STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315313	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Cresskill	221 County Road Cresskill, NJ 07626

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 0637 Level of Harm - Potential for minimal harm Residents Affected - Many	Assess the resident when there is a significant change in condition 38327 Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure that a Significant Change in Status Assessment (SCSA) was completed for Resident #53. This deficient practice was identified for one (1) of 20 residents reviewed, and was evidenced by the following: According to the CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, updated October 2024 showed: An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD (assessment reference date) must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill. On 10/16/24 at 10:50 AM, the surveyor observed Resident # 53's room door was closed, with a PPE (personal protective equipment) box hung outside the door and with a posted sign for EBP (Enhanced Barrier Precautions). A staff entered the resident's room and stated that the surveyor had to wait and come back later. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #53 as follows: According to the Admission Record (admission summary), Resident #53 was admitted to the facility with a diagnosis that included but was not limited to Parkinsonism (a disorder of the central nervous system that affects movement, often including tremors) unspecified, dementia in other diseases classified elsewhere with other behavioral disturbance, depression unspecified, and neuromuscular dysfunction of bladder unspecified. A review of the Physician Order dated 01/10/24 showed an order for hospice evaluation and treatment for end stage PKD (Polycystic kidney disease causes fluid-filled cysts in the kidneys, leading to kidney damage and failure). (continued on next page)

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

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Many	A review of the personalized care plan revealed a focus that the resident in hospice due to an end-stage disease that was created on 01/10/24. A review of the Progress Noted that was electronically signed by the Social Worker (SW) on 01/10/24 showed that SW completed the referral to hospice for evaluation during the stay. The resident's modified quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an ARD of 01/13/24 had a brief interview for mental status (BIMS) score of 03 out of 15 which reflected that the resident's cognitive status was severely impaired. The qMDS also reflected in Section O Special Treatments, Procedures, and Programs that the resident was coded for hospice care. On 10/18/24 at 9:47 AM, the surveyor interviewed the MDS Coordinator/Licensed Practical Nurse (MDSC/LPN) who informed the surveyor that the facility followed the RAI Manual with regard to MDS. The MDSC/LPN stated that a SCSA MDS will be done within eight days of the resident's enrollment with hospice care. At that time, the surveyor notified the MDSC/LPN of the above findings/concerns that there was no SCSA was done at the time the resident was enrolled and admitted to hospice care on 01/10/24. The MDSC/LPN stated that she would get back to the surveyor. On 10/18/24 at 12:55 PM, the MDSC/LPN in the presence of the survey team informed the surveyor that it was an oversight that the SCSA was not done in January 2024. The MDSC/LPN acknowledged that qMDS ARD 01/13/24 should have been a SCSA. On 10/18/24 at 01:02 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The surveyor notified the facility management of the above concerns and findings about MDS. On 10/21/24 at 8:15 AM, the surveyor interviewed the assigned Certified Nursing Aide (CNA). The CNA informed the surveyor that the resident was in hospice care. On 10/21/24 at 12:14 PM, the survey team met with the LNHA and DON. LNHA stated that the MDS ARD 01/13/24 should have been the SCSA and not a qMDS. On 10/22/24 at 12:25 PM, the survey team met with the LNHA, DON, and [NAME] President of Special Clinical Projects for an exit conference. The facility management did not refute the findings. NJAC 8:39-11.2(i)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49078 Based on observation, interview, record review, and review of pertinent facility documentation, 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, for two (2) of 20 residents, (Residents #15 and #53) reviewed for MDS accuracy, and was evidenced by the following: According to the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual October 2024, for Use Effective October 1, 2024, revealed: Section B: Hearing, Speech and Vision included Item Rationale. Health-related Quality of Life. Unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment. Coding Instructions: Code 0, adequate: No difficulty in normal conversation ., Code 1, minimal difficulty: Difficulty in some environments (e.g., when a person speaks softly or the setting is noisy) ., Coding Tips for Special Populations. Residents who are unable to respond to a standard hearing assessment due to cognitive impairment will require alternate assessment methods Section C Cognitive Patterns: Coding Tips o Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) . C0100: Should Brief Interview for Mental Status Be Conducted? Coding Instructions o Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Section J Health Conditions: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intent: The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the management of pain, the presence of pain, pain frequency, effect of pain on sleep, and pain interference with therapy and day-to-day activities. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF (Skilled Nursing Facility) care. 1. On 10/16/24 at 10:54 AM, Surveyor #1 (S#1) observed Resident #15 seated in a wheelchair (w/c) in their room with eyeglasses in use and stated that they were hard of hearing. The resident was able to answer and respond when asked how they were and if they had breakfast already. On 10/21/24 at 01:03 PM, Surveyor #2 (S#2) interviewed Resident #15. The resident was observed in their room seated in a w/c with a lunch meal tray. The resident stated that they feel ok, no complaints. S#2 asked the resident if they can hear the surveyor. The resident stated that it was a little difficult to hear when someone has a mask on, and they hear a little better if there was no mask. The surveyor asked if the resident has any hearing problems other times. The resident stated, yes, they do have some difficulty hearing at times. On 10/21/24 at 01:15 PM, S#2 interviewed the facility Assistant Administrator (AA). The AA stated she was familiar with Resident #15 who has been in and out of the facility several times. She also stated that the resident has some confusion and some hearing impairment. The AA stated the resident's family was discussing possible long-term placement. On 10/21/24 at 01:25 PM, S#2 interviewed the Certified Nursing Assistant (CNA) who cared for Resident #15. The CNA stated that the resident was confused often, but easily re-directable. The CNA also stated that the resident cannot hear well due to wearing a mask and she did not want to yell at the resident. On 10/21/24 at 01:30 PM, S#2 observed Resident #15 in the hallway in front of their room. The resident did not initially recognize the surveyor but did when re-introduced. The resident stated they could not hear the surveyor's questions very well in the hallway. On 10/21/24 at 01:44 PM, S#2 interviewed the facility MDS Coordinator/Registered Nurse (MDSC/RN). The surveyor asked the MDSC/RN who was the person who signed Resident #15's MDS. The MDSC/RN stated that the person was a per-diem, remote worker. MDSC/RN stated she did not know the first name or credentials of that remote MDS worker and to her knowledge was 100% remote and did not come into the building. The surveyor asked the MDSC/RN if the MDS dated [DATE] for Resident #15 was current and was it done remotely or in person interview. The MDSC/RN stated it was current and that it was done remotely and did not have any in-person interview from the remote MDS worker. The surveyor asked the MDSC/RN about Resident #15's hearing. The MDSC/RN stated she could not be sure if there was any hearing impairment or if it was related to the resident's cognitive (thinking, reasoning, remembering) ability. The surveyor reviewed Resident #15's hybrid medical record (paper and electronic) which revealed the following: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Record (AR; admission summary) reflected that Resident #15 was admitted to the facility with diagnoses that included but were not limited to urinary tract infection and