STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Evesham	870 East Route 70 Marlton, NJ 08053

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43936 Based upon observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain an orderly physical environment for 2 of 2 facility units (100 & 200) reviewed under the Environmental Task. The deficient practice is evidenced by the following: On 04/11/2024 at 10:20 AM during a tour of the 100 Unit communal shower room, the surveyor observed a shelf on the wall adjacent to the shower stall. On the shelf was an unpackaged incontinence brief, a hairbrush with hair entangled in the bristles, and various hygienic bottled toiletries. The room also emanated a foul odor. On the same date at 10:27 AM during a tour of the 100 Unit common area across from the nurses station, the surveyor observed a table that had food debris and two partially consumed beverages left on top. On the floor under the table was a single, blue slipper. The surveyor observed Residents participating in an activities exercise in the same common area at the time of the observation. On the same date at 10:37 AM during a tour of the 100 Unit communal shower room, the surveyor observed five PVC (polyvinyl chloride) constructed mobile trash bins stored in the shower room. At least one of the trash bins still contained clear plastic bags filled with trash. The room contained a scale chair (chair fitted with a scale to measure a persons weight) that had but was not limited to unpacked incontinence briefs, disposable glove boxes, and plastic bags on top of it. On the same date at 10:52 AM, the surveyor observed Resident # 72's room. At that time, the surveyor observed a chair near the foot of the bed. The chair had an unpackaged incontinence brief, towels, a linen sheet, and a hospital gown left on the seat. At that time, during an interview with the surveyor, Resident # 72 stated, I don't want it [items observed on chair] there because my son and grandbaby visit and I don't want them seeing a diaper. I keep telling them [the facility] to not do that. On 04/16/2024 at 10:58 AM in the hallways outside of room [ROOM NUMBER], the surveyor observed a geriatric recliner chair. On the chair was a grey plastic container that included unpackaged, blue incontinence briefs. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the same date at 11:02 AM while in Resident # 11's room, the surveyor observed a chair near the foot of the bed. The chair had a hospital gown and white linens left on the seat. At that time during an interview with the surveyor, Resident # 11 replied , I don't want that there. when the surveyor asked if he/she wanted the hospital gown and linens on the chair. Resident # 11 further said he/she does not use hospital gowns because they are not warm enough. On 04/16/2024 at 10:58 AM during an interview with the surveyor, Housekeeper # 1 said he was not responsible for removing linens from room. He said he was responsible for mopping, sweeping, garbage, and cleaning. On 04/17/2024 at 12:29 PM during an interview with the surveyor, the Director of Nursing (DON) replied, They should be stored in the closets and if on the floor, in carts. when the surveyor asked what was her expectation for storing linens including but not limited to unpackaged incontinence briefs and linens. Lastly, she replied, Closets in the rooms. when the surveyor asked where should they (incontinence briefs, linens) be stored. 49707 On 04/11/2024 at 12:04 PM during the initial tour, Surveyor # 2 entered room [ROOM NUMBER]-D and observed linen mixed with unpackaged incontinence briefs in the chair. Further, there were pillows and more linen observed on another chair in the corner. On 04/16/2024 at 10:22 AM, Surveyor # 2 entered room [ROOM NUMBER]-B, and observed untied bags of linen on the floor. On 04/17/2024 at 12:38 PM, during an interview with surveyor # 2, the Director of Nursing (DON) confirmed that resident's linen should be kept in the supply closet. Secondary, the DON confirmed that the nursing staff was responsible for removing linen and incontinence briefs from resident rooms. Lastly, the DON and the Licensed Nursing Home Administrator confirmed that linen and incontinence briefs should be kept in the resident's room closet and not on their chairs. A review of the facility policy titled, Departmental (Environmental Services) - Laundry and Linen with a revised date of January 2014, revealed under Washing Linen and Other Soiled Items but not limited to, 7. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts. N.J.A.C. S 8:39-31.4 (a)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964 Based on interview and record review it was determined the facility failed to conduct a new Preadmission Screening and Resident Review (PASRR) level 1 assessment after a resident was newly diagnosed with a mental illness. This deficient practice was identified in 1 of 1 resident reviewed for PASRRs (Resident #54) and was evidenced by the following: On 04/15/2024 the surveyor reviewed Resident #54's electronic medical record (EMR) which included review of the PASRR level 1 completed on 06/21/2019, which was negative and marked no for any diagnosis of mental illness. A review of the Admission Minimum Data Set (MDS), an assessment tool dated 07/15/2019, revealed a Brief Interview of Mental Status (BIMS) score of 7/15, indicating severe cognitive impairment and review of section I did not include any psychiatric diagnoses. A review of the annual MDS dated [DATE], indicated