdue.</p> <p>3. On 1/8/24 at 1:04 PM, the surveyor observed Resident #47 in the day room seated in their recliner wheelchair. The resident was alert and responsive.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The surveyor reviewed Resident #47's hybrid medical records. The AR reflected that Resident #47 was admitted to the facility with medical diagnoses which included but were not limited to Metabolic Encephalopathy, Urinary Tract Infection, Unspecified Severe Protein-Calorie Malnutrition and Dysphagia.</p> <p>A review of the Significant Change in Status Assessment Minimum Data Set, an assessment tool used to facilitate the management of care, dated 11/29/23 reflected that the resident had a BIMS score of 00 out of 15 indicating that the resident had severely impaired cognition.</p> <p>On 1/9/24 at 12:35 PM, the surveyor reviewed the resident's PO in the electronic medical chart which revealed in red print indicating, Next Order Review: 11/1/23 - 70 days overdue.</p> <p>4. On 1/4/24 at 12:09 PM, the surveyor observed Resident #27 in bed with eyes closed.</p> <p>A review of the AR for Resident #27 reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Fracture Part of right clavicle; Nontraumatic intracerebral hemorrhage; Cognitive Communication Deficit, Dementia and Dysphagia.</p> <p>A review of the resident's MDS, an assessment tool used to facilitate the management of care dated 12/21/23, reflected that Resident #27 had a BIMS score of 00 out of 15, indicating severe cognitive impairment.</p> <p>On 1/9/24 at 12:35 PM, the surveyor reviewed the resident's PO in the electronic medical chart which revealed in red print indicating, Next Order Review: 11/1/23 - 70 days overdue.</p> <p>The surveyor reviewed the hybrid medical records (paper and electronic) for the residents listed above which revealed the resident's primary physician had not signed the Order Summary Reports (monthly physician's orders) located in the residents' chart. To clarify the documentation, there were no electronic or handwritten signatures under the PO.</p> <p>On 1/10/24 at 1:30 PM, the surveyor interviewed the facility's Regional Registered Nurse who stated that the physician must review and sign the PO electronically every month.</p> <p>On 1/10/24 at 2:15 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administrator and [NAME] President of Special Clinical Projects (VPSCP). The VPSCP stated that the physician's must electronically review and sign the PO monthly. There was no further information provided.</p> <p>NJAC 8:39- 23.2 (b)</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>39399</p> <p>Based on interview, and record review, it was determined that the facility failed to ensure that the responsible physician supervising the care of residents conducted face to face visits and wrote progress notes at least once every sixty days. This deficient practice was identified for 1 of 26, Resident #76, reviewed for physician visits and was evidenced by the following:</p> <p>1. On 1/4/24 at 11:27 AM, the surveyor observed Resident #76 in bed. When interviewed, Resident #76 was noted alert and responsive.</p> <p>The surveyor reviewed the Admission Record (one page summary of important information about a resident) for Resident #76. The resident was admitted to the facility with diagnoses that included but were not limited to End Stage Renal Disease; Major Depressive Disorder; Cognitive Communication Deficit and Muscle Weakness.</p> <p>A review of the Quarterly Minimum Data Set , an assessment tool used to facilitate the management of care, dated 11/21/23, reflected that Resident #76 had a Brief Interview for Mental Status score of 12 out of 15, indicating moderately impaired cognition.</p> <p>A review of the Physician's progress notes reflected the following:</p> <p>6/2/23 Physician progress notes completed by Advanced Practice Nurse (APN).</p> <p>7/25/23 Physician progress notes completed by APN.</p> <p>8/31/23 Physician progress notes completed by APN.</p> <p>9/28/23 Physician progress notes completed by APN.</p> <p>10/30/23 Physician progress notes completed by APN.</p> <p>11/30/23 Physician progress notes completed by APN.</p> <p>12/28/23 Physician progress notes completed by APN.</p> <p>There was no documented evidence that the physician visited and examined Resident #76 at least every 60 days.</p> <p>On 1/10/24 at 12:10 PM, the surveyor interviewed the APN who worked in collaboration with the physician via a telephone call. The APN informed the surveyor that the PO must be reviewed and signed electronically every month. The NP further stated that she had not reviewed and signed Resident #76's PO.</p> <p>On 1/10/24 at 2:15 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administrator and [NAME] President of Special Clinical Projects (VPSCP) who both stated that the Physician failed to conduct a face-to-face visit at least every 60 days.