atrial fibrillation (a rapid irregular heartbeat). The most recent comprehensive MDS ARD 8/05/2024, reflected under Section B200, Hearing, a zero (0) reflecting adequate hearing. The MDS also indicated under Section C, a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which reflected severely impaired cognition. The MDS also reflected that it was signed by remote MDS worker on 8/18/24 at 3:15 AM. The MDS Section Z reflected a completion date of 8/21/24. The resident's Care Plan (CP; relevant information about a patient's diagnosis, the goals of treatment) dated 8/04/24. The CP reflected a focus initiated 8/20/24 by the Social Worker (SW).has difficulty understanding/communicating relating to decline in cognitive status and hearing impairment. It also reflected an intervention dated 8/20/24 by the SW, Provide accommodation for hearing impairments for activity participation such as placing near speaker, written instructions, adaptive TV, etc. A Resident Evaluation nursing note dated 8/02/24, created 8/24/24 that reflected BIMS Score 1.0. On 10/22/24 at 9:58 AM, S#2 interviewed the MDSC/RN. The MDSC/RN stated that the quarterly and annual (comprehensive) MDS should be completed 7 days after the ARD and transmitted 14 days after the ARD. The MDSC/RN further stated that the lookback period (the time period over which the resident's condition or status is captured by the MDS assessment) for Sections B, C, and J in the MDS was seven days. The MDSC/RN also stated that for sections B, C, and J in the MDS, interview should be done. The surveyor asked the MDSC/RN if it would be appropriate to interview a resident at 3:15 AM. The MDSC/RN stated that if it was the resident's normal schedule to be awake at that time, yes, but generally no. On 10/22/24 at 10:29 AM, S#2 interviewed Resident #15's power of attorney (POA) by telephone. The POA stated that the resident had a hearing impairment for quite a while and had attempted to get hearing aids for the resident when resident was at home but were unsuccessful with resident compliance. On 10/22/24 at 11:42 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) and discussed the above findings. The facility management did not provide additional information. 38327 2. On 10/16/24 at 10:50 AM, S#1 observed Resident #53's room door was closed, with a PPE (personal protective equipment) box hung outside the door and with a posted sign for EBP (Enhanced Barrier Precautions). A staff entered the resident's room and stated that the surveyor had to wait and come back later. The surveyor reviewed the hybrid medical records of Resident #53 as follows: According to the AR, Resident #53 was admitted to the facility with a diagnosis that included but was not limited to Parkinsonism (a disorder of the central nervous system that affects movement, often including tremors) unspecified, dementia in other diseases classified elsewhere with other behavioral disturbance, depression unspecified, and neuromuscular dysfunction of bladder unspecified. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the most recent quarterly MDS (qMDS) with an ARD of 9/06/24 under Section B Hearing, Speech, and Vision, B0700 Makes Self Understood: Ability to express ideas and wants, consider both verbal and non-verbal expression was coded 2 (sometimes understood), B0800 Ability To Understand Others: Understanding verbal content, however able (with hearing aid or device if used) was coded 2 (sometimes understood). The 9/06/24 qMDS Section C Cognitive Patterns showed that the interview was not attempted and was coded as 0. A review of the qMDS with an ARD of 6/07/24 and Significant Change Status Assessment (SCSA) MDS with an ARD of 3/07/24 both reflected that resident was coded 2 (sometimes understood) on Section B and Section C was coded 0 (interview not attempted). On 10/18/24 at 9:47 AM, the surveyor interviewed the MDS Coordinator/Licensed Practical Nurse (MDSC/LPN) who informed the surveyor that the facility followed the RAI Manual with regard to MDS. The MDSC/LPN stated that MDS person assigned to do MDS for Section C should always attempt to interview the resident according to the RAI Manual. At that time, the surveyor notified the MDSC/LPN of the above findings/concerns that Resident #53's Section C of MDS interview was not attempted. The MDSC/LPN stated that she would get back to the surveyor. On 10/18/24 at 11:10 AM, the MDSC/LPN and the Director of Therapy (DOT) met with the surveyor. The MDSC/LPN stated that the resident's MDS most recent MDS in September 2024 was done by herself. The MDSC/LPN confirmed that the Section B was coded correctly that the resident was sometimes understood. The surveyor then asked the MDSC/LPN why the Section C interview was not attempted if the resident was sometimes understood. The MDSC/LPN stated that she will get back to the surveyor On 10/18/24 at 01:02 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above concerns and findings about MDS. On 10/21/24 at 12:14 PM, the survey team met with the LNHA and DON. LNHA stated that the staff should have attempted to interview the resident in Section C. On 10/22/24 at 12:25 PM, the survey team met with the LNHA, DON, and [NAME] President of Special Clinical Projects for an exit conference. The facility management did not refute the findings. NJAC 8:39-33.2 (d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38327 REPEAT DEFICIENCY Based on observation, interview, record review, and review of other pertinent facility provided documentation, the facility failed to follow the physician orders for one (1) of four (4) residents (Resident #61), by one (1) of four (4) nurses (Registered Nurse) observed during medication administration according to the standard of clinical practice. 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 10/21/24 at 7:38 AM, the surveyor observed the Registered Nurse (RN) in the South unit prepared and administered six medications (meds) to Resident #61. The following meds had the following orders in October 2024 electronic Medication Administration Record (eMAR) that the RN read during medication (med) administration observation: -Active Liquid Protein Sugar Free 15 GM (gram)/30 ML (milliliters) one time a day -Acidophilus Capsule Give 1 capsule by mouth one time a day for GI (gastrointestinal) -Losartan Potassium Oral Tablet (tab) 25 MG Give 1 tab by mouth one time a day for HTN (hypertension) hold SBP (systolic blood pressure) less than 100 mmHg (millimeters of mercury) -oxyBUTYnin Chloride ER (extended-release) Oral Tab 15 MG (Oxybutynin Chloride) Give 1 tab by mouth one time a day for bladder spasms -Ascorbic Acid Oral Tab 250 MG Give 2 tablets (tabs) by mouth two times a day for supplement 2 (two) 250 mg tabs=500 mg total dose -Divalproex Sodium ER Oral Tab 500 MG Give 1 tab by mouth three times a day for schizo affective disorder (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On that same date and time, the RN informed the surveyor that there was no available Ascorbic Acid 250 mg in the med cart. The RN stated that she had Ascorbic Acid 500 mg that she will administer to the resident because it was the same dose. She further stated that the order was to give two of 250 mg Ascorbic Acid but since she did not have the 250 mg, she could administer the one tab of 500 mg instead. After the med preparation, the RN entered the resident's room and administered the six meds including the Ascorbic Acid 500 mg one tab. The resident took all six meds whole with water. On 10/21/24 at 8:04 AM, the RN signed the eMAR and confirmed to the surveyor that she was done. The surveyor interviewed the RN regarding the Ascorbic Acid. The RN informed the surveyor that it was okay to administer the 500 mg even if the order was to give two tabs of 250 mg. The RN further stated that What I will do is to check if there was 250 mg tab available in the stock or call the doctor to change the order. On 10/21/24 at 12:14 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The surveyor notified the concern regarding Resident #61's med pass observation about Ascorbic Acid that the RN did not follow the physician order to give two 250 mg. On 10/22/24 at 11:42 AM, the survey team met with the LNHA and DON. The surveyor asked the facility management, what should had happened when there was no Ascorbic Acid 250 mg available according to the physician's order. The DON stated that the nurse should have called the doctor. A review of the facility's Administering Medications Policy with a revision date of April 2019 that was provided by the LNHA revealed: Policy Statement: Meds are administered in a safe and timely manner, and as prescribed. On 10/22/24 at 12:25 PM, the survey team met with the LNHA, DON, and [NAME] President of Special Clinical Projects for an exit conference. The facility management did not refute the findings. NJAC 8:39-11.2(b) 46049

