STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315477	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Wayne	493 Black Oak Ridge Road Wayne, NJ 07470

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, it was determined that the facility failed to follow a physician's order for 1 of 5 residents (Resident #125) observed during medication administration, according to the standards of clinical practice and the facility's policy.This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, 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 casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 12/18/2025 at 8:24 AM, the surveyor observed a Licensed Practical Nurse (LPN) administer medications to Resident #125. The resident was alert, verbally responsive, and able to swallow their medications whole. The surveyor observed the LPN prepare and administer to the resident Aspirin (ASA) 81 milligram (mg) enteric coated (EC; delayed release) to Resident #125. The surveyor reviewed Resident #125's electronic medical record. The admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, multiple sclerosis. A Brief Interview/Assessment for Mental Status evaluation dated 12/17/2025 was completed by the facility to assess the resident's cognition. Resident #125 scored a 15 out of 15 which indicated the resident was cognitively intact.A review of the physician's orders and the December 2025 Medication Administration Record (MAR) revealed the resident had an order dated 12/18/25 for ASA 81 mg chewable tablet by mouth one time a day at 8 AM. The 12/18/25 ASA 81 mg chewable order entry was signed as administered by the LPN on the MAR. The LPN did not administer an ASA 81 mg chewable tablet as ordered by the physician during the medication administration. On 12/18/2025 at 10:00 AM, the surveyor with the LPN checked the medication cart for ASA 81 mg tablets available. The LPN showed the surveyor a house stock ASA 81 mg EC tablet bottle and a house stock ASA 81 mg chewable bottle. The LPN stated the physician's order would determine which form of ASA would be administered to the resident. The surveyor discussed with the LPN regarding the observation that ASA 81 mg EC was administered to Resident #125 and not ASA 81 mg chewable as ordered by the physician. The LPN acknowledged ASA 81 mg EC should not be administered for a resident with an order for ASA 81 mg chewable.On 12/18/2025 at 10:16 AM, the surveyor informed the Director of Nursing (DON) of the concern that the LPN administered ASA 81 mg EC and not ASA 81 mg chewable as ordered by the physician. The DON acknowledged the concern and stated he would follow up with the LPN. On 12/18/2025 at 12:17 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the DON about the above concerns. On 12/19/2025 10:11 AM, the DON and the LNHA met with the (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	survey team. The LNHA stated the nurse was provided in-service education, the physician was made aware, and the resident was okay. The surveyor reviewed the facility provided policy titled, Administering Medications with a last revised date of April 2019 revealed under Policy Statement: Medications are administered in a safe and timely manner, and as prescribed.NJAC 8:39-11.2 (b); 29.2(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, it was determined that the facility failed to follow a physician's order for the application of a resting hand splint to the left hand of one resident. The deficient practice was identified for 1 of 3 residents (Resident #11) reviewed for positioning and mobility.This deficient practice was evidenced by the following: On 12/16/2025 at 11:00 AM, the surveyor observed that Resident #11's left hand did not have any resting splint. The resident stated they did not know where it was, and the staff must have forgotten to put it on. The resident acknowledged the importance of using the splint. When asked if they refused to use it, the resident denied refusing the splint. On 12/17/2025 at 10:15 AM, the surveyor observed Resident #11 again, not wearing the splint. Resident #11 stated that they were waiting for their family member to help put the splint on. Resident #11 added that the staff usually put the splint on, but the sgtaff probably forgot. On 12/17/25 at 1:26 PM, the surveyor reviewed the hybrid medical record, which included the electronic medical record and the paper medical record of Resident #11, which revealed the following: A review of the admission Record (AR) (an admission summary) reflected that Resident #11 was admitted to the facility with diagnoses that included but were not limited to hemiplegia (complete loss of strength on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (blood vessel in the brain becomes blocked) affecting right dominant side. A review of the admission Minimum Data Set, an assessment tool dated 11/23/25, reflected that Resident #11 had a Brief Interview for Mental Status score of 14 out of 15, which indicated an intact cognition. A further review is reflected in Section GG, Functional Limitation in Range of Motion A. Upper extremity (shoulder, elbow, wrist, hand) 1. Impairment on one side. A review of the resident's Order Summary Report reflected an active order of applying a resting hand splint to the left hand every shift to be worn when in bed. Remove for hygiene and skin checks, with the start date of 11/24/25. A review of the electronic Medication Administration Record revealed that the nurses were signing the order for a resting hand splint on the left hand every shift and this included the dates of 12/16/25 and 12/17/25. A review of the Care Plan (CP) report with an initiated