STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Valley	300 Old Hook Road Westwood, NJ 07675

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 4/23/26 and 4/24/26, it was determined that the facility failed to provide a safe environment for its residents. The facility failed to ensure that a resident (Resident #2) who was an elopement risk upon admission, remained in the facility. The facility failed to provide adequate supervision to prevent residents from eloping from the facility. This deficient practice was identified for 1 of 4 residents reviewed for elopement (Resident #2).A review of the Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) was dated 4/17/26 and contained information regarding Resident #2's elopement. Resident #2 eloped from the facility which led the facility initiate a Code grey for a missing resident. Resident #2 was located at home after answering the facility's phone call to them and was escorted back to the facility with a staff member from the facility who lived in Resident #2's vicinity. Resident #2 did not suffer any harm from this elopement.According to the admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to: cellulitis of the abdominal wall (a bacterial skin infection characterized by red, hot, swollen, and tender skin), atelectasis (a condition resulting from airway blockages which can cause breathing difficulties), and muscle weakness.According to the Minimum Data Set (MDS), an assessment tool dated 4/17/26, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated the resident's cognition was moderately impaired.A review of Resident #2's Care Plan (CP) revealed that the CP had been initiated on 3/19/26 under Focus, Elopement risk related to New admission/change of environment -Wanderguard to left wrist. Under Interventions, Accompany to meals and scheduled activities, allowed to vent feelings and/or frustration as needed, ask family/visitors to notify staff when leaving following patient visit, check for placement and function of security bracelet as indicated, elicit family input into former customary routine which might explain attempts to leave unescorted, engage in activities/tasks to keep occupied.A review of the facility's summary and conclusion for this FRE stated that: An immediate review of surveillance footage by the Administrator and Environment Services Director (JV), confirmed that the wander-guard alarm system engaged and a manual reset was entered by the receptionist, as no one was in the immediate lobby area when the receptionist disengaged the alarm. As per review of this event, the resident appeared from behind the receptionist after the code was entered and exited through the door. (Resident #2) was dressed in a jacket and carrying large envelopes, presenting as a visitor.On 4/23/26 at 9:16 AM, Resident #2 refused an interview with the surveyor stating that they were eating breakfast and the surveyor was instructed to speak to their roommate until they were done with breakfast.On 4/23/26 at 09:24 AM, Resident #2 finished their breakfast and when asked regarding when they left the facility, Resident #2 stated, I escaped from this place. I couldn't tell you when. I think everyone wants to go home. You don't have freedom. I want to get up and go. I feel like this is confinement. When asked how they left the facility Resident #2 stated, I walked out and I walked home and made sure not to get caught. No one helped me. I had to be careful. I don't remember the details.On 4/23/26 at 9:57 AM, the surveyor interviewed a Certified Nursing Assistant (CNA) from the facility regarding Resident #2 and Wanderguards. The CNA stated (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #2 is a wanderer who does not need assistance walking. The CNA also reported that Resident #2's picture is around the facility so that everyone knows to keep an eye out for Resident #2. She further stated that if she sees Resident #2 wandering or activating the Wanderguard alarm she will engage with Resident #2 and redirect them back towards their room or away from the doors. When asked about the Wanderguard system, the CNA said that the Wanderguard alarm system is very loud and comes from the door themselves. She said that if the resident or the Wanderguard that is activating the alarm is moved away and 10 seconds pass the alarm will turn itself off. The CNA said that even if a resident with a Wanderguard were to reach the exit doors, the doors would not open.On 4/23/26 at 10:29 AM, the surveyor interviewed a Licensed Practical nurse from the facility who was familiar with Resident #2. The LPN stated that Resident #2 was an elopement risk which is why Resident #2 has a Wanderguard. She said that Resident #2 walks around the facility a lot and if Resident #2 ends up setting the Wanderguard alarm off Resident #2 will walk themselves away from the alarm. The LPN also stated that Resident #2's picture is posted at the timeclock for employee as well as the nurses station and throughout the facility so that everyone can keep an eye out for Resident #2. The LPN revealed that Resident #2 is the only elopement risk for the long-term care portion of the facility as the other elopement risk for the facility resides in the assisted living memory center. The LPN also stated that Wanderguards are checked every shift by the primary nurse who has the resident with the Wanderguard in their assignment. When asked how she would respond to a Wanderguard alarm, the LPN replied: If a Wanderguard alarm goes off I will look around to see what is causing the alarm to go off because anything can happen. We have to make sure we can visualize the patient and make sure the patient is safe and able to be located.On 4/23/26 at 10:51 AM, the surveyor interviewed a Registered Nurse (RN) from the facility who was familiar with Resident #2. When asked about Resident #2 the RN said that Resident #2 likes to wander all over the place which is why they have a Wanderguard. The RN stated that Resident #2 typically doesn't set the Wanderguard alarm frequently and that Resident #2 is frequently rounded on to prevent Resident #2 from going towards the front entrance. When asked about what interventions are used when Resident #2 is wandering, the RN replied that Resident #2 is engaged in conversation for redirection. When asked about staff members response to a Wanderguard alarm the RN stated that the staff will get up and physically go check to see who is setting the alarm off. She further stated that the doors will automatically lock so that the resident can be located. She also stated that if the Wanderguard alarm is going off and