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46049 Complaint # NJ177383 Based on observation, interview, record review and review of pertinent facility documents it was determined the facility failed to ensure a.) resident's plan of care was provided and followed during an acute change in condition, b.) the resident's request to be sent to the hospital was honored, and c.) a Registered Nurse obtained a physician's order prior to administering a medication to a resident in accordance with professional standards of clinical practice and the facility's policy and procedure for one (1) of 20 residents, Resident #50, reviewed for quality of care. 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 10/17/24 at 10:08 AM, the surveyor observed Resident #50 sitting in a wheelchair in their room. The resident was alert, verbally responsive, and had no concerns with their care in the facility. On 10/18/24 at 9:45 AM, the surveyor reviewed a Facility Report Event investigation for Resident #50 which revealed the following: An AAS-45 (Reportable Event Record/Report) dated 6/03/24 was submitted to the Department of Health (DOH) for an event that occurred approximately 6/01/24 at 11 PM. The resident reported to the nursing staff they thought they were having an allergic reaction. Registered Nurse #1 (RN#1) observed the resident was scratching their legs and noted welts and redness on their skin. The resident was unable to recall having anything unusual and reported taking their usual evening medications (meds). While RN#1 attempted to notify the physician Resident #50 used their call light and notified RN#1 they would like to go to the hospital. The resident was having shortness of breath (SOB) and administered their own epinephrine pen (epi-pen) which was noted to have positive results. The resident's condition remained stable, the physician responded to RN #1's call, was notified, and ordered PRN [as needed] Benadryl. The Director of Nursing (DON) was contacted on 6/03/24 by Resident #50's resident representative (RR) who had concerns of not being notified of the incident and the resident not being sent to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A grievance report initiated on 6/03/24 which detailed the RR's concern for Resident #50 not being sent out to the hospital. The investigation report summary included findings of the investigation and actions to be taken. The findings of the investigation detailed the Resident was noted to be in stable condition and the nurse did not feel hospital transport was warranted. The plan to resolve the complaint/grievance was in-service, education, disciplinary action. The grievance report documented Resident #50, and the RR were made aware of investigative findings and actions taken. RN#1 who was assigned to care for the resident on 6/01/24 on the 11 PM-7 AM shift and RN #2 who was assigned to care for the resident on 6/01/24 on the 3 PM-11 PM shift were suspended pending investigation findings. The investigation included a timeline, supportive documentation of the facility reviewing potential causes for the resident's allergic reaction, including medication (med), food, and environmental causes. Statements from the resident, the staff at the time of the incident, and the resident's physician were also obtained. The summary and conclusion of the facility's investigation determined there was no willful abuse or neglect that occurred. It detailed that RN#1 failed to obtain an order for the Benadryl med and administered it to the resident without a physician's order (PO) at the time. Additionally, RN #1 failed to notify the RR and the DON about the incident. Termination of RN#1 was to be recommended. Education in-service to the nursing staff was provided on responding to an emergency, self-administration of a med by a resident, resident rights, incident reports, and DON notification of events. A termination request form, dated 6/06/24 by the Licensed Nursing Home Administrator (LNHA), indicated a request to terminate RN #1 was initiated as RN#1 administered med out of her scope of practice and without a PO. Additionally, RN#1 failed to notify the DON about the resident's change in status and failed to comply with the resident's request to be sent out to the hospital. On 10/18/24 at 11:35 AM, the surveyor interviewed Resident #50 in their room regarding the incident in June 2024. Resident #50 did recall the incident, and stated they had redness, bumps and itchy arms. The resident called for the nurse. Resident #50 stated the nurse said she could give the resident Benadryl and the nurse left the room. Resident #50 stated they had many allergies, was very careful, and knew well when an allergic reaction was coming on, including the symptoms to look out for. The resident further explained they called the nurse a few minutes later as they felt the reaction was getting worse and reported to the nurse they wanted to go to the hospital. The resident stated they retrieved an epi-pen from their bag and self-administered the injection. The resident further explained they did not want to wait for the nurse to get the med from the crash cart and that they felt better after taking the med. On that same date and time, the surveyor asked the resident if the nurse administered anything to the resident. Resident #50 stated the nurse gave them Benadryl. The resident stated they did feel better after receiving the med but the stated the nurse did not send them to the hospital when they requested. The resident confirmed that after the facility was made aware of the concern they did investigate and discussed their investigative findings with them. Resident #50 stated that the nurse was no longer working at the facility. The surveyor reviewed the paper and electronic medical record (EMR) of Resident #50. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, osteomyelitis (infection in a bone), systemic lupus erythematosus (a disease that occurs when the immune system attacks health tissues and organs), and asthma. The resident had allergies to different meds, chemical agents, and food items which were listed in the resident's medical records. A comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/21/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #50 scored a 15 out of 15, which indicated the resident was cognitively intact. A review of the June 2024 Medication Administration Record (MAR) revealed: An order entry for Epinephrine injection solution 0.3 milligram (mg)/0.3 milliliter (ml) inject 0.3 mg intramuscularly as PRN for anaphylaxis (a severe allergic reaction) with a start date of 3/14/24. The med was signed as administered by RN#1 on 6/02/24 at 12:05 AM. An order entry for Diphenhydramine HCl [hydrochloride] 25 mg 2 tablet by mouth one time only for allergic reaction for 1 day total dose 50 mg with a start date and time of 6/02/24 12 AM. The med was signed as administered by RN#1 on 6/02/24 at 12:10 AM. A review of the PO revealed the one-time order for Diphenhydramine 25 mg 2 tablets was entered by RN#1 on 6/02/24 at 5:44 AM. A nurse progress note written by RN#1, dated and timed, 6/02/24 at 6:52 AM, documented the resident called around midnight reporting generalized itchiness, with redness and welts noted on the arm with vital signs taken and stable. The RN indicated a call to the physician was placed twice with no return call for a Benadryl order. The resident reported feeling SOB with epinephrine and Benadryl 50 mg tab being administered. The note also documented the interventions being effective and that the physician later returned the call, was informed of what occurred and approved of the interventions. The note did not indicate Resident #50's request to be transferred to the hospital. On 10/21/24 at 9:08 AM, the surveyor interviewed RN#1 over the phone regarding the incident. The RN no longer worked at the facility and recalled the incident. The RN recalled Resident #50 called the RN to the room and complained they were having an allergic reaction. The RN stated she assessed the resident and asked about possible causes including food the resident ate and the med the resident had taken. Resident #50 had welts on their arm and was scratching at them. The RN stated she called the physician for orders, checked the vital signs, monitored the resident, and then gave Benadryl to the resident. On that same date and time, the surveyor asked RN#1 about any other interventions and the PO for the epi-pen med for the resident. The RN stated the resident had self-administered it already from their personal belongings. The RN further explained that she monitored the resident and vital signs throughout the shift, the resident felt better