diagnoses of anxiety disorder, depression, psychotic disorder, and schizophrenia noted in Section I. A review of the quarterly MDS dated [DATE], indicated diagnoses of anxiety disorder, depression, psychotic disorder, and schizophrenia noted in Section I. A review of Resident #54's care plans included but were not limited to a focus of At risk for changes in mood related to anxiety, depression, hx (history) of alcohol dependence and At risk for adverse effects related to use of antidepressant medication, use of antipsychotic medication. No additional PASRR including the diagnosis of anxiety disorder, depression, psychotic disorder, or schizophrenia was located. On 04/15/24 at 10:50 AM, the surveyor interviewed the Social Worker (SW) who stated that if a resident presents with a new diagnosis, then a new PASRR was done and sent to the state. When asked for new PASRR on Resident #54, after searching the EMR, SW stated, I don't see where that is captured. I don't see one. A new PASRR should've been completed. On 04/17/24 at 12:38 PM, the surveyor interviewed the Administrator who stated there was no policy on reevaluating PASRR. She stated that audits were done, but there is no regulation that they have to be updated annually. Review of facility policy Admission Criteria, edited 06/23/22, which addressed PASRR under number 9, does not address a resident with a new psychological diagnosis after admission. N.J.A.C. 8:39.5.1(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40744 Based on observation, interview, and review of facility documentation, it was determined the facility failed to develop a comprehensive person-centered care plan for a resident with pain. This deficient practice was identified for Resident #27, 1 of 24 residents reviewed for care plans and was evidenced by the following: On 04/10/24 at 10:06 AM, during the initial tour of the facility Resident #27 told the surveyor he/she had right hip pain and left foot pain. The surveyor asked if he/she received pain medication and the resident replied, Oh they are so busy. The surveyor asked the resident to rate the pain on a zero to 10 scale and the resident said it was a seven, meaning moderate pain level. Review of the Admission Record revealed Resident #27 had medical diagnoses which included but were not limited to sciatica (pain affecting back, hip, and outer side of leg), fibromyalgia (long term condition that involves body pain and tiredness), depression, anxiety, and low back pain. Review of the Admission Minimum Data Set (MDS), an assessment tool dated 03/31/24, indicated the resident had a Brief Interview of Mental Status of 14/15, which indicated the resident was cognitively intact. Section J of the MDS, health conditions, showed the resident had moderate pain and was receiving pain medications when necessary. On 04/12/24 at 12:10 PM, the surveyor reviewed the following orders: Acetaminophen Tablet 325 milligrams, give two tablets by mouth every six hours as needed for mild pain (Pain Score 1, 2, 3, 4). Do not exceed three grams in 24 hours. Total 650 mg. Pain Score every shift 0=No pain 1,2,3,4 =Mild Pain 5,6,7 = Moderate pain 8,9,10 =Severe pain every shift for Pain. Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give one tablet by mouth every eight hours as needed for moderate to severe pain (5-10). On 04/12/24 at 12:24 PM, the surveyor reviewed the Medication Administration Record (MAR) which showed that for the month of April 2024 the resident's pain was assessed every shift. Twice the resident had a pain level of 1, meaning mild pain, and once the resident had a pain level of 7, meaning severe pain. On 04/15/24 at 01:17 PM, the surveyor reviewed the care plan which did not include a focus of pain. At the same time, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) regarding the pain care plan. The care plan was then updated with a focus of pain after surveyor inquiry. On 04/17/24 at 01:10 PM, the surveyor reviewed the most recent physician progress note which indicated the following documentation under the physician assessment: Right sided sciatica-Continue Lyrica, lidocaine patches, and tramadol. On 04/22/24 at 11:55 PM, the surveyor reviewed the policy titled, Care plans, Comprehensive Person-Centered, the policy was dated 04/25/22. Under number eight it indicated that services are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/24 at 12:38 PM, the surveyor reviewed the policy titled, Pain Assessment and Management, a policy dated 11/10/22. Under the section titled, Defining Goals and Appropriate Interventions, number one indicated that the pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan. NJAC 8:39-11.2 (d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 NJ Complaint # NJ00169132, NJ00171624 Based on observations, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) obtain a physician's order for residents to be discharged from the facility prior to discharge, b). change a central line catheter dressing as ordered by the physician (Resident #84), c.) follow physician orders to offload a residents heels while in bed (Resident #467), d.) follow physician order to check for helmet placement every two hours (Resident #468), and e.) maintain medication records that were complete with staff signatures according to professional standards of clinical practice for Resident #35, 1 of 29 residents reviewed for professional standards. This deficient practice was identified for 3 of 3 residents (Residents #88, #34 and #46) on 2 of 2 nursing