a resident can't be located a Code Grey is started and administration and the resident's family are automatically notified.On 4/23/26 at 11:03 AM, the surveyor interviewed the Assistant Director of Nursing (ADON). The ADON stated that in regards to Resident #2's elopement, the primary nurse from the 3pm-11pm shift realized Resident #2 was missing and a Code Grey was initiated. She stated that being able to locate a resident is important for safety and that there is a major highway right outside the facility doors so there is potential for a resident to get hit. The ADON stated that Resident #2's narrative of the elopement is inconsistent but that it would not be feasible for Resident #2 to have walked home because Resident #2's home was located about 35-40 minutes away by car with no traffic. The ADON also stated that Resident #2 is aware of their Wanderguard and the alarm system and stated that Resident #2 will often redirect themself away from the door when the Wanderguard alarm is activated. When asked if it was policy for the Wanderguard alarm to be manually turned off before the resident causing the alarm is located, the ADON stated no.On 4/23/26 at 11:26 AM, the surveyor interviewed the Director of Nursing (DON). The DON stated that if a resident is an elopement risk, the facility will identify that the resident is a wanderer and put interventions in place to prevent elopement such as a Wanderguard. The DON further stated that to her knowledge, when a Wanderguard alarm is activated, the alarm will not shut off unless it is de-activated. When asked about what staff is supposed to do when a Wanderguard alarm goes off the DON replied: If the alarm is going off staff are supposed to locate what is causing the alarm to go off. You typically search the area and once you locate what is causing the alarm to go off you enter the code.On 4/23/26 at 11:46 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, the surveyor interviewed the receptionist who was working. The receptionist was questioned as to what she would do if a Wanderguard alarm went off. The receptionist replied: If I hear a Wanderguard alarm going off I look around to see who is setting the alarm off. I type in the code to stop the alarm. I check outside to see if anyone is outside but this is only if I can't locate who is setting the alarm off and then I will inform the Licensed Nursing Home Administrator (LNHA) and DON if I can't locate the resident. I can't leave the front desk. This is how I have been trained since I started here. I am able to text the LNHA and DON if they are not in the office immediately. We will also contact maintenance to make sure nothing is faulty with the system.On 4/23/26 at 11:59 AM, the surveyor interviewed the LNHA who summarized Resident #2's elopement and it correlated with the FRE submitted to the NJDOH. The LNHA stated that when Resident #2 entered the facility after being located the Wanderguard beeped. The LNHA was questioned on the Wanderguard system and how it worked. She replied that the Wanderguard works as sa radiofrequency and the sensor for the Wanderguard is at the Exit doors for the facility. When asked about how she expects staff to react to a Wanderguard alarm she stated that staff are trained to locate what is causing the alarm and that staff are aware who the elopement risks are for the building and emphasized that elopement risk resident pictures are everywhere throughout the facility. She also stated that the facility checks placement and function of a Wanderguard every shift. The LNHA also stated that the receptionists know not to deactivate the code manually if the source of the Wanderguard alarm is not located and how to handle other residents and visitors if they are upset by the alarm not being turned off. When asked how Resident #2 was able to leave the facility if the Wanderguard and alarm system were functioning properly, the LNHA stated that review of the surveillance footage revealed that because the receptionist did not see anyone in the lobby, she entered the code to disengage the alarm. She also stated that Resident #2 often likes to sit in the Magnolia lounge of the facility which is close to sensors in the Lobby exit doors and can trigger the Wanderguard alarm system. The LNHA stated that the receptionist enters the code, Resident #2 goes behind the receptionist fully dressed with papers and leaves the facility. The LNHA stated that Resident #2 was quick and looked different, however, that the receptionist should have questioned why the alarm was going off and done a better job to look around.On 4/23/26 at 12:43 PM the surveyor interviewed DON and LNHA together. The LNHA stated that believes the receptionist believed Resident #2 was a visitor leaving when Resident #2 walked behind her. The LNHA stated that the process is that if the Wanderguard alarm is going off, the supervisors are notified, and the supervisors will do a headcount of the residents. The surveyor asked if that is what occurred the night of Resident #2's elopement and the LNHA and DON both did not respond.On 4/24/26 at 9:00 AM, the surveyor requested a Wanderguard and sat in the Magnolia lounge. The surveyor could not hear the alarm system alarming, however once exiting nursing station 3 and entering the lobby the alarm could be hear. The receptionist was requested to disengage the alarm after the LNHA confirmed the Wanderguard was with the surveyor.On 4/24/26 at 10:12 AM, the surveyor interviewed the LNHA regarding the receptionist's statement related to Resident #2 eloping. The surveyor questioned if the receptionist notified the facility about an elderly woman leaving the facility after the Code Grey was initiated. The LNHA stated that the receptionist reported that she had not seen Resident #2 and that Resident #2 looked different dressed up and holding papers.On 4/24/26 at 10:45 AM, the surveyor and LNHA activated the Wanderguard together to observe if the exit doors automatically lock and if the alarm would shut off when the Wanderguard was moved away from the sensor. The alarm did not go off until a manual code was entered.On 4/24/26 at 10:54 AM, the surveyor heard the Wanderguard alarm and went to observe what was happening as the lobby was empty. Resident #2 was sitting in the Magnolia lounge causing the Wanderguard alarm to go off and when Resident #2 was redirected, the alarm disengaged.A review of the facility's policy titled, Wandering and Elopements, with a revision date of March 2019 included the following information under Policy Statement: The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.N.J.A.C. 8:39-27.1 (a)