after the med was administered and there were no further changes with the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that same time, the surveyor asked RN#1 if Resident #50 requested to go to the hospital. RN #1 replied that initially the resident stated they wanted to because the RN was not able to reach the physician. RN #1 stated she discussed it with the resident who had agreed to try the med first. Furthermore, the surveyor asked RN#1 when she spoke with the physician for the Benadryl order. RN #1 stated she spoke with the physician in the morning. The surveyor asked the RN about the specific time she spoke with the physician. The RN replied that she was not sure but that the order had the time it was entered into the EMR. The surveyor asked the RN if she had notified anyone else besides the physician about what had occurred. The RN stated that normally the DON would be called but she did not since the resident's condition was stable. The RN further explained she provided report to the incoming nurse at shift change and that the nurse manager was at the nurses' station during report. The surveyor asked the RN what happened afterward. The RN replied the facility called her about two days after the incident asking what happened and if the resident wanted to go to hospital. The RN stated she told them what happened and could not recall anything else about it. The surveyor asked the RN about her last day of work. The RN stated she worked the night after and then in the morning the facility called her to asked about what occurred. The RN stated she had resigned from her position, could not recall the exact date or any other details. On 10/18/24 at 01:05 PM, the surveyor, in the presence of the survey team, informed the LNHA and the DON about the concern of the nurse's response to the resident's request to go to the hospital and administering a med prior to obtaining an order by the physician. The LNHA confirmed the resident had a PO for an epi-pen as needed and that the resident self-administered an epi-pen from their personal belongings. The LNHA further explained that the facility did a thorough investigation to determine a potential cause for the reaction, worked with the resident and ruled out all causes. Resident #50 had lifelong allergies, was knowledgeable on symptoms, their meds, and what allergens to avoid. The LNHA stated that although the epi-pen was effective the resident wanted to go to hospital which was their right, and the nurse should have followed the appropriate procedure to transfer the resident to the hospital. Additionally, the nurse did not obtain the Benadryl med order from the physician and did not inform the DON of what had occurred. The nurse was suspended immediately, pending the outcome of the investigation. The LNHA also acknowledged that RN#1 should have followed the plan of care to administer the order for Epi-pen. At that same time, the LNHA stated there was a plan to terminate the nurse as she did not perform to the expectations of her responsibilities and that the RN resigned prior to termination. The surveyor asked what the expected response was for when a RN could not get in contact with a physician. The DON stated a nurse should call the medical director and if not then they could call the DON or LNHA. The surveyor reviewed the facility's policy titled Change in a Resident's Condition or Status with a last revised date of February 2021. Under Policy Statement it documented: The facility promptly notifies the resident, their attending physician, and the RR of changes in the resident's medical/mental condition and/or status. The surveyor reviewed the facility's policy titled Resident Rights with a last edited date of 5/30/24. Under Policy Interpretation and Implementation, it documented: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	These rights include the resident's right to: .e. self-determination .p. be informed of, and participate in, his or her care planning and treatment .s. choose an attending physician and participate in decision-making regarding his or her care . The surveyor reviewed the facility's policy titled Administering Medications with a revised date of April 2019. Under Policy Interpretation and Implementation, it specified, . 4. Medications are administered in accordance with prescriber orders, including any required timeframe . On 10/22/24 at 12:25 PM, the survey team met with the LNHA, DON, and [NAME] President of Special Clinical Projects for an exit conference. The facility management did not refute the findings. N.J.A.C. 8: 39-3.2 (a), (b); 4.1 (a)3; 27.1

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident's medication times were adjusted to accommodate their dialysis (a clinical purification of blood as a substitute for the normal function of the kidneys) schedule for one (1) of one (1) resident (Resident #26) reviewed for dialysis. This deficient practice was evidenced by the following: On 10/16/24 at 10:29 AM, the surveyor observed Resident #26 resting in bed. The resident was alert and verbally responsive. Resident #26 stated they were receiving physical therapy and went to dialysis. The resident had no concerns with their care. The surveyor reviewed the paper and electronic medical record (EMR) of Resident #26. The Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, end stage renal disease, and dependence on renal [kidney] dialysis. A comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/03/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #26 scored a 10 out of 15, which indicated the resident had moderate cognitive impairment. A physician's order (PO) dated 9/26/24 indicated the resident had dialysis every Monday, Wednesday, and Friday at a dialysis center with a chair time of 02:00 PM. A care plan with a focus related to dialysis, last revised on 10/16/24 included an intervention to administer medications (meds) per PO. A review of progress notes revealed the nurses documented that the resident returned to the facility from dialysis at 7:45 PM on 10/02/24 and 7:49 PM on 10/11/24. A review of September 2024 Medication Administration Record (MAR) revealed the following: An entry with a start date of 9/27/24 for tamsulosin (used in men to treat the symptoms of an enlarged prostate) 0.4 mg (milligram) oral capsule (cap), 1 cap by mouth in the evening was scheduled at 5 PM. An entry with a start date of 9/30/24 for metoprolol tartrate (blood pressure medication) 25 mg oral tablet (tab), 1 tab by mouth two times a day was scheduled for 8 AM and 5 PM. An entry with a start date of 9/30/24 for active liquid protein (supplement) sugar free 15 gram (gram)/30 ml (milliliters), three times a day 30 ml by mouth was scheduled for 9 AM, 1 PM, and 5 PM. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An entry with a start date of 9/27/24 for Humalog (diabetic medication) kwikpen (insulin lispro), inject as per sliding scale subcutaneously before meals was scheduled for 7:30 AM, 11:30 AM and 4:30 PM. An entry with a start date of 9/30/24 for metoprolol tartrate 25 mg oral tab, 1 tab by mouth two times a day was scheduled for 8 AM and 5 PM. On 10/17/24 at 10:12 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to care for the resident. The LPN stated that the resident had dialysis on Monday, Wednesday and Friday and would leave the facility for dialysis between 1 PM to 2 PM. The LPN could not speak to the time the resident would return from dialysis and stated there was a dialysis communication binder. The LPN provided the surveyor with the dialysis communication binder for Resident #26. A review of the dialysis communication book included forms titled Dialysis Progress Notes which consisted of two sections to be completed. The first section was filled out by the facility nurse sending the resident to dialysis including vital signs (blood pressure, heart rate, temperature, and respiratory rate) and note of any acute changes with the resident. The second section was to be completed by the dialysis center nurse including dialysis start and end time, pre and post weight for dialysis, and any concerns related to the resident. A review of the October 2024 dialysis progress notes revealed the resident's dialysis session ended after 6 PM which indicated the resident would not have returned from dialysis prior to that time. A review of the October 2024 MAR documented the nurses signing for meds administered at 4:30 PM and 5 PM. On 10/17/24 at 10:20 AM, the surveyor asked the LPN asked about meds administered. The LPN stated meds should be signed at the time of administration. The surveyor asked about the scheduling of meds for residents who received dialysis. The LPN stated it was expected for meds to be timed around a resident's dialysis session. The LPN further explained that if there was a medication (med) scheduled for when the resident was not in the facility, the nurse should call the physician to clarify the order. On 10/17/24 at 10:58 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who stated meds should be scheduled to accommodate a resident's dialysis session and if a med was scheduled during a resident's dialysis time the nurse was expected to call the physician to clarify the med order time. The surveyor informed the RN/UM about the concern for med timed when the resident was at dialysis. The RN/UM stated she would review the resident's medical record. On 10/17/24 at 11:07 AM, the surveyor interviewed the Director of Nursing (DON) who stated meds should be plotted around dialysis times and if there was a conflict the nurse should contact the physician to change the med time. The surveyor informed the DON of the concern in which the dialysis progress notes indicated Resident #26's dialysis session ended after 6 PM and med entries were signed at 4:30 PM and 5 PM were signed as administered. The DON stated he would review the resident's medical record to provide additional information. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 12:01 PM, the DON informed the surveyor that the nurses administered the meds when the resident returned from dialysis. The surveyor asked the DON if it was appropriate protocol for the nurse to administer and sign a med after its scheduled time. The DON did not provide a verbal response to the surveyor's question. On 10/18/24 at 8:55 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) the med administration report for the October 2024 MAR which would indicate the actual time of the meds' administration. On 10/18/24 at 9:15 AM, the LNHA provided the document titled Medication Admin Audit Report for [DATE] MAR. A review of the document revealed meds scheduled for 4:30 PM and 5 PM on dialysis days for the month of October were signed as administered after 7 PM. On 10/18/24 at 01:05 PM, the surveyor, in the presence of the survey team, informed the LNHA and DON about med times not being adjusted to accommodate when the resident with to their scheduled dialysis. The LNHA acknowledged the concern and stated education was being provided to staff with a QAPI (quality assurance performance improvement) being initiated as well. The LNHA provided the facility's dialysis policy with survey entrance documentation and confirmed that was the only dialysis policy. A review of the facility policy titled Hemodialysis Pre and Post Care with an effective date of January 2010. The policy did not address accommodating a resident's med times with dialysis sessions. A review of the facility's policy titled Administering Medications with a revised date of April 2019. Under Policy Interpretation and Implementation, it specified, . 4. Meds are administered in accordance with prescriber orders, including any required timeframe .7. Meds are administered within one (1) hour of their prescribed time, unless otherwise specified NJAC 8:39-27.1(a)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure a.) sufficient nursing staff and b.) call bells were answered timely for three (3) of three (3) residents (Residents # 11, #32, and 40) during the resident council meeting, and one (1) of one (1) resident (Resident #27) during an interview. This deficient practice was evidenced by the following: On 10/16/24 at 10:00 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) for an Entrance Conference meeting. The surveyor provided to the LNHA a copy of the facility's CASPER (the acronym for Certification and Survey Provider Enhanced Reporting system) Reports including the PBJ (Payroll-Based Journal (PBJ) was created by CMS [Centers for Medicare and Medicaid Services] as a method to collect auditable and verifiable staffing data from nursing facilities) Staffing Data Report. The PBJ report revealed: -FY (fiscal year) Quarter 3 2024 (April-June 30) -This Staffing Data Report identifies areas of concern that will be triggered (e.g., requires follow-up during the survey). -Metric: Excessively Low Weekend Staffing. Result: Triggered. Definition: Triggered-submitted weekend staffing data is excessively low. On 10/18/24 at 10:39 AM, the surveyor met with Residents #11, #32, and #40 in the main dining room for the resident council meeting. All residents informed the surveyor that they attended the resident council meeting monthly, and that facility management was present during the meeting. On that same date and time, Resident #11 stated that the 3-11 and 11-7 shifts were short of staff, the call bell was not answered timely, and they had to wait for more than 15 minutes. Resident #11 also stated that the call light was on the whole time. The resident further stated that it had been going and the most recent it happened was last night (10/17/24 at 3-11 and 11-7 shifts). The resident claimed that last night there were two aides in the unit (North) and it affected the call bell response due to short staff. At that same time, Resident #40 informed the surveyor that it also happened to the resident that the resident had to wait for an hour for the call bell to be answered on the 11-7 shift, which happened two weeks ago. The resident was unable to state the exact date. The resident further stated I'm not sure but I think there were only two aides at that time which affected the call bell response time. Also, Resident #32 stated that it sometimes 15 minutes to wait for the response to the call bell at night and evening. The resident also stated that in the day shift, depending on how busy, someone was there in five minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/18/24 at 01:02 PM, the survey team met with the LNHA and Director of Nursing (DON). The LNHA stated that there was no way for us to check how long the call bell system was on. The LNHA further stated that when residents complained we did have grievances, weekly audits were done by the manager on duty, and the facility had audit sheets. The surveyor asked for grievance reports about call bells and the audit for the last four months. On 10/21/24 at 6:14 AM, the surveyor went to the South Unit (SU) and interviewed Registered Nurse #1 (RN#1). RN#1 informed the surveyor that she was the nurse for the 11-7 shift, the census (total number of residents) was 33, one RN (herself) and there was no other nurse in the unit for the 11-7 shift. The RN stated that usually there were two nurses. She further stated that there were two Certified Nursing Aides (CNA) last night that worked, CNA#1 and CNA#2 for the 11-7 shift, and usually there were three CNAs. The RN showed the schedule of the 11-7 shift and revealed: -Date 10/20/24 Sunday 11 PM to 7 AM -CNA#1 total of 19 residents -CNA#2 total of 17 residents On 10/21/24 at 6:24 AM, the surveyor observed CNA#2 in the hallway came out from room [ROOM NUMBER]P, Resident #142's room with a big plastic bag of used towels and gowns. The surveyor interviewed CNA#2. The CNA informed the surveyor that there were 30 something residents in the SU and there were two CNAs.CNA#2 stated that usually there were three CNAs for the 11-7 shift. She further stated that she had 17 residents this 11-7 PM shift. On that same date and time, the CNA stated that she was not aware of the New Jersey (NJ) mandated law for staffing ratio for the 11-7 shift. She acknowledged that it was hard to have 17 residents and that we get used to it. The CNA further stated that she changed residents in her assignments at least two to three times per shift depending on the residents. On 10/21/24 at 6:29 AM, the surveyor went to the North Unit (NU). The surveyor interviewed the Licensed Practical Nurse (LPN) who claimed that she was one of the nurses at the NU for the 11-7 shift. The LPN informed the surveyor that there were two nurses, herself, and RN#2, the census was 49, and there were three CNAs. On 10/21/24 at 6:31 AM, the surveyor interviewed CNA#3 who was assigned to NU. CNA#3 informed the surveyor that he had 17 residents in the 11 PM-7 AM shift. The CNA was not aware of the NJ mandated staffing law. On 10/21/24 at 6:35 AM, RN#1 informed the surveyor that the census at the SU was not 33 but 34. On 10/21/24 at 6:42 AM, the DON provided a copy of the NU assignment and revealed: -Date 10/20/24 Sunday 11 PM to 7 AM -CNA#3 total of 17 residents -CNA#4 total of 16 residents (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA#5 total of 16 residents On 10/21/24 at 12:14 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the concern with the facility's PBJ that was provided to the LNHA during an Entrance Conference meeting on 10/16/24 that showed very low weekend staffing. The surveyor also notified the facility management of the concerns with short