</p> <p>(continued on next page)</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>NJAC 8:39 - 23.2 (d)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>31656</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that expired and discontinued medications were removed from active inventory after it had expired and/or had been discontinued by the physician in accordance with professional standards of clinical practice. This deficient practice was identified for 2 of 2 units inspected involving Resident #6, #28, #36, #49, #66, #90, #260, #263, #265, #266, #268, #269 and #270,</p> <p>This deficient practice was evidence by the following:</p> <p>1. On 1/4/2024 at 11:47 AM, the surveyor inspected the [NAME] Unit Nursing Station. Inspection of the [NAME] Unit Nursing Station resulted in the absence of an Emergency Kit (designed to help nursing facilities provide medication to their residents during emergency situations). The [NAME] Unit Registered Nurse and Licensed Practical Nurse (LPN1) on the unit could not locate or explain why there was no required Emergency Kit on the unit when interviewed.</p> <p>2. On 1/4/2024 at 11:55 AM, the surveyor inspected the medication cart 3 (MC3) on the East Unit. The surveyor found an opened, actively used Humalog Kwik pen 100 units/ml delivered by the pharmacy on 11/21/23 and opened on 11/26/23. As per manufacturers recommendation, once opened the Humalog Kwik pen should be discarded after 28 days, 12/24/23.</p> <p>The surveyor inspected the East Unit refrigerator located in the medication room. The refrigerator thermometer read 28 degrees. A medication refrigerator should provide a stable temperature of between 36 and 46 degrees F.</p> <p>Within the refrigerator, the surveyor found an actively used and open bottle of Mucomyst/Acetylcysteine 20% Solution documented as opened on 12/21/23. The Mucomyst had a warning label from the pharmacy, Warning Discard Opened container after 96 hours. The documentation on the bottle did not include an opening time, only a date which meant that the Mucomyst had to be discarded sometime on 12/25/23.</p> <p>3. On 1/4/2024 at 12:07 PM, the surveyor noticed the East Unit LPN 2 on the unit holding a large plastic bag filled with medications. The surveyor approached LPN2 and asked about the large plastic bag filled with medication. At that point the Registered Nurse Infection Preventionist (IP) responded by explaining that LPN2 was removing discontinued medications from the medication cart.</p> <p>The surveyor inspected the medications in the plastic bag in the presence of the (IP) and found:</p> <p>a. Medication for Resident #6 found in the plastic bag was Fluticasone Furoate/Elipta Inhaler 100 mcg/25mcg, Albuterol HFA 90 mcg and Vitamin D3 50,000 units.</p> <p>Review of the facility medical records documented that Resident #6 was moved to another room on 11/30/23 and the medication was not moved but new medication was ordered from the pharmacy.</p> <p>b. Medication for Resident #28 found in the plastic bag was Livale 2mg (Cholesterol treatment.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility medical records documented that Resident #28 was discharged from the facility on 12/31/23.</p> <p>c. Medication for Resident #36 found in the plastic bag was Acetaminophen 650 mg Suppositories, Prochlorperazine 10 mg Clonidine Transdermal Patch 0.3 mg, and Hyoscyamine 0.125mg.</p> <p>Review of the facility medical records documented that Resident #36 was moved to another room on 11/30/23 and the medication was not moved but new medication was ordered from the pharmacy.</p> <p>d. Medication for Resident #49 found in the plastic bag was 2 Albuterol Sulfate HFA Inhalers 18 gm, Calcium Carbonate 648 mg, and Famotidine 40 mg.</p> <p>Review of the facility medical records documented that Resident #49 was discharged from the facility on 8/8/23.</p> <p>e. Medication for Resident #66 found in the plastic bag was Acyclovir 200 mg, Fluconazole 100 mg, Benzonatate 100 mg, Clonidine 0.1 mg, Magnesium Oxide 400 mg, and Calcium with Vitamin D 500/200.</p> <p>Review of the facility medical records documented that Resident #49 was discharged from the facility on 12/29/23.</p> <p>f. Medication for Resident #90 found in the plastic bag was Atrovent HFA Inhaler.</p> <p>Review of the facility medical records documented that Resident #90 was discharged from the facility on 12/29/23.</p> <p>g. Medication for Resident #260 found in the plastic bag was Mycophenolate 250 mg and Tacrolimus 1mg (both immunosuppressants).</p> <p>Review of the facility medical records documented that Resident #260 was discharged from the facility on 1/3/24.</p> <p>h. Medication for Resident #263 found in the plastic bag was Scopolamine 1 mg.</p> <p>Review of the facility medical records documented that Resident #263 was discharged from the facility on 12/18/23.</p> <p>i. Medication for Resident #265 found in the plastic bag was Albuterol Sulfate Inhaler 90 mcg.</p> <p>Review of the facility medical records documented that Resident #265 was discharged from the facility on 10/8/23.</p> <p>j. Medication for Resident #266 found in the plastic bag was Nitroglycerin 0.4 sublingual tablets.</p> <p>Review of the facility medical records documented that Resident #266 was discharged from the facility on 9/27/23.</p> <p>k. Medication for Resident #268 found in the plastic bag was Benzonatate 100 mg .</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility medical records documented that Resident #268 was discharged from the facility on 12/15/23.</p> <p>l. Medication for Resident #269 found in the plastic bag was Scopolamine Transdermal 1 mg patch.