units (100 and 200 units) and 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. a. The surveyor reviewed Resident #88, Resident #34, and Resident #46's closed medical records. Review of the physician orders revealed that none of the resident's had a physician's order placed in the medical record prior to resident discharge from the facility. On 04/17/24 at 12:45 PM, during an interview with both the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the presence of the survey team, the LNHA stated that she confirmed that Resident #88, Resident #34 and Resident #46 did not have a physician's order to be discharged from the facility but were required to. On 04/18/24 at 8:49 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) and asked why Resident #88 and Resident #34 did not have discharge orders placed in their medical records prior to being discharged from the facility. LPN/UM stated a discharge order was required to be obtained from the physician prior to resident discharge. LPN/UM stated the nurse must have forgotten to put the order in the computer. LPN/UM further stated that the assigned desk duty nurse was responsible to put the discharge order in the computer prior to a resident being discharged from the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/18/24 at 8:55 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that a discharge order was required prior to resident discharge from the facility. RN/UM stated the doctor was notified and a discharge order was obtained prior to resident discharge. RN/UM stated that she was responsible to put the order in the computer. RN/UM further stated that it must have been a nursing oversight that a discharge order not placed in the computer before Resident #46 was discharged from the facility. Review of the facility policy, Discharging a Resident without a Physician's Approval (Revised 10/22) revealed the following: An order for an approved discharge must be signed and dated by a physician and recorded in the resident's medical record no later than seventy-two (72) hours after the discharge. 40744 b. On 04/10/24 at 10:21 AM, during the initial tour of the facility Resident #84 was in the bed awake. The resident told the surveyor that he/she was on intravenous (IV) antibiotics (medications given through an access in a vein) for a long time. The surveyor asked the resident about his/her IV access and the resident showed the surveyor a clear plastic dressing on the resident's right chest wall and said it was a [NAME] (central line catheter placed on the right side of the chest wall). The surveyor asked if the staff were changing the dressings or if the dressing had a date and the resident showed the surveyor the dressing that was dated 03/27/24. The resident then told the surveyor that it's been a long time since they changed it, maybe they didn't change it because it may come out soon. Review of Resident #84's Admission Record (an admission summary) revealed that the resident had medical diagnoses which included but were not limited to bacteremia (bacteria in the blood stream), appendicitis (appendix becomes inflamed and painful), and septic shock (a widespread infection causing organ failure and dangerously low blood pressure). The surveyor reviewed the most recent Minimum Data Set (MDS), an assessment tool dated 03/05/24, which indicated the resident had a Brief Interview of Mental Status of 15/15, which indicated the resident was cognitively intact. On 04/12/24 at 09:52 AM, the surveyor reviewed the physician orders which showed the following order dated 2/28/24: Dressing: PICC (peripherally inserted central catheter, a type of central catheter inserted in the arm)/Midline/ Tunneled & Non-Tunneled: 24 hours after insertion, then weekly and as needed. Change needleless connector with weekly dressing change and after blood draw. If securement device is used, change at time of dressing change. No signs and symptoms of any infusion related complications present. Dressing is adherent and intact; catheter & tubing properly secured; needleless connectors are present. After reviewing the physician orders, it revealed the resident was no longer on IV antibiotics. On 04/12/24 at 10:01 AM, the surveyor reviewed the care plan which showed a focus of IV insertion and potential for complications. The care plan was initiated 01/02/24. One of the interventions included: Change IV site dressing per physician order and as needed if soiled or wet. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/12/24 at 11:42 AM, the surveyor reviewed the Treatment Administration Record (TAR) for Resident #84 which showed the resident was scheduled for a tunneled catheter dressing change on 04/03/24 and it was left blank, meaning not signed as completed by the nursing staff. Further review of the TAR showed that the dressing was changed on 4/10/24. On 04/17/24 at 11:48 AM, the surveyor interviewed facility Licensed Practical Nurse (Agency LPN #1) regarding care of central catheters. The surveyor asked what was the date that on a central line dressing indicated and Agency LPN#1 said, That is the date that it was changed. The surveyor asked how often the dressings for central catheters were changed and Agency LPN#1 said, weekly and as needed. The surveyor then asked where the dressing changes would be documented when completed by the nursing staff and Agency LPN#1 said it would be documented in the Medication Administration Record (MAR) or TAR. Agency LPN#1 said, It will pop up for the weekly changes on the MAR or