

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315472	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Careone at East Brunswick		STREET ADDRESS, CITY, STATE, ZIP CODE 599 Cranbury Road East Brunswick, NJ 08816	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Repeat Deficiency</p> <p>Complaint #NJ00174978, and NJ00176742</p> <p>Based on observation, interview and record review, it was determined that the facility failed to; a) clarify physician's admitting medication orders for 1 of 2 residents admitted for Hospice services (Resident #81); b) ensure a resident received their medications as prescribed by their physician for 1 of 24 residents sampled (Resident #88), in accordance with professional standards of practice.</p> <p>This deficient practice was as follows:</p> <p>1. On 6/23/25 at 9:03 AM, the surveyor reviewed the closed medical record of discharged Resident #81.</p> <p>A review of the Resident admission Record (an admission summary) reflected the resident was admitted for Hospice respite to the facility with diagnoses which included multiple sclerosis, heart failure, and chronic kidney disease.</p> <p>A review of the Order Summary Report (OSR) with active orders as of 6/22/24 included physician orders (PO) for Farxiga oral tablet 10 mg (milligram) (Dapaglifozin propanediol); give one tablet by mouth for DM and an order for Jardiance 25 mg tablet; give one tablet by mouth one time a day for Diabetes Mellitus.</p> <p>A review of the June 2024 Medication Administration Record (MAR) revealed on 6/18/24, 6/19/24, 6/20/24, 6/21/24 and 6/22/24 at 9:00 AM, Resident #81 received both Jardiance and Farxiga.</p> <p>A review of the Consultant Pharmacist (CP) Comments report dated 6/18/24 revealed a recommendation concurrent use of Farxiga and Jardiance may be considered duplicate therapy. Please document clinical rationale if continuing present therapy.</p> <p>On 6/23/25 at 2:02 PM, the surveyor asked the Director of Nursing (DON) for any evidence the resident's physician had been notified of the potential duplication of therapy using Farxiga and Jardiance together. The DON was unable to provide documentation the orders had been clarified.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/24/25 at 1:44 PM, the survey team met with the facility Licensed Nursing Home Administrator and the DON. The DON explained the resident was a Hospice Respite admission and the resident's family would bring in the resident's medication list and medication bottles when he/she was admitted . The nurse would enter the medications into the computer after verifying with the physician and that's when the pharmacist would review the medications for irregularities including duplication of therapy. The surveyor asked for this report and the DON stated it was unavailable.</p> <p>On 6/25/25 at 1:12 PM, via telephone the surveyor interviewed the Regional CP for the facility, she was not the CP who made the recommendation on 6/18/24 to clarify the possible duplication of therapy. The CP was notable to confirm the physician had been contacted regarding the CP recommendations and stated the facility would have those records. When asked if in her professional opinion there was an indication to take Jardiance and Farxiga together she stated not that she was aware of.</p> <p>On 6/25/25 at 1:24 PM, the surveyor attempted to interview the resident's Nurse Practitioner (NP) via telephone. The surveyor left a message but did not receive a return phone call from the NP.</p> <p>On 6/25/25 at 2:25 PM, the DON and the LNHA acknowledged they were unable to locate the pharmacy reconciliation report. The DON further stated there was no documentation the CP recommendations were acted upon. The DON also acknowledged she was unaware of any indication for using both Farxiga and Jardiance together. The DON stated she believed the resident had used their own medications during their stay and that possibly the pharmacy substituted the Jardiance, but confirmed one of the medications should have been discontinued.</p> <p>2. The surveyor reviewed the closed record for Resident #88.</p> <p>A review of the admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included acute and chronic respiratory failure, chronic obstructive pulmonary disease, morbid obesity, and pulmonary fibrosis (chronic lung disease when lung tissue becomes damaged and scarred)</p> <p>A review of the Order Summary Report (OSR) included the following physician's order (PO):</p> <p>Acetazolamide oral tablet 250 mg (milligram); give one tablet by mouth every 12 hours for diuretic, dated 8/25/24.</p> <p>A review of the corresponding September 2024 Medication Administration Record (MAR) revealed on three occasions the nurse documented 9. According to the key 9 indicated other- see nurses note.