</p> <p>Review of the facility medical records documented that Resident #269 was moved to another room and the medication was not moved but new medication was ordered from the pharmacy.</p> <p>m. Medication for Resident #270 found in the plastic bag was Vancomycin 250 mg.</p> <p>Review of the facility medical records documented that Resident #270 was moved to another room and the medication was not moved but new medication was ordered from the pharmacy.</p> <p>4. On 1/5/24 at 9:47 AM, the surveyor observed the [NAME] Unit RN2 prepare medications for administration. The surveyor noticed a bottle of Aspirin Enteric Coated 81 mg which had an expiration date of 5/2023 located in Medication Cart 3.</p> <p>The surveyor then inspected Cart 1 located on the [NAME] Unit and found another bottle of Aspirin Enteric Coated 81 mg which had the expiration date crossed out with a black magic marker.</p> <p>The surveyor interviewed the RN2 who could not explain why these expired medications were in Cart 1 and Cart 3.</p> <p>Review of the monthly Consultant Pharmacist Unit Inspection Reports from June 7, 2023, to December 20, 2023, provided evidence that many medications were found expired or with discrepancies in labeling and removed from stock.</p> <p>Review of the Medication Labeling and Storage Policy documents, 3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. The policy adds, Multi-dose that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</p> <p>On 1/5/24 at 3:24 PM, the surveyor discussed the issues that related to expired and discontinued medications with the Registered Nurse VP Special Clinical Projects and Acting Licensed Nursing Home Administrator who could not explain or provide any further information related to the discrepancies found. The Registered Nurse VP Special Clinical Projects did explain that all medications should be removed from active use in the medication cart as soon as the medication is discontinued or the resident is discharged . She added that all expired medications should be removed from active use in the medication cart prior to their expiration date.</p> <p>NJAC 8:39-29.4(g)</p>		

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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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>44605</p> <p>Based on observation, interview, and record review, it was determined that the Consultant Pharmacist (CP) failed to clarify medication dosage for a newly admitted resident to the facility during the initial medication review for 1 of 1 Residents, Resident #21.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 1/4/24 at 11:16 AM, the surveyor interviewed Resident # 21 in the resident's room. The resident stated they had anxiety which they took the medication sertraline (Zoloft) and they had been receiving the incorrect dose. Resident #21 explained that prior to admission to the facility they were receiving 75 milligrams (mg) of sertraline and since admission to the facility had been receiving 50mg daily. The resident stated they noticed this about a week ago. Resident #21 reported to a staff member and had not heard anything since that time.</p> <p>The surveyor reviewed Resident #21's paper and electronic medical records which revealed the following:</p> <p>A review of the resident's Admission Record (an admission summary) documented that the resident was admitted to the facility with diagnoses that included but were not limited to: sepsis, anxiety, and muscle weakness.</p> <p>A Quarterly Minimum Data Set (an assessment tool used for the management of care) dated 11/24/24, documented the resident had a Brief Interview for Mental Status (BIMS) and scored a 15 out of 15, indicating that Resident #21 was cognitively intact.</p> <p>A review of the January 2023 Physician Orders (PO) included a PO dated 11/17/23 that read, Sertraline HCL Tablet 50 mg, Give 1 tablet by mouth one time a day for Anxiety.</p> <p>A review of the hospital records indicated the resident was receiving sertraline 75 mg during their hospital stay. An After Visit Summary a summary of Resident #21's hospital stay, included medication administered to the resident during the hospital stay and a discharge medication list. The After Visit summary documented that Resident #21 received Sertraline 50 mg tablet, dose: 75mg daily for Generalized Anxiety Disorder.</p> <p>A review of the initial medication review for Resident #21 by the CP read under Recommendations, 1. This [electronic CP] review is based on the information provided by the POS [Physician Order Summary], MAR [Medication administration Record]. Transfer Orders/ Medication discharge List not available at time of review. There was no documentation found of the sertraline medication.</p> <p>On 1/5/24 at 1:00 PM, the [NAME] President of Special Clinical Projects (VPSCP) provided the surveyor with the CP Service Agreement and the facility policy titled, Psychotropic Medication Use with an edited date of 2/2/2023.