TAR and there will also be an area for the as needed changes. On 04/18/24 at 10:50 AM, the surveyor reviewed the policy titled, Central Venous Catheter Care and Dressing Changes, a policy with a revision date of 03/2022. Under the general guidelines section of the policy, number 3 indicated to change the catheter dressing if it becomes damp, loosened or visibly soiled and at least every seven days for transparent dressing. Review of the documentation section indicated that the medical record should include the date and time the dressing was changed. c. On 04/17/24 at 11:08 AM, the surveyor reviewed the physician orders for Resident #467 which showed an order to offload heels while in bed as tolerated. It was ordered on 02/13/24. The surveyor reviewed Resident #467 Admission Record which revealed the resident was admitted to the facility for short term rehabilitation. Medical diagnoses included but were not limited to hypertension (high blood pressure), repeated falls, heart failure, and muscle weakness. Review of the Admission Minimum Data Set (MDS) indicated the resident had a Brief Interview of Mental Status score of 12/15, which indicated the resident had moderate cognitive impairment. Review of section M, skin conditions indicated the resident was at risk for developing pressure ulcers. On 04/17/24 at 11:30 AM, the surveyor reviewed Resident #467's Medication Administration Record (MAR) and the Treatment Administration Record (TAR). The order for offloading of the heels was not documented on either record. On 04/17/24 at 11:46 AM, the surveyor reviewed the Certified Nursing Assistant (CNA) task list which included float/offload heels marked as for your information. There was no documentation by the CNA that the task was completed, tolerated, or refused by the resident. On 04/17/24 at 11:52 AM, the surveyor interviewed Agency LPN #1 regarding residents with orders to offload heels while in bed and was that a task that would be documented if done. Agency LPN #1 said, If it was a physician order it would pop up on the MAR or TAR for nursing to sign it as done. On 04/17/24 at 1:20 PM, the Director of Nursing (DON) met with the surveyor and provided a care plan that showed offload heels while in bed. The intervention was initiated on 2/19/24. The surveyor asked where it was documented from the order date of 2/13/24 until the care plan intervention was initiated on 2/19/24 and the DON responded, I understand. 44833 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d.) On 4/16/24 at 9:56 AM, the surveyor reviewed Resident #468's closed medical records. Review of the resident's Admission Record indicated Resident #468 was admitted to the facility with diagnosis which included but were not limited to hemiplegia and hemiparesis (weakness and paralysis of one side) following cerebral infarction (stroke), seizures, and nontraumatic subarachnoid hemorrhage from unspecified middle cerebral artery (the accumulation of blood in or around the brain not caused by trauma). Review of the resident's admission MDS indicated the resident had a BIMS score of 9 out of 15, which indicated moderate impaired cognition. Review of the physician orders included an order with a start date of 8/31/2023 to check helmet placement every two (2) hours. Must be worn at all times. Review of Resident #468's TAR for September and October 2023 revealed the following missing or blank documentation areas for the physician's order to check placement every two hours: 9/10 4 PM, 6 PM, 8 PM, 10PM 9/30 4 AM, 6 AM 10/3 4 AM, 6 AM 10/8 10 AM 10/27 2 PM On 4/17/24 at 11:09 AM, the surveyor interviewed LPN2 who stated that when administering medication or performing ordered treatments, nurses should document in the electronic medical record. She further stated there should be no blanks in the TAR and that if it is blank, it would indicate it was not done. LPN2 also informed the surveyor that there are appropriate codes to use in the TAR to indicate why a treatment was not completed, for example, if the resident was unavailable at that time, but it should still be documented and not left blank. On 4/17/24 at 11:15 AM, the surveyor interviewed the DON who confirmed that there should not be any blanks in documentation on the TAR and nursing staff should use one of the available numeric codes to document why a treatment was not done. The DON stated she did not agree with the adage if it's not documented, it's not done stating, I would say it was done, just forgot to sign it. While presenting the DON with the blank documentation in the resident's TAR to check for helmet placement, the DON stated, the resident has his helmet on in the picture referring to the picture used on the medical record for resident identification. Review of the facility's Charting and Documentation policy with edited date 5/27/2022 included but was not limited to: 4. The following information is to be documented in the resident's medical record: a. objective observations; b. medications administered; c. treatments or services performed; d. changes in the resident's condition; e. events, incidents or accidents involving the resident; and f. progress toward or changes in the care plan goals and objectives. 