</p> <p>9/5/24 6:00 AM 9, 9/5/24 6:00 PM 9, and 9/6/24 6:00 AM 9.</p> <p>A review of the corresponding Progress Notes revealed the following:</p> <p>On 9/5/24 at 6:31 AM, acetazolamide oral tablet 250 mg give one tablet by mouth every 12 hours for diuretic. Medication not available, awaiting delivery from pharmacy.</p> <p>On 9/5/24 at 7:04 PM, acetazolamide oral tablet 250 mg give one tablet by mouth every 12 hours for diuretic. Awaiting delivery from pharmacy.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/5/24 at 11:53 PM, acetazolamide 250 mg not available, a call was made to pharmacy, and I spoke to [redacted], and told me the medication is coming at midnight delivery.</p> <p>On 9/6/24 at 7:08 AM, acetazolamide oral tablet 250 mg give one tablet by mouth every 12 hours for diuretic. Awaiting delivery from pharmacy.</p> <p>On 6/24/25 at 1:44 PM, the survey team met with the facility Licensed Nursing Home Administrator and the Director of Nursing (DON) stated the resident's records were reviewed and the nursing supervisor would enter the medication orders after reviewing them first with the attending physician. If a medication was not available, the nurse should have called the attending physician as to how to proceed. The DON further stated a medication could be considered stat and could be delivered within four hours. The DON reviewed the resident medical record and confirmed the nurse indicated the medication was not available and that the nurse should have documented the physician had been notified.</p> <p>On 6/25/25 at 2:39 PM, the surveyor interviewed the [NAME] President of special clinical projects who acknowledged the physician should have been notified the resident had not received their medication and they should have had medication delivered from the pharmacy stat.</p> <p>A review of the facility's Unavailable Medications policy with an effective date of February 2019, included . The facility must make every effort to ensure the medications are available to meet the needs of each resident .Nursing staff shall notify the attending physician of the situation and explain the circumstances, expected availability and optional therapies that are available .</p> <p>NJAC 8:39-11.2(b); 27.1(a)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Complaint #NJ00175069</p> <p>Based on interviews, medical record reviews, and a review of other pertinent facility documentation, it was determined that the facility failed to revise the comprehensive care plan (CP) interventions for 1 (one) of 18 residents (Resident #83) reviewed for a comprehensive CP.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 6/23/25 at 9:18 AM, the surveyor reviewed the hybrid medical records (paper and electronic) of Resident #83, which revealed the following:</p> <p>A review of the admission Record (AR, an admission summary) reflected that Resident #83 was admitted with diagnoses that included but were not limited to displaced bimalleolar (ankle) fracture of right lower leg, subsequent encounter for closed fracture with routine healing disease, and dementia (loss of memory).</p> <p>A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) on 6/18/24 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated that the resident had a moderately impaired cognition. Further review of A/MDS, as reflected in Section M - Skin Conditions, revealed that Resident #83 has a pressure reducing device for bed.</p> <p>A review of the June 2024 Order Summary Report (OSR) air mattress monitor for function and placement every shift, with a start date of 6/29/24.</p> <p>A review of the June 2024 Treatment Administration Record (TAR) revealed that the nurses documented that the air mattress was started on 6/29/24.</p> <p>A review of the form [Name Redacted] Wound Care dated 6/18/24 revealed a wound location to the coccyx to the buttock unstageable pressure ulcer (PU) with measurement of 5x7x0.1 with 100% necrotic material. Treatment recommendations include, but are not limited to, a low-air-loss mattress with measures in place for turning and positioning.</p> <p>A review of Resident #83's comprehensive CP review revealed actual skin breakdown related to coccyx PU initiated on 6/12/24. There are no interventions or tasks associated with a pressure-relieving air mattress.</p> <p>On 6/24/25 at 9:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that she would report the skin condition to her supervisor. The supervisor would then call the physician to inform them about the wound and request a treatment order, including an air mattress, and it should be added to the CP.</p> <p>On 6/24/25 at 9:14 AM, the surveyor interviewed the LPN/UM (Unit Manager), who stated that the CP should be updated if there is an additional order from the physician or wound doctor that includes a pressure relieving device.