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the CP Service Agreement dated 12/11/08 read, .The Consultant shall be responsible for the guidance of the Facility's pharmaceutical care as follows: a. General supervision of the facility's procedures for the control and accountability for all medications and biologicals throughout the facility and that such medications and biologicals shall be approved and dispensed in compliance with federal and state laws and the facility's own policy and procedures. The agreement further documented, .The Facility shall be responsible for the following .c. Assure complete access by the Consultant to any and all records and supplies necessary to perform pharmaceutical care.</p> <p>A review of the Psychotropic Medication Use with an edited date of 2/2/2023 under the Policy Interpretation and Implementation read: 3. Residents, families and/or representative are involved in the medication management process .Psychotropic medication management includes .b. dose.</p> <p>On 1/09/24 at 11:45 AM, the surveyor interviewed the CP over the phone. The CP stated that a remote pharmacist would review the medications sent by the facility for new admissions if the CP is unable to come to the facility within 48 hours of admission. For new admissions, The CP explained the remote pharmacist reviews the hospital discharge medication list with medication dosages to make sure the medication from the hospital match what is order in the facility. The CP stated she would conduct on-site visits to review the resident's medications to ensure the physician orders and medications, including dosages, were correct. I look at the hospital transfer forms which includes the medication list as well. The CP further stated, if a discrepancy with the medication dosage was found, it would be reported to the nursing supervisor.</p> <p>The surveyor informed the CP about the concerns found with Resident #21's sertraline medication dosage. The CP stated she was not aware of the differing dosages and that the resident's discharge medication list was not available to the CP. The CP stated she only reviewed Resident #21's medications that were entered in the electronic medical record because the hospital discharge medication list was not available. The CP further stated in December of 2023, I saw the patient was evaluated by the psychologist and observed an ordered for 50mg Sertraline and I did not question the order. The CP in cases where the hospital medication list is not available, I just look at the medications entered by the MD and nurse.</p> <p>On 1/9/24 at 12:30PM, the surveyor made multiple attempts to interview the MD and Licensed Nurse Practitioner (LPN #1) who entered Resident #21's medication from the hospital. Both were unable to be reached. Voicemail messages were left by the surveyor. The surveyor did not receive a call back from the MD or LPN.</p> <p>On 1/11/24 at 10:53 AM, the surveyor met with the Licensed Nursing Home Administrator and the VPSCP. The VPSCP acknowledged the resident's sertraline medication dosage was incorrect. The VPSCP stated the process upon admission, was for a resident's medication regimen to be reviewed with the resident and physician. The physician's orders for medication were to be entered into the electronic medical record. The PO summary and the hospital medication list were to be faxed to the CP group to be reviewed. The VPSCP could not explain why the CP did not receive the resident's hospital discharge medication record. There was no further information provided by the facility.</p> <p>NJAC 8:39- 29.3 (a)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605</p> <p>Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as discard potentially hazardous foods in a manner to prevent food borne illness.</p> <p>This deficient practice was observed and evidenced by the following:</p> <p>On [DATE] 09:17 AM, the surveyor in the presence of the Culinary Director (CD), observed the following during the kitchen tour:</p> <ol style="list-style-type: none"> 1. On a storage shelf below Chef Preparation Table #3, the surveyor observed an opened one (1) gallon bottle of molasses with a label that read, use by [DATE]. 2. In the food preparation area, the surveyor observed dietary aide (DA) #1 with hair not fully restrained under their hairnet and DA #2 wore large, hooped earrings. <p>The CD stated, all dietary staff need to have their hair fully restrained under the hairnets and large hooped earrings were not allowed to be worn in the kitchen. The CD stated the bottle of molasses should have been discarded on [DATE].</p> <p>On [DATE] at 10:30 AM, the CD provided the surveyor facility policies titled, Food and Nutrition Services Department Employee Uniform Policy, with a revision date on [DATE] and Food Receiving and Storage, with a revised date of [DATE].</p> <p>The Food and Nutrition Services Department Employee Uniform Policy revealed under the Process section, 2. Jewelry will be kept to a minimum of wedding bands a non-dangling earring. This is to prevent contamination of the food hazards to employees during food preparation.</p> <p>The Food Receiving and Storage policy revealed under Dry Storage, foods are labeled, dated, and monitored so they are used by their use-by date or discarded.</p> <p>On [DATE] at 10:53 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and [NAME] President of Special Clinical Projects (VPSCP). The VPSCP acknowledged dietary staff should not wear large, hooped earrings and hair should be completely covered by a hairnet. The VPSCP also acknowledged the expired molasses found should have been discarded based on the use by date.