38680 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. According to the admission record Resident #35 was admitted with diagnoses that included, but were not limited to, paranoid schizophrenia and major depressive disorder. The surveyor reviewed the 1/20/24 Minimum Data Set, an assessment tool, and observed that the facility had identified Resident #35 as not being cognitively intact. On 4/16/24 at 9:51 AM, the surveyor reviewed the March and April Medication Administration Record (MAR) for Resident #35. When medications are ordered by the physician, the order is placed on the MAR. When administered by the nurses, the nurse will sign their initials on the MAR indicating that they have given the medication. The surveyor noted a 11/9/2023 physician's order (PO) for the cognition enhancing medication donepezil give 1 tablet by mouth at bedtime. The surveyor observed a blank on the MAR, there were no nurse's initials indicating administration on 3/29/24 and 4/7/24 at 2100. The surveyor observed a PO for levothyroxine sodium (a medication used to treat a low thyroid) 50mcg ordered on 3/16/24 give 1 capsule by mouth in the morning. The MAR had a blank on 3/22/24 at 2200. The surveyor observed a PO for Lipitor (used to treat high cholesterol) 40mg ordered on 7/13/23 give 1 tablet by mouth at bedtime. The MAR had blanks on the MAR on 3/29/24 and 4/7/24 at 2100. The surveyor observed a PO for metoprolol succinate (used for high blood pressure) ER 25mg ordered on 7/14/23 give 1 tablet by mouth in the evening. The MAR had blanks on 3/3/24, 3/29/24, 4/7/24, and 4/8/24 at 1700. The surveyor observed a PO for Paxil (an antidepressant) ordered on 7/14/23 give 1 tablet by mouth in the evening. The MAR had blanks on 3/3/24, 3/29/24, 4/7/24, and 4/8/24 at 1700. The surveyor observed a PO for Seroquel (a medication used for schizophrenia) ordered on 2/28/24 give 1 tablet by mouth at bedtime. The MAR had blanks on 3/29/24 and 4/7/24 at 2100. The surveyor observed a PO for Depakote delayed release (used for mood disorders) ordered on 10/13/23 give 1 tablet two times a day. The MAR had blanks on 3/3/24, 3/29/24, 4/7/24, and 4/8/24 at 1700 and on 4/14/24 at 0900. The surveyor observed a PO for metformin (used for diabetes) ordered on 7/14/23 give 1 tablet two times a day. The MAR blanks on 3/3/24, 3/29/24, 4/7/24, 4/8/24 at 1700 and on 4/14/24 at 0900. The surveyor observed a PO for Namenda (a medication used to improve cognition) ordered on 7/14/23 give 1 tablet by mouth every morning and at bedtime. The MAR had blanks on 3/29/24 and 4/7/24 at 2100 and 4/14/24 at 0900. The surveyor observed a PO for Xanax (a medication used for anxiety) ordered on 3/21/24 give 1 tablet every 12 hours. The MAR had blanks on 3/27/24, 3/29/24, and 4/7/24 at 2100 and 4/14/24 at 0900. The surveyor observed a PO for amlodipine besylate (used to treat high blood pressure) ordered on 7/14/23 give 1 tablet once a day. The MAR had a blank on 4/14/24 at 0900. The surveyor observed a PO for Aspirin delayed release 81mg (used for the heart) ordered on 7/14/23 give 1 tablet by mouth once a day. The MAR had a blank on 4/14/24 at 0900. There was no documented evidence in the medical record that Resident #35 experienced a negative reaction/harm for not receiving the medications. During an interview on 4/16/24 at 9:58 AM, Licensed Practical Nurse (LPN)1 stated that If there is a blank in the MAR the medication was not signed out. She would assume that if the MAR was not signed out, the medication was not given. During an interview on 04/16/24 at 10:15 AM the Registered Nurse/Nurse Manager stated that if the MAR is blank, it means the medication was not signed out. If not signed out there is no way of knowing if a medication was given or not. (continued on next page)

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	315464	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Evesham	870 East Route 70 Marlton, NJ 08053

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility provided policy titled Documentation of Medication Administration edited on 04/06/2023, reflected that administration of medication is documented immediately after it is given. Documentation of medication administration includes at minimum: g. initial, signature, and title of the person administering the medication. NJAC 8:39-27.1(a)

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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. 38680 Based on observation, interview, and record review, it was determined that the facility failed to ensure that a safety device used to prevent residents from elopement was in place for 1 of 3 residents reviewed for accidents (Resident #35). This deficient practice was evidenced by: According to the admission record Resident #35 was admitted with diagnoses that included, but were not limited to, paranoid schizophrenia and major depressive disorder. The surveyor reviewed the 1/20/24 Minimum Data Set (MDS), an assessment tool, and observed that the facility had identified Resident #35 as not being cognitively intact. The MDS reflected that Resident #35 had no wandering behavior during the lookback period and he/she used an elopement alarm daily. During initial tour on 04/10/24 at 10:45 AM, the surveyor observed Resident # 35 in the activity area painting. According to the Registered Nurse/Unit Manager (RN/UM) Resident #35 utilized an elopement alarm. On 04/11/24 at 10:27 AM, the surveyor observed Resident #35 in the room ambulating. The resident did not have an elopement alarm to the right wrist. On 04/12/24 at 9:30 AM, the surveyor observed Resident #35 in the room on the telephone. The resident did not have an elopement alarm to the right wrist. The surveyor spoke to a staff member who is familiar with this resident. The staff member stated that Resident #35 had never tried to leave the