staffing during the resident council meeting that affected the call bell response. A review of the provided copies of 3-11 and 11-7 shifts CNA Assignments for NU and SU from 10/16/24-10/20/24 revealed: NU 3-11 shift: 10/16/24=4 CNAs [CNA#6 with 13 residents, CNA#7 with 13 residents, CNA#8 with 12 residents, CNA#5 with 12 residents] 10/17/24=4 CNAs [CNA#6 with 12 residents, CNA#7 with 12 residents, CNA#10 with 12 residents, CNA#5 with 11 residents] 10/18/24=4 CNAs [CNA#6 with 12 residents, CNA#7 with 12 residents, CNA#11 with 12 residents, CNA#5 with 11 residents] 10/19/24 (Saturday)=4 CNAs [CNA#10 with 12 residents, CNA#8 with 12 residents, CNA#12 with 12 residents, CNA#9 with 12 residents] 10/20/24 (Sunday)=4 CNAs [CNA#13 with 12 residents, CNA#7 with 12 residents, CNA#14 with 12 residents, CNA#5 with 12 residents] NU 11-7 shift: 10/16/24=3 CNAs [CNA#3 with 17 residents, CNA#4 with 17 residents, CNA#9 with 17 residents] 10/17/24=3 CNAs [CNA#9 with 17 residents, CNA#4 with 16 residents, and CNA#5 with 16 residents] 10/18/24=3 CNAs [CNA#3 with 17 residents, CNA#9 with 16 residents, and CNA#5 with 16 residents] 10/19/24 (Saturday)=3 CNAs [CNA#3 with 17 residents, CNA#4 with 17 residents, and CNA#9 with 16 residents] 10/20/24 (Sunday)=3 CNAs [CNA#3 with 17 residents, CNA#4 with 16 residents, and CNA#5 with 16 residents] South 3-11 shift: 10/16/24=3 CNAs [CNA#15 with 12 residents, CNA#14 with 13 residents, CNA#16 with 9 residents] 10/17/24=4 CNAs [CNA#17 with 8 residents, CNA#18 with 8 residents, CNA#11 with 7 residents, CNA#14 with 9 residents] (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Cresskill	221 County Road Cresskill, NJ 07626

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/18/24=4 CNAs [CNA#15 with 9 residents, CNA#18 with 5 residents, CNA#14 with 7 residents, CNA#16 with 8 residents] 10/19/24 (Saturday)=3 CNAs [CNA#15 with 12 residents, CNA#20 with 12 residents, CNA#21 with 12 residents] 10/20/24 (Sunday)=4 CNAs [CNA#15 with 10 residents, CNA#12 with 10 residents, CNA#20 with 6 residents, CNA#17 with 9 residents] South 11-7 shift: 10/16/24=2 CNAs [CNA#1 with 17 residents and CNA#2 with 16 residents] 10/17/24=2 CNAs [CNA#1 with 17 residents and CNA#2 with 18 residents] 10/18/24=2 CNAs [CNA#19 with 18 residents and CNA#2 with 18 residents] 10/19/24 (Saturday)=2 CNAs [CNA#1 with 18 residents and CNA#12 with 17 residents] 10/20/24 (Sunday)=2 CNAs [CNA#1 with 19 residents and CNA#2 with 17 residents] A review of the provided Nursing Home Resident Care Staffing Report by the LNHA for date 10/20/24 showed: Day shift 7-3 PM: census 89, 1 RN:29.7 Residents, 1 LPN:29.7 Residents, 1 CNA:11.1 Residents [3 RNs, 3 LPNs, 8 CNAs] Evening Shift 3-11 PM: census 89, 1 RN:44.5 Residents, 1 LPN:22.3 Residents, 1 CNA:11.1 Residents [2 RNs, 4 LPNs, 8 CNAs] Night Shift 11-7 AM: census 89, 1 RN:44.5 Residents, 1 LPN:89 Residents, 1 CNA:17.8 Residents [5 RNs, 1 LPNs, 5 CNAs] A review of the provided Complaint/Grievance Report (grievance binder) of the LNHA revealed: -On 9/14/24 Resident #43 reported verbally to the Social Worker an hour waiting for a call light response to transfer from the wheelchair into the bed. -On 10/16/24 Resident #147 reported verbally to the Director of Rehabilitation that resident felt it takes over an hour for the call light to be answered. The surveyor reviewed the Minimum Data Set (MDS) of the above residents and showed: -Resident #11's 5-Day MDS with an assessment reference date (ARD) of 10/14/24 showed a brief interview for mental status (BIMS) score of 15 out of 15 which reflected that the resident had intact cognition. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #27's comprehensive MDS (cMDS) ARD of 9/27/24 BIMS score of 15 out of 15 that showed the resident was cognitively intact. -Resident #32's cMDS ARD of 9/04/24 BIMS score of 14 out of 15 that showed the resident was cognitively intact. -Resident #43's cMDS ARD of 9/15/24 BIMS score of 15 out of 15 that showed the resident was cognitively intact. -Resident #147's cMDS ARD of 7/11/24 BIMS score of 15 out of 15 that showed the resident was cognitively intact. On 10/22/24 at 8:28 AM, the surveyor interviewed the LNHA. The surveyor asked the LNHA if she was aware of the NJ mandated law. The LNHA stated yes, day shift 1 CNA:8 residents, evening 1 CNA:10 residents, and night 1 CNA:14 residents. The surveyor asked if the facility met the requirements for the NJ mandated staffing law, especially on the weekends. The LNHA stated We tried very hard to meet the requirements. The LNHA further stated that she knew the facility did not meet the requirements. On 10/22/24 at 11:30 AM, the surveyor interviewed Resident # 27. The resident informed the surveyor that the call bell response was still an issue because last night at the 3-11 shift, the resident put the call light on, and it was 20 minutes until it was responded. On 10/22/24 at 11:42 AM, the survey team met with the LNHA and DON. The LNHA stated that the DON provided an in-service for the above-mentioned CNAs who were not aware of the staffing ratio. On 10/22/24 at 12:11 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of Residents #11, #27, #32, and #40's concern regarding the call bell response due to a shortage of staff. A review of the facility's Staffing, Sufficient, and Competent Nursing Policy with a revision date of August 2022 that was provided by the LNHA revealed: Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessments. Policy Interpretation and Implementation: Sufficient Staff . 8. Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing . A review of the facility's provided Facility Assessment Tool with a date of assessment 7/24/24 by the LNHA revealed: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose: To determine what resources are necessary to provide ongoing care for our resident population during regular 24/4/365 operations and during emergencies based on the specific needs of our residents . Part 3: Facility resources needed to provide competent support and care for our resident population every day and during emergencies. 3.1 Based on the above information and programming goals, a staffing plan has been developed to meet the professional, technical, and administrative needs of the center .The approach takes into consideration both the type of staff and number of staff required for each unit, including nights and weekends. The plan is customizable and updated with changes in staffing, census, occupancy, and specialty needs such as 1:1. Staffing by shift must consider staffing needs for each resident unit in the facility as well as each shift . On 10/22/24 at 12:25 PM, the survey team met with the LNHA, DON, and [NAME] President of Special Clinical Projects for an exit conference. The facility management did not refute the findings. NJAC 8:39-25.2(a,b)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38327 Based on interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain accurate medical records. This deficient practice was identified for two (2) of the 20 residents reviewed (Residents #4 and #66). This deficient practice was evidenced by the following: 1. On 10/16/24 at 11:12 AM, the surveyor observed Resident #4 seated in a wheelchair with hoyer pad underneath, with a visitor at the bedside. The resident and the visitor both stated that there were no concerns with care. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #4 as follows: According to the Admission Record (AR; admission summary), Resident #4 was admitted to the facility with a diagnosis that included but was not limited to noninfective gastroenteritis (an illness triggered by the infection and inflammation of the digestive system) and colitis (an inflammatory reaction in the colon, often autoimmune or infectious) unspecified, muscle weakness (generalized), other abnormalities of gait and mobility, primary generalized (osteo)arthritis, and depression. The resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 9/25/24 had a brief interview for mental status score of 11 out of 15 which reflected that the resident's cognitive status was moderately impaired. A review of the Physician/Practitioner Progress Note (PN) from July through October 2024 showed that the resident's current medications (meds) included but were not limited to Valacyclovir (an antiviral medication used for treating infections caused by herpes viruses, including genital herpes, cold sores, and shingles (herpes zoster) in adults) 1 gram (gm) oral tablet (tab) by oral route 3x/day (three times per day). A review of the Order Summary Report revealed a physician's order (PO) for Valacyclovir HCL (hydrochloride) oral tab 1 gm, give one tab by mouth 3x/day for shingles for 7 days. The order date was 6/21/24 and the end date was 6/28/24 (completed). The above order for Valacyclovir was transcribed into the June 2024 electronic Medication Administration Record (eMAR), signed as administered by nurses from 6/21/24 through 6/28/24. Further review of July, August, September, and October 2024 eMAR revealed that there was no PO for Valacyclovir. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/24 at 01:02 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The surveyor notified the facility management of the above concerns and findings. The LNHA stated that it was the responsibility of the physician to have accurate documentation in the PN including the accurate meds of the resident. On 10/21/24 at 12:14 PM, the survey team met with the LNHA and DON. LNHA stated that the physician clarified the Valacyclovir documentation in the PN and that the medication (med) was discontinued (d/c) on 6/28/24. 2. On 10/18/24 at 9:05 AM, the surveyor observed the Licensed Practical Nurse (LPN) in the South unit prepared meds to be administered to Resident #66. The LPN verified the PO in the eMAR and reflected Special Instructions: Fluid restriction 1L (one liter). /day takes meds whole with water. On that same date and time, the surveyor interviewed the LPN after med administration. The surveyor asked the LPN how she knew how much fluid to give to Resident #66 during her shift according to the special instructions in the eMAR. The LPN checked the eMAR again and confirmed the special instructions written in the eMAR. The LPN further stated that there was no accountability in the eMAR per shift fluids the resident was allowed to drink for the resident to have 1L/day. On 10/18/24 at 9:27 AM, the surveyor notified the Registered Nurse/Unit Manager (RN/UM) in the presence of the LPN about the above findings and concerns. Both the RN/UM and LPN had no answer as to why there were special instructions for fluid restrictions and no specifics about how the nurses would follow the special instructions. The RN/UM stated she would have to check. The surveyor reviewed the hybrid medical records of Resident #66 and showed: The AR reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to a syndrome of inappropriate secretion of antidiuretic hormone (SIADH; is a condition in which the body makes too much antidiuretic hormone) and Parkinson's Disease (is a movement disorder of the nervous system that worsens over time) without dyskinesia, without mention of fluctuations. According to the Clinical PO, the orders revealed: -Fluid restriction of 1000 ml (milliliters)/day Nursing: 400 ml, Dietary: 600 ml, 7-3 shift: 160 ml, Breakfast: 240 ml, 3-11 shift 120 ml, Lunch: 120 ml, 11-7 shift: 120 ml, Dinner: 240 ml. The order date was 6/27/24 and the end date (d/c date) was 7/01/24. On 10/18/24 at 01:02 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above findings and concerns regarding Resident #66's fluid restrictions. The DON stated that there was no order for fluid restrictions, and it was only special instructions. The DON further stated that the order for fluid restrictions was previously d/c. The surveyor asked the facility management what they expected the nurse to do if there were special instructions like fluid restrictions and the order was d/c. The DON responded that the expectation was for the nurse to verify the order or instructions for fluid restrictions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 11:42 AM, the survey team met with the LNHA and DON. The DON stated that the special instructions, all nurses have access to resident profile on the electronic medical records care profile of the resident. The surveyor then asked the DON if the special instructions in the resident's profile were considered part of the resident's medical records. The DON stated yes it's part of the resident's medical records. A review of the facility's Charting and Documentation Policy with a revision date of July 2017 that was provided by the LNHA showed: Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation: 3. Electronic entries that are auto filled or auto prompts must be reviewed and updated when more current information is available or required; or accepted as is after review . 5. Documentation in the medical record will be objective, complete, and accurate . On 10/22/24 at 12:25 PM, the survey team met with the LNHA, DON, and [NAME] President of Special Clinical Projects for an exit conference. The facility management did not refute the findings. NJAC 8:39-23.2 (a)(b); 35.2 (c)(d)(6)(g)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for two (2) of nine (9) staff (two Licensed Practical Nurses [LPN]), b.) follow appropriate infection control practice during the medication and treatment pass observations for two (2) of six (6) nursing staff (one LPN and one Registered Nurse), and c.) follow isolation precautions for a resident who was on Transmission Based Precautions (TBP) by one (1) of one (1) Housekeeping (HK) staff for Residents #77 to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. According to the CDC guidelines dated 4/02/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) included information for EBP (enhanced barrier precautions) when to use PPE during high contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use for EBP include: Dressing . Providing hygiene Wound care Changing linens . Device care or use: central line, urinary catheter, . Implementation (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When implementing Contact Precautions or EBP, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) . 1. On 10/16/24 at 10:00 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) for an entrance conference. The LNHA informed the surveyor that the facility was still in a COVID-19 (an infectious disease caused by the SARS-CoV-2 virus) outbreak. On that same date and time, the LNHA informed the surveyor that residents with openings in their bodies like wounds, catheters, and tube feedings were on EBP. She also stated that it was an expectation that staff and visitors would wear a surgical mask in the facility, and complete PPE (masks, gowns, gloves, and eye protection) when entering a COVID-19 room. She further stated that in EBP rooms, the staff and visitors were expected to wear complete PPE when providing direct care to the resident. On 10/18/24 at 8:00 AM, the surveyor observed LPN#1 during medication (med) administration of Resident #139. Before med administration, LPN#1 obtained the resident's vital signs (v/s; measurements of the body's most basic functions) with bare hands. The surveyor observed the LPN touched the resident's immediate environment (bed) and the resident's left arm. The LPN did not perform hand hygiene after direct contact with the resident and the resident's environment, took gloves from the resident's toilet room, and donned (put on) gloves without performing hand hygiene. The LPN with gloves disinfected the blood pressure (BP) cuff and oxygen (O2) saturation (sat) machine. On 10/18/24 at 8:45 AM, LPN#1 asked Resident #139 if okay to take the resident's BP again and the resident agreed. The resident was seated at that time. The LPN with bare hands obtained the resident's BP on the resident's left arm which read BP: 159/67 and HR (heart rate): 68. The surveyor observed LPN#1 did not perform hand hygiene after direct contact with the resident's table, the resident's clothing, and the left arm, and immediately took gloves from the resident's toilet room and donned gloves to her right hand. The LPN with the right-hand glove disinfected the BP cuff. On that same date and time, the surveyor interviewed LPN#1 about hand hygiene. The LPN stated that she should perform hand hygiene after direct contact with the resident and the resident's environment. She further stated that she should perform hand hygiene before and after donning and doffing (taking off) gloves or PPE. At that time, the surveyor notified the LPN of the concerns and observations that the LPN did not perform hand hygiene twice when the LPN checked the resident's BP. The LPN stated that she should have washed her hands. 