</p> <p>NJAC 8;.d+[DATE].2(g)</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>31656</p> <p>Complaint #NJ00154940</p> <p>Complaint #NJ00150195</p> <p>Complaint #NJ00151010</p> <p>Refer to deficiencies F658, F755</p> <p>Based on observation, interview, record review, and review of facility provided documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey.</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/2021, Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21:</p> <p>Nurse Staffing Reports were completed by the facility for 4 distinct periods of time equaling 8 weeks in total. The weeks of 09/12/2021 ending 09/25/2021; 12/19/2021 and ending 01/01/2022 and 5/14/23 ending 5/27/23 were reviewed due to complaints filed for low staffing during these 2 periods. A third period was reviewed for the 2 weeks of staffing prior to the standard recertification survey from 12/17/23 ending 12/30/23.</p> <p>Staffing had been calculated for the following time frames and revealed the following:</p> <p>1. A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the 2-week period beginning 09/12/2021 and ending 09/25/2021 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 8 of 14 day shifts and 2 of 14 evening shifts.</p> <p>The facility was deficient in CNA staffing for residents on 8 of 14 day shifts and 2 of 14 evening shifts as follows:</p> <p>-09/12/21 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs.</p> <p>-09/12/21 had 6 CNAs to 15 total staff on the evening shift, required at least 7 CNAs.</p> <p>-09/13/21 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs.</p> <p>(continued on next page)</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-09/17/21 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs.</p> <p>-09/17/21 had 8 CNAs to 18 total staff on the evening shift, required at least 9 CNAs.</p> <p>-09/18/21 had 9 CNAs for 94 residents on the day shift, required at least 12 CNAs.</p> <p>-09/21/21 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.</p> <p>-09/22/21 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.</p> <p>-09/23/21 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.</p> <p>-09/25/21 had 7 CNAs for 91 residents on the day shift, required at least 11 CNAs.</p> <p>2. A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the 2-week period beginning 12/19/2021 and ending 01/01/2022 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 13 of 14 day shifts and 9 of 14 evening shifts.</p> <p>The facility was deficient in CNA staffing for residents on 13 of 14 day shifts and 9 of 14 evening shifts as follows:</p> <p>-12/19/21 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.</p> <p>-12/20/21 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.</p> <p>-12/20/21 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.</p> <p>-12/22/21 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs.</p> <p>-12/23/21 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs.</p> <p>-12/23/21 had 7 CNAs to 18 total staff on the evening shift, required at least 8 CNAs.</p> <p>-12/24/21 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs.</p> <p>-12/25/21 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs.</p> <p>-12/25/21 had 7 CNAs to 17 total staff on the evening shift, required at least 8 CNAs.</p> <p>-12/26/21 had 3 CNAs for 97 residents on the day shift, required at least 12 CNAs.</p> <p>-12/26/21 had 3 CNAs to 15 total staff on the evening shift, required at least 7 CNAs.</p> <p>-12/27/21 had 1 CNA for 97 residents on the day shift, required at least 12 CNAs.</p> <p>-12/27/21 had 5 CNAs to 14 total staff on the evening shift, required at least 7 CNAs.</p> <p>(continued on next page)</p>

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-12/28/21 had 1 CNA for 97 residents on the day shift, required at least 12 CNAs.</p> <p>-12/29/21 had 2 CNAs for 97 residents on the day shift, required at least 12 CNAs.</p> <p>-12/29/21 had 5 CNAs to 15 total staff on the evening shift, required at least 7 CNAs.</p> <p>-12/30/21 had 1 CNA for 103 residents on the day shift, required at least 13 CNAs.</p> <p>-12/30/21 had 5 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.</p> <p>-12/31/21 had 1 CNA for 103 residents on the day shift, required at least 13 CNAs.</p> <p>-12/31/21 had 6 CNAs to 17 total staff on the evening shift, required at least 8 CNAs.</p> <p>-01/01/22 had 3 CNAs for 103 residents on the day shift, required at least 13 CNAs.</p> <p>-01/01/22 had 4 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.</p> <p>3. A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the 2-week period beginning 5/14/23 and ending 5/27/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 10 of 14 day shifts.</p> <p>The facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows:</p> <p>-05/14/23 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -05/15/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs</p> <p>-05/16/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -05/18/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs.</p> <p>-05/20/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs.</p> <p>-05/21/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs.</p> <p>-05/23/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.