facility. On 04/15/24 at 10:54 AM and 12:57 PM, the surveyor observed Resident #35 in bed. The resident did not have an elopement alarm to the right wrist. The surveyor reviewed Resident #35's Physician's Orders. There was an order dated 7/13/23 for: Wanderguard every shift Wanderguard to right wrist. Check placement and function every shift. The April 2024 Medication Administration Record reflected that the wanderguard was in place each shift from 4/2/2024 through 4/15/24. A review of Resident # 35's care plans reflected a focus of wandering/pacing related to Dementia and elopement risk related to Cognitive impairment. The interventions included but were not limited to check for replacement and function of security bracelet (elopement alarm) as indicated. During an interview on 04/16/24 09:51 AM, the Lisensed Practical Nurse1 (LPN1) stated that elopement alarms require a physician's order. LPN1 furthered that the nurses check for placement and function each shift and document in the MAR. She stated that if the elopement alarm is missing then the nurse should replace the elopement alarm immediately. On 04/16/24 at 09:58 AM LPN1and the surveyor visualized Resident #35. LPN1 confirmed that Resident #35 should have an elopement alarm on her wrist but did not. LPN1 stated that she did not thouroughly check Resident #35 to ensure that the elopement alarm was in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/16/24 at 10:10 AM, the RN/NM stated the nurses should ensure that an elopement alarm is in place and if not on the resident it should be replaced. When the surveyor informed the RN/NM that Resident #35 did not have an elopement alarm in place she stated that the nurses should have replaced the elopement alarm. During an interview on 04/16/24 at 12:01 PM, the Lisenced Nursing Home Administrator(LNHA) stated that the PO for the elopement alarm for Resident #35 was dated July 2023. She stated that Resident #35 was reassessed for the need for the elopement alarm in October 2023 and it was determined that he/she did not need the elopement alarm but the PO was not updated. The LNHA stated that the nurses were not following the PO for the elopement alarm. A review of the facility policy Wandering and Elopements revised March 2019 reflected that 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. NJAC 8:39 - 27.1 (a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43936 Based on observation, interview, record review, and pertinent facility documentation, it was determined that the facility failed to provide appropriate and sufficient services based upon current standards of practice and the resident's comprehensive care plan to document urinary output in the Treatment Administration Record (TAR). The deficient practice was identified for 1 of 2 residents (Resident # 72) investigated for Urinary Catheter or UTI. The deficient practice was evidenced by the following: A review of Resident # 72's Minimum Data Set (MDS; an assessment tool) dated 03/16/2024 under section, H revealed that he/she had an indwelling urinary catheter (tube inserted into the bladder through the urethra to allow urine to drain from the bladder for collection). A review of Resident # 72's Electronic Medical Record (EMR) revealed under the section, Diagnoses that he/she was diagnosed with Paraplegia (paralysis typically of the lower body) and Neuromuscular Dysfunction of Bladder (lack of lack bladder control due to a brain, spinal cord or nerve problem). A review of Resident # 72's EMR under the section, Orders revealed a physician's order to, Measure and record foley catheter output Q [every] shift every shift for Neurogenic Bladder. The order became active on 03/28/2023. A review of Resident # 72's EMR under the section, Care Plan revealed an intervention to, Report changes in amount, color or odor of urine. The intervention was initiated on 11/28/2022. A review of Resident # 72's Treatment Administration Record for March, 2024 revealed blank sections of documentation to measure and record catheter output Q [every] shift on the following dates and shifts: 03/04/2024 night shift blank 03/08/2024 day shift blank 03/12/2024 night shift blank 03/13/2024 day shift blank 03/21/2024 night shift blank 03/27/2024 evening & night shift blank 03/30/2024 day shift blank (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident # 72's Treatment Administration Record for February, 2024 revealed blank sections of documentation to measure and record catheter output every shift on the following dates and shifts: 02/02/2024 day shift blank 02/06/2024 day shift blank 02/09/2024 day shift blank 02/12/2024 night shift blank 02/24/2024 day shift blank 02/27/2024 day shift blank On 04/17/2024 at 12:29 PM during an interview with the surveyor, the Director of Nursing replied, Document in the MAR [Medication Administration Record] or TAR if there is an order for it. Secondly, the DON replied, No when the surveyor asked should the Treatment Administration Record be left blank. Lastly, the DON replied, I wouldn't say it was or was not. It could be they forgot to document it. A review of the facility policy with a revised date of August 2022, titled, Catheter Care, Urinary revealed under section, Input/Output to, 2. Follow the facility procedure for measuring and documenting input and output. A review of the facility policy titled, Medication and Treatment Orders did not reveal pertinent information. N.J.A.C. S 8:39-27.1 (a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49712 