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/25 at 10:44 AM, the surveyor met with the Clinical Nurse/RN, who stated that the nurses failed to update the CP according to the physician's order.</p> <p>On 6/25/25 at 01:56 PM, the surveyor interviewed the Director of Nursing (DON) regarding the concern above but did not provide further information.</p> <p>A review of the facility policy titled Care Plans, Comprehensive Person-Centered with the revised date of 3/2022 stated under Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.</p> <p>On 6/26/25 at 11:15 AM, the surveyor met with the Licensed Nursing Home Administrator, DON, and Regional Clinical Nurse for the exit conference; no further pertinent information provided.</p> <p>NJAC 8:39-11.2(f)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #NJ00183311</p> <p>Based on interview and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) an allegation of staff to resident abuse within two hours of being made aware of the allegation. The incident allegedly occurred on 11/23/24 when the Certified Nursing Assistant (CNA) allegedly inappropriately touched a resident during an initial skin evaluation (Resident #90). This deficient practice was identified for 1 of 3 investigations reviewed, and was evidenced by the following:</p> <p>On 6/24/25 at 9:49 AM, the surveyor reviewed the closed medical record for Resident #90 who was discharged from the facility.</p> <p>The surveyor reviewed the medical record for Resident #90.</p> <p>A review of the admission Record face sheet reflected the resident was admitted to the facility in November of 2024 with diagnoses which included acute cystitis (inflammation of the bladder caused by infection), other specified sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), diabetes and muscle weakness and difficulty in walking.</p> <p>A review of the most recent annual Minimum Data Set (MDS), and assessment tool dated 11/26/24, reflected a brief interview for mental status (BIMS) score of 14 out 15, which indicated an intact cognition and could understand others and make self-understood with clear speech.</p> <p>On 6/24/25 at 9:57 AM, the surveyor reviewed the facility provided Concern Form dated 11/27/24 the concern was reported to Assistant Director of Nursing (ADON) (now current Director of Nursing [DON]) reported by resident's family on day of discharge 11/27/24 was as follows:</p> <p>On 11/27/2024, received a report from patient's family member (redacted) that when the patient was admitted on [DATE] the family member thought they saw the CNA's hand on the residents private part. The family member stated they were in the room and both the nurse, and the CNA went in to do a skin assessment and after they turned the resident on their back this is when the family member thought they saw the incident happen. The family member however did not report this to any staff members.</p> <p>A review of the Nursing Progress notes revealed a resident evaluation dated 11/23/24 at 10:34 PM, which included the resident was oriented to time, place and person. Physical abilities were the resident required the assistance of one person for bed mobility, bathing and dressing. The resident was independent with eating but required total dependence with toileting (assistance of two persons), and transfers. At this time the resident's skin was assessed and revealed redness on the sacrum and a left flank opened blister.</p> <p>A further review of the resident's Progress Notes revealed the following:</p> <p>On 11/24/24 at 4:38 PM, the resident had a social service admission evaluation. There was no documentation the resident or family reported inappropriate touching.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/25/24 at 9:36 AM, the resident had an admission follow-up with the Nurse Practitioner (NP). There was no documentation the resident or family reported inappropriate touching.</p> <p>On 11/25/24 at 12:20 PM, the resident was seen by the Physician's Assistant (PA). There was no documentation the resident or family reported inappropriate touching.</p> <p>A review of the facility provided Investigation Report dated 11/27/24 completed by the DON which included a timeline of events. The events were as follows:</p> <p>On 11/27/24 at approximately 10:00 AM, Resident # 90's family met with the ADON and alleged while Resident # 90 was having their skin assessed at the time of admission on [DATE] the resident's family thought they witnessed the CNA place her hand on the resident's private part when turning them in bed.</p> <p>On 11/27/24 at approximately 10:15 AM, the DON and the ADON met Resident # 90 to discuss the allegation made by their family member. Resident # 90 was adamant and stated no one touched me inappropriately. The resident stated they did not know why their family member would say that.