</p> <p>-05/25/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.</p> <p>-05/26/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.</p> <p>-05/27/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs.</p> <p>4. A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the 2-week period beginning 12/17/23 and ending 12/30/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 12 of 14 day shifts.</p> <p>(continued on next page)</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows:</p> <ul style="list-style-type: none"> -12/17/23 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/18/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/19/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/20/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/21/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/22/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/23/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -12/24/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/25/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/26/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/28/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/29/23 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. <p>On 1/11/23 at 11:24 AM , the surveyor discussed the lack of required staff with the Registered Nurse VP Special Clinical Projects and Acting Licensed Nursing Home Administrator who did not provide any further information.</p> <p>NJAC 8:39-5.1(a)</p> <p>NJAC 8:39-27.1(a)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>46049</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for 1 of 22 residents reviewed (Resident #42).</p> <p>This deficient practice was evidenced by the following:</p> <p>On 1/5/24 at 11:02 AM, the surveyor observed Resident #42 in their room sitting in a reclining chair, watching television. The resident was awake, alert, and verbally responsive to simple questions.</p> <p>On 1/11/24 at 12:20 PM, the surveyor reviewed the hybrid (paper and electronic) medical records of Resident #42.</p> <p>According to the Admission Record (an admission summary), Resident #42 had diagnoses that included but were not limited to: Epilepsy, Type 2 Diabetes Mellitus, muscle weakness, dysphagia, and Chronic Obstructive Pulmonary Disease.</p> <p>A Quarterly Minimum Data Set (QMDS) assessment, a tool used to facilitate management of care, dated 12/18/23, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #42 scored 00 out of 15, which indicated the resident had severe cognitive impairment.</p> <p>A review of physician progress notes for Resident #42 found there were no physician progress notes documented by the resident's primary physician. The surveyor requested from the Regional Clinical Nurse to provide further information.</p> <p>On 1/12/24 at 12:39 PM, the Regional Clinical Nurse, in presence of Licensed Nursing Home Administrator (LNHA), stated they reached out to the resident's primary physician who was currently out of the country. The Regional Clinical Nurse stated the physician notes were in the physician's office and could not be faxed to the facility.</p> <p>The Regional Clinical Nurse and the LNHA acknowledged that the physician's documentation for the resident should be documented and stored in the resident's hybrid medical record. There was no additional documentation provided.</p> <p>A review of the facility's undated policy titled Physician Progress Notes, under Policy Interpretation and Implementation it read: 1. Physician progress notes are maintained for each resident residing in this facility . 3. The resident's Attending Physician must write, sign, and date the physician progress notes upon each visit .</p> <p>A review of the facility's undated policy titled Physician Visits, under Policy Interpretation and Implementation read: .5. The Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation .</p> <p>(continued on next page)</p>		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	N.J.A.C. 8:39-35.2(d)		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39399</p> <p>Based on observation, interview, it was determined that the facility failed to maintain proper infection control practices which was identified during dining observation and was evidenced by the following:</p> <p>On 1/9/24 at 12:28 PM, the surveyor observed a Certified Nursing Assistant (CNA) in the [NAME] Wing dining room and was holding a clear plastic bag. In addition the surveyor observed the CNA walking towards a resident who was eating their lunch. The CNA was observed touching the resident's meal tray and the resident's utensils while holding the clear bag.</p> <p>The surveyor interviewed the CNA who stated that the clear bag contained a dirty bib (food protector) for one of the residents who was also in the dining room. The CNA then placed the clear plastic bag on top of the bedside table in the hallway, sanitized her hands using an alcohol-based hand rub gel, took the soiled plastic bag and went to the dirty utility room to discard the bag.</p> <p>On 1/9/24 at 1:48 PM, the Administrator, and the Clinical Lead RN were made aware of the surveyor's observation. They both agreed that the CNA failed to adhere to infection control practices by holding a soiled bag while aiding a resident during lunch.</p> <p>NJAC 8:39-19.4 (a) (1) (2) (n)</p>		