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to maintain the necessary care and maintenance of respiratory equipment for 3 of 4 residents, reviewed for respiratory care. This deficient practice was evidenced by the following: On 04/10/2024 at 10:02 AM during initial tour, the surveyor observed Resident # 53 oxygen tubing not labeled, and the bag that held the tubing when not in use was dated 04/2/2024. According to the Admission Record, Resident #53 was admitted to the facility with diagnoses including but not limited to; Chronic obstructive pulmonary disease (COPD). COPD is an airflow limitation caused by airway narrowing and/or obstruction, loss, or elastic recoil, or both. A review of the Order Summary Report for resident # 53, revealed a physician order for oxygen at 2 liters/minute via nasal canula (a device that delivers extra oxygen through a tube into the nose) every shift for shortness of breath. There was no order to change oxygen tubing weekly. On 04/15/2024 at 11:21 AM during an observation of other residents on oxygen, the surveyor observed Resident # 15's nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) tubing and mask laying on the bed side table not stored in a bag. The surveyor also observed Resident # 17's nebulizer mask and tubing laying not in a bag, and the oxygen tubing laying across the bed. A review of the Admission Record revealed, Resident # 15 was admitted to the facility with diagnoses including but not limited to, Interstitial Pulmonary Disease. A term used for a large group of diseases that case scarring of the lungs. A review of the Order Summary Report for resident # 15, revealed a physician order for oxygen at 2 liters/minute via nasal canula every shift for shortness of [NAME], and Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligrams/3milliters, 1vial inhale orally every 6 hours for shortness of breath. There was no order to change respiratory tubing weekly. A review of the Admission Record revealed, Resident # 17 was admitted to the facility with diagnoses including but not limited to, Acute Respiratory Failure with hypoxia. A condition where you don't have enough oxygen in the tissues in your body, A review of the Order Summary Report for resident # 17, revealed a physician order for oxygen at 2 liters/minute via nasal canula every shift for desaturation, Albuterol Sulfate Nebulization Solution (2.5 milligrams/3 milliliters) 0.083% 1 vial inhale orally via nebulizer every 4 hours as needed for wheezing or shortness of breath. There was also an order to change respiratory disposable supplies weekly and as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/2024 at 11:06 AM with the surveyor, The Licensed Practical Nurse Unit Manager (LPN/UM) said we change respiratory tubing weekly, we label the tubing and bag with the date. LPN/UM also said the tubing is placed in the bag when not in use. When asked how do you know when to change the tubing, LPN/UM stated, there are orders, we change them on Tuesday's The LPN/UM agrees there should be orders for changing the tubing weekly. During an interview on 04/15/2024 at 11:16 AM with surveyor, The Director of Nursing (DON) said the Respiratory Therapist changs the respiratory tubing once a week, they date the tubing and the bags. The DON said there aren't orders in for the weekly change due to the nurses don't change them. The DON agreed that respiratory tubing should be placed in the bag when not in use. A review of the facility policy titled, Departmental (Respiratory Therapy)- Prevention of Infection with an edited date of 03/18/2024 revealed under Infection Control Considerations Related to Oxygen administration 6. Change the oxygen cannulae and tubing every seven (7) days. Or as needed.; 8. Keep the oxygen cannulae and tubing used PRN in a plastic bag when not in use. Revealed under Infection Control Consideration Related to Medication Nebulizers/Continuous Aerosol: 7. Store circuit in plastic bag, marked with date and residents name, between uses.; 9. Discard the administration set up every seven (7) days. N.J.A.C. S 8:39-27.1(a)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 43936 Complaint # NJ163924 Based on interview, review of Nursing Staffing Report sheets and facility provided documents, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 1 of 7 days reviewed for the week of 04/30/2023 through 05/06/2023 under the Sufficient and Competent Nurse Staffing Task. The deficient practice was evidenced by the following: A review of the Nurse Staffing Report completed by the facility for the week of 04/30/2023 through 05/06/2023 revealed the facility documented one Registered Nurse (RN) as having worked on 05/06/2023 during the day shift. A review of the facility provided schedule for 05/06/2023 revealed the previous Director of Nursing was scheduled. However, the Nurse Staffing Report, completed by the Facility revealed a resident census of 87. On 04/15/2024 at 12:49 PM during an interview with the surveyor, the Licensed Nursing Home Administrator confirmed that the previous Director of Nursing was counted as the RN on duty. A review of the facility policy with a revised date of August 2022 titled, Staffing, Sufficient and Competent Nursing revealed under the section titled, Sufficient Staff that, 3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RN may be scheduled more than eight (8) hours depending on the acuity needs of the resident. N.J.A.C. S 8:39-25.2 7(h)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964 Based on