</p> <p>On 11/27/24 at approximately 10:30 AM. the DON left voicemails for the nurse and CNA who were accused for statements.</p> <p>On 11/27/24 at 3:00 PM, the DON and the ADON interviewed the CNA who stated she was with the nurse when Resident # 90 was admitted and assisted with turning and positioning the resident so the nurse could check their skin. The CNA denied the allegation of touching the resident's private part and stated her hand was on the resident's back while turning.</p> <p>On 11/27/24 at approximately 3:10 PM, the DON and ADON met with the Registered Nurse (RN) who stated nothing of that sort happened during the skin assessment.</p> <p>In addition, the report included that upon receiving the allegation from the resident's family member, the DON and ADON immediately went to speak with the resident. As per the resident the aide did not touch their private part. The DON reviewed the admission skin assessment dated [DATE] which included a left flank open blister and redness to the sacrum as well as that the resident was alert and oriented X 3 and denied any allegation of inappropriate touching.</p> <p>The investigation conclusion was After a thorough investigation including interviews with the staff and resident, the team has concluded that the allegation of inappropriate touching did not occur and was not substantiated.</p> <p>On 6/24/25 at 1:44 PM, the survey team met with the DON and the Licensed Nursing Home Administrator. The DON stated every staff member was responsible for reporting allegations of abuse, no matter the type of abuse. The LNHA and the DON both confirmed an allegation of sexual abuse should be reported to the NJDOH within two hours of when the allegation was reported. The LNHA stated he reviewed the reportable file from the previous LNHA and confirmed he could not find any additional documentation that this event was reported to the NJDOH as required. The LNHA stated he thought that if the facility could substantiate an allegation before the two hours then the allegation did not have to be reported.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated revised September 2022, included . All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours if an allegation that does not involve abuse or result in serious bodily injury .</p> <p>NJAC 8:39-9.4(f)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #NJ00175069</p> <p>Based on the interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) consistently document an actual skin condition of the pressure ulcer (PU, damaged to the skin or underlying tissue) upon admission, b.) provide a necessary treatment and services consistent with professional standards of practice, to promote healing, and prevent worsening of a PU, c.) ensure pressure-relieving interventions according to the physician's order, and d.) consistently complete a weekly skin condition assessment. This deficient practice was identified in 1 (one) of 2 residents (Resident #83) reviewed for pressure ulcers/injuries.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 6/23/25 at 9:18 AM, the surveyor reviewed the hybrid medical records (paper and electronic) of Resident #83, which revealed the following:</p> <p>A review of the admission Record (AR, an admission summary) reflected that Resident #83 was admitted with diagnoses that included but were not limited to displaced bimalleolar (ankle) fracture of right lower leg, subsequent encounter for closed fracture with routine healing disease, and dementia (loss of memory).</p> <p>A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) on 6/18/24 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated that the resident had a moderately impaired cognition. Further review of A/MDS reflected in Section M - Skin Conditions revealed that Resident #83 has unstageable - slough (a soft, yellow or white, often stringy material that accumulates on the surface of a wound) and/or eschar (a layer of dry, dead tissue that forms over a deep wound): known but not stageable due to coverage of wound bed by slough and/or eschar.</p> <p>A review of the Resident Evaluation assessment dated [DATE] revealed that the resident's Braden score (a tool used to predict risk for developing PU) is 14, which indicated moderate risk for developing pressure ulcers. Furthermore, there is no documentation of the site and description for the coccyx/buttocks PU.</p> <p>A review of the Progress Notes (PN), dated 6/11/24 at 7:53 PM, stated skin evaluation reveals current skin breakdown/skin conditions; refer to the completed evaluation and physicians' orders for type and location.</p> <p>A review of the PN dated 6/12/24 at 1:36 PM stated, second skin check findings include sacrum wound.