2. On 10/18/24 at 9:05 AM, the surveyor observed LPN#2 during med administration of Resident #66. After med administration, LPN#2 did not perform hand hygiene after direct contact with the resident's table, resident's clothing, and before exiting the resident's room. The LPN immediately signed the electronic Medication Administration Record (eMAR), pushed her med cart in front of the nursing station, and completed med administration without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, the surveyor interviewed LPN#2 about hand hygiene. The surveyor also notified the LPN of the above observation and concerns regarding hand hygiene. The LPN stated that she should have washed her hands. On 10/18/24 at 01:02 PM, the survey team met with the LNHA and Director of Nursing (DON). The surveyor notified the concerns with med pass observations of LPN#1 and LPN#2 for hand hygiene and PPE use. 3. On 10/21/24 at 6:43 AM, the surveyor asked LPN#3 if the surveyor could observe her with med administration and the LPN agreed. LPN#3 went inside room [ROOM NUMBER] and took Resident #75's BP, temperature (temp), and O2 sat with the use of the v/s equipment in the cart that she brought inside the room. The LPN did not disinfect the v/s equipment after use with Resident #75 and immediately took it to the next bed. At that time, LPN#3, with the use of the same v/s equipment, the LPN obtained Resident #76's BP, temp, and O2 sat. Resident #76 held the thermometer with bare hands and tried to stop the LPN from obtaining their temp. Afterward, outside the room, LPN#3 used the ABHR for hand hygiene, donned gloves and disinfected the O2 sat, doffed off gloves, and used the ABHR. The LPN did not disinfect the thermometer. On 10/21/24 at 6:55 AM, LPN#3 entered the v/s of Residents #75 and #76 in the electronic medical records, checked the eMAR, and stated to the surveyor that there were no medications (meds) due at this time for both residents. At this time, the surveyor asked LPN#3 about hand hygiene and cleaning of v/s equipment. The surveyor asked the LPN if she should disinfect the v/s equipment in between uses, and the LPN stated yes, and that she should have disinfected the O2 sat machine and thermometer in between uses and that she forgot and stated, I think I skipped that. She acknowledged that Resident #76 touched the thermometer and that she should have cleaned it. 4. On 10/21/24 at 9:11 AM, the surveyor observed Registered Nurse #1 (RN#1) perform wound treatment with the help of RN#2 to Resident #65. The resident's room had a posted sign for EBP, and a PPE box hung outside the resident's door. The surveyor observed: At 9:21 AM, RN#1 proceeded to prepare all supplies: 4x4 gauze, NSS (normal saline solution), cotton sticks, disposable blue liner, border gauze, two plastic cups, a black marker which the RN previously disinfected, and meds: Santyl (ointment is used to remove damaged tissue from chronic skin ulcers and severely burned areas) in 30 ml (milliliters) cup in a green basket. RN#1 placed in one of the plastic cups disinfecting wipes that she took from the blue top disinfecting (germicidal bleach wipes) container that showed three minutes of contact time and the RN entered the resident's room. The disinfecting wipes were exposed to air. The RN performed hand hygiene in between resident's wound care. At 9:36 AM, RN#1 cleaned the table that was used for wound treatment with the use of disinfecting wipes that were previously removed from the container. The surveyor observed the table was not totally wet (some areas on the table were dry) when RN#1 wiped the table. The disinfecting wipes were exposed to air for a total of 15 minutes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:41 AM, outside the resident's room, RN#1 stated that she was finished. The surveyor interviewed RN#1 in the nursing station and asked about the disinfecting wipes. RN#1 stated that she took from the blue top container wipes that she used to disinfect the table after the treatment which she usually does. RN#1 acknowledged the three-minute contact time of the disinfecting wipes. The surveyor notified the concern that it was not wet in the surrounding area of the table when she wiped it. The RN stated that she could not bring the whole container of the disinfecting wipes inside the room which was why she had to remove it from the canister prior to entering the resident's room. On 10/21/24 at 12:14 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above findings and concerns about disinfecting the table and v/s equipment. The surveyor also notified the facility management of the concern during the wound treatment observation of Resident #65 done by RN#1 with the use of disinfecting wipes that were exposed to air for a total of 15 minutes. On 10/22/24 at 11:42 AM, the survey team met with the LNHA and DON. The DON stated that the nurse should have cleaned the v/s apparatus in between residents. The DON also stated that education was provided to the RN that disinfecting wipes should retained in the canister until being used. A review of the facility's Dressings, Dry/Clean Policy with a revision date of September 2013 that was provided by the LNHA showed: Steps in the Procedure: 22. Clean the bedside stand . A review of the disinfecting wipes [germicidal bleach wipes] with three minutes kill time (contact time; how long a disinfectant must stay wet on a surface to do its job effectively) copy that was provided by the LNHA revealed: Storage and Disposal: Keep this product in a tightly closed canister, when not in use . Directions for use: 1. Always use PPE. 2. Visible soil must be removed from surfaces prior to disinfecting. 3. Open bleach germicidal bleach wipes canister. 4. Remove premoistened 6x5 wipe. 5. Apply the saturated towelette and wipe desired surface to be disinfected .Reapply as necessary to ensure that the surface remains visibly wet for the entire contact time. 6. Allow surface to dry and discard use wipe and empty canister. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315313	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Cresskill	221 County Road Cresskill, NJ 07626

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Handwashing/Hand Hygiene Policy with edited date of 3/18/24 that was provided by the LNHA showed: Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task; c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. 48423 5. On 10/16/24 at 10:50 AM, during the initial tour, the surveyor observed there was a pink colored STOP-ISOLATION sign at Resident #77's door. The signage indicated Staff and Providers MUST: Clean hands, put on gown, N95 Respirator, Eye protection and gloves. There was also an isolation supply equipment bag hanging on the door with PPE. On 10/18/24 at 9:58 AM, the surveyor observed the HK staff wearing a N95 mask, gown and gloves before entering in Resident #77's room. The HK staff was not observed wearing an eye protection as the sign on the resident's door indicated was to be worn while inside the room. At 10:08 AM, the surveyor conducted an interview with the HK staff upon exiting Resident #77's room. The HK staff acknowledged that he did not have eye protection on when he entered into Resident #77's room. The HK staff stated we need full PPE including gown, gloves, N95 mask and glasses/face shield before entering into this room because the resident had [COVID] infection and I don't want to get infection. The HK staff further stated that I should have put the goggles before I went to clean this room. During an interview with the surveyor on 10/18/24 at 10:27 AM, the Registered Nurse/Unit Manager (RN/UM) stated it was expected that the staff would put full PPE before entering into isolation room and it was important to do so to prevent the spread of COVID infection. Later that day, the RN/UM provided a copy of in-service (training) sheet, dated 10/14/24, that was provided to the HK staff regarding donning and doffing of PPE. The surveyor reviewed the medical records for Resident #77 which revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315313	A. Building B. Wing	10/29/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record face sheet (an admission summary) reflected that the Resident #77 was admitted to the facility with diagnoses which included but were not limited to: hypertension (high blood pressure), dysphagia (difficulty swallowing) and muscle weakness. A review of the October 2024 Order Summary Report (OSR) included a physician's order (PO) dated 10/10/24, for COVID isolation 10/09/24 -10/19/24 every shift for covid positive dx [diagnosis] until 10/19/24. On 10/18/24 at 01:06 PM, the survey team met with LNHA and DON. The surveyor notified the facility management of the above findings. The DON and LNHA acknowledged that HK staff should have been wearing full PPE and there was a sign posted on the door. The LNHA further stated that the HK staff was in-serviced on donning and doffing on 10/14/24. A review of the facility provided Coronavirus Disease (COVID-19)- Using Personal Protective Equipment policy dated revised 9/22, included under section 4.c. Eye Protection; 1.) Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) is applied upon entry to the resident room or care area. On 10/22/24 at 12:25 PM, the survey team met with the LNHA, DON, and [NAME] President of Special Clinical Projects for an exit conference. The facility management did not refute the findings. NJAC 8:39-19.4(a)(1,2),(l,n), 27.1(a)