observation, interview, and policy review, it was determined that the facility failed to ensure that medications were stored appropriately. This deficient practice was identified in two (2) of four (4) medication carts inspected on one (1) of two (2) units. This deficient practice was evidenced by the following: On 04/12/2024, Surveyor #1 was observing medication pass on the 100 unit. At 08:40 AM, Agency Licensed Practical Nurse #2 (Agency LPN #2) left medication cart 2 in the hallway, locked, with a grey box of individual medication envelopes on top of the cart, in the hallway on the opposite side of the hallway from room [ROOM NUMBER], while he went into room [ROOM NUMBER] to take the resident's vital signs. Surveyor #1 stayed with the medication cart. While Agency LPN #2 was in room [ROOM NUMBER], another resident wheeled past the medication cart. When Agency LPN #2 came back to the medication cart at 08:43 AM, Surveyor #1 asked if the cart should've been left in the hallway the way it was. Agency LPN #2 stated, Sorry, the medications should not have been left on top of the cart. On 04/12/2024 at 09:07 AM, Surveyor #1 approached medication cart 3 on the 100 unit and noted a grey box with individual medication envelopes on top of the locked unattended medication cart. When Agency LPN #3 approached the medication cart, Surveyor #1 asked if the medication cart should've been left in the hallway as it was. Agency LPN #3 stated that the cart was okay, then added that she's only been to this facility a few times. On 04/12/24 at 09:23 AM, Surveyor #1 interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the grey boxes with medication envelopes should not be left on top of the medication carts if the medication nurses walk away from the cart. On 04/17/24 at 12:35 PM, Surveyor #1 interviewed the Administrator and Director of Nursing who stated that the individual medication envelopes should not have been left on top of the medication cart unattended. A review of the facility policy Administering Medications edited on 5/21/19, revealed: #19. During administration of medications . No medications are kept on top of the cart. 43936 On 04/11/2024 at 10:37 AM during a tour of the 200 Unit communal shower room, Surveyor # 2 observed two, sealed plastic bottles filled with clear liquid located in an opened cabinet on the wall. Upon closer observation, the bottles both had pharmacy labels. The labels revealed that the bottles contained, acetic ac 1000ml 0.25% irrig s (Acetic Acid Irrigation Solution; a sterile, nonpyrogenic hypotonic solution for irrigation of the urinary bladder). The labels revealed the name of an unsampled resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the same date at 10:41 AM during an interview with Surveyor # 2, Licensed Practical Nurse/Unit Manager (LPN/UM) replied I didn't know these were in here and they should not be in here. when Surveyor # 2 asked is there a any reason the bottled were in there. LPN/UM confirmed that the bottles belong in a medication cart or in the medication room. On 04/17/2024 at 12:29 PM during an interview with Surveyor # 2, the Director of Nursing (DON) replied, No when asked if prescribed medications be stored in the shower room cabinets. The DON confirmed that prescribed medications should be stored in a treatment cart of medication cart. A review of the facility policy titled, Medication Labeling and Storage revised February 2023 revealed under, Policy Heading that, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls . N.J.A.C. 8:39-29.4(h)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49712 Based on observation, interview, and pertinent facility documents, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness in 1 of 2 Pantries, Pantry on Unit 1. This deficient practice was evidenced by the following: On 04/12/2024 at 09:42 AM during observations of the pantry on Unit 1, the surveyor observed 3 frozen meals, and a container of rice pudding not labeled in the freezer. On 04/16/2024 at 10:11 AM during a second observation of the pantry on Unit 1, the surveyor observed, a burger not labeled or dated in the refrigerator. Also observed in the refrigerator was a muffin tin covered with in foil with the edge folded back and a muffin exposed, and a cup with pink liquid without a lid not dated or labeled. During an interview with the surveyor on 04/10/2024 at 09:22 AM, the Food Service Director, they said that the pantries on the nursing floor are managed by housekeeping and nursing. During an interview with the surveyor on 04/16/2024 at 10:13 AM with Licensed Practical Nurse (LPN) # 3. The LPN # 3 stated all food should be labeled and dated, if they aren't they get thrown away. During an interview with the surveyor on 04/17/2024 at 10:01AM, the Director of Nursing (DON) said all food should be labeled and dated. When asked if all food should be covered the DON replied with yes. During an interview with the surveyor on 04/17/2024 at 10:33 AM, the Director of Environmental Services stated, the golden rule is that if it is not labeled it is thrown out. A review of a facility provided policy revised on March 2022 titled Foods Brought by Family/Visitors revealed under, Policy Interpretation and implementation that 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility food. The policy also revealed under section 5., b. Perishable foods are stored in re-sealable containers with tight-fitting lids. Containers are labeled with the resident's name, the item and the use by date. N.J.A.C. 18:39-17.2(g)