</p> <p>A review of the June 2024 Order Summary Report (OSR) is as follows:</p> <p>1. Phytoplex Z-Guard paste (petrolatum zinc oxide) applied to the sacral area topically every shift for a preventative measure for redness, with a start date of 6/11/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Cleanse the open area on the coccyx to the buttock with Dakin's 0.125% solution. Apply calcium alginate to the wound base, then cover it with a silicone foam dressing twice daily, starting on 6/20/24.</p> <p>3. Bi-weekly skin observations every evening shift every Tuesday and Friday for 0- no skin breakdown, 1-previously identified wound, and 2-newly identified wounds with a start date on 6/14/24.</p> <p>4. Braden scale on admission x 3weeks post admission, every evening shift, and every Tuesday for 3 weeks. Complete the Braden Scale in Forms.</p> <p>5. Air mattress monitor for function and placement every shift, with a start date of 6/29/24.</p> <p>A review of the June 2024 Treatment Administration Record (TAR) stated that Bi-weekly skin observations every evening shift, every Tuesday and Friday, for 0- no skin breakdown, 1-previously identified wound, and 2-newly identified wounds with a start date on 6/14/24. The nurse documented 0 - no skin breakdown on the evening shifts of 6/14/24, 6/18/24, 6/21/24, and 6/25/24.</p> <p>There is no documentation for biweekly observations and Braden scale assessments for the 3 weeks following admission from the hybrid medical record.</p> <p>A review of the form [Name Redacted] Wound Care dated 6/18/24 revealed a wound location to the coccyx to the buttock unstageable PU with measurement of 5x7x0.1 with 100% necrotic material. Treatment recommendations include, but are not limited to, a low-air-loss mattress with measures in place for turning and positioning.</p> <p>A review of Resident #83's comprehensive CP review revealed actual skin breakdown related to coccyx PU initiated on 6/12/24 with a cancelled date on 7/30/24. There are no interventions or tasks associated with a pressure-relieving mattress.</p> <p>On 6/24/25 at 9:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1) who stated that the process of admitting a new resident they check the skin condition, document it and if there is any pressure injury/wound she will report it to the supervisor then the supervisor will call the physician to inform about the wound to get a treatment order. She will inform the wound consult doctor who comes to the facility every Tuesday.</p> <p>On 6/24/25 at 9:14 AM, the surveyor interviewed the LPN/UM (Unit Manager), who stated that if the resident refused to be seen on the day of admission, she will go and meet the resident for a second skin assessment then document the PU in the Wound Assessment tab including the location, measurement, and the overall condition of the PU.</p> <p>On 6/24/25 at 10:01 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) who stated that there is a documented wound on 6/12/24, second skin check findings include sacrum wound and there is documentation from the wound doctor on 6/18/25 for unstageable PU.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315472	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Careone at East Brunswick		STREET ADDRESS, CITY, STATE, ZIP CODE 599 Cranbury Road East Brunswick, NJ 08816	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/25 at 10:44 AM, the surveyor met with the Clinical Nurse/RN, who stated that the nurses failed to document or report the wound, may not have taken the measurement, and did not realize or recognize the need to complete the full assessment. The staff did order a treatment, but there should be an assessment or description of the wound, including the size and the location of the pressure sores.</p> <p>On 6/25/25 at 12:51 PM, the surveyor interviewed LPN#2 over the phone, who stated that she no longer works at the facility and has forgotten the resident, as the incident occurred in 2024. The LPN#2 added that she must have missed the documentation for the PU, and it should be documented, including the measurement and location of the wound. If the resident refused, she would report it to the nurse in charge.</p> <p>On 6/25/25 at 01:56 PM, the surveyor interviewed the Director of Nursing (DON) regarding the concern above and stated that the PU should be documented, including the measurement, and followed the physician's orders accordingly.</p> <p>A review of the facility policy title, Pressure Ulcer/Skin Breakdown-Clinical Protocol with the revised date of April 2018 stated under Assessment and Recognition: 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; 3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions.</p> <p>On 6/26/25 at 11:15 AM, the surveyor met with the Licensed Nursing Home Administrator, DON, and Regional Clinical Nurse for the exit conference; no further pertinent information provided.</p> <p>NJAC 8:39-27.1(a,e)</p>