date of 11/17/25, which focused on ADL self-care deficit related to physical limitations, right-sided hemiparesis due to cerebrovascular accident (stroke). The CP interventions included, but were not limited to, a resting hand splint on the left hand while in bed, removed for hygiene and skin checks with date initiated on 11/24/25. On 12/17/2025 at 10:45 AM, the surveyor interviewed the Certified Nurse Assistant, who stated that sometimes she puts the splint, but she will usually refer to the nurse. On 12/17/2025 at 10:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that she was supposed to put the splint on the resident, but she got busy. The LPN stated that during care, the resting hand splint should be removed, and the nurse should check the skin integrity, and then she would put the splint back as soon as she checks the resident's skin for any redness. On 12/17/2025 11:25 AM, the surveyor interviewed the Occupational Therapy (OT), who stated that he knew the resident well because he was the OT who took care of the resident. He stated that OT recommended using a rolled-up small towel, then the resting splint. The OT stated that the resident verbalized that they want to use the resting hand splint. The OT added that they have given in-service training to the family, aids, and nurses on how to put on the resting splint. The OT said that he did put the resting hand splint on Resident #11 yesterday after lunch. The OT was not sure if the resident did or did not have a splint on yesterday. On 12/18/2025 at 10:33 AM, the team of surveyors met with the Licensed Nursing Home Administrator and the Director of Nursing, but did not provide further information. The surveyor reviewed the facility policy titled Orthotic/Splint with the revised date of 6/14/2007, which revealed under Purpose: an orthosis/splint is a device that can be added to a person's body to support, position, or immobilize a part; to correct deformities; to assist weak muscles and restore function; or to modify tone. NJAC 8:39-27.1(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review it was determined the registered dietitian failed to provide a timely initial comprehensive nutritional evaluation for 1 resident (#94) of 3 residents reviewed for nutrition. The deficient practice was evidenced by the following: The surveyor observed the resident asleep in bed on 12/17/2025 at 9:40 AM. One container of a nutritional supplement and 2 bottles of water were observed on the over bed table. The surveyor interviewed the unit licensed practical nurse (LPN) on 12/17/2025 at 12:13 PM. The LPN stated the resident eats poorly at times and has lost weight since admission. She further stated the resident's spouse brings in food from home daily and the resident is on appetite stimulating medication. The LPN stated the nurse practitioner sees the resident frequently and would be in later that day to adjust the appetite stimulating medication. She stated the resident was able to feed themself. She stated the resident was depressed and that would be re-addressed by the nurse practitioner. During the conversation with the LPN, the resident's spouse was observed assisting the resident with their lunch. The surveyor reviewed the electronic medical record which revealed the following information. The resident had been admitted recently with diagnosis including but not limited to type 2 diabetes mellitus with hypoglycemia, anorexia, anxiety, depression, and urinary tract infection. Upon Resident # 94's admission, the Registered Dietitian (RD) put a comprehensive nutritional care plan in place, yet there was no documented comprehensive nutritional evaluation in place upon admission. The resident's record revealed that one week after the resident's admission to the facility, the Registered Dietitian (RD) documented a ?Mini Nutritional Assessment.(MNA).' The screening tool included information that the resident had a moderate decrease in food intake and weight loss within the last 3 months, mobility needs, psychological problems, and height and weight. The screen did not include calculations for the resident's nutritional needs. The resident scored a ?7' on the assessment indicating malnutrition. There was no comprehensive nutritional evaluation or diet type documented within MNA as well. At that time the primary physician ordered a medication to stimulate the appetite. The interdisciplinary team updated the resident's food preferences. The resident's spouse continued to bring in food from home daily. The surveyor interviewed the RD on 12/22/25 at 9:40 AM regarding the omission of an initial comprehensive nutritional evaluation for this resident. The RD stated the week the resident was admitted there were many admissions and 2 of her assistants were not in. She stated while she handwrote the comprehensive evaluation in a timely manner in a notebook, she failed to document the evaluation in the medical record. The RD provided a photocopy of a comprehensive nutritional evaluation created on 12/19/25 which reflected the status of the resident at the time of the initial comprehensive assessment. The RD stated (and the surveyor confirmed) she initiated a comprehensive nutritional care plan at the time of admission along with the resident's food preferences. She stated the primary physician and the nurse practitioner were also closely following the resident for nutrition. The surveyor reviewed physician orders for weight monitoring, nutritional supplementation, appetite stimulating medication and mood enhancing medication beginning within a week of admission and continuing to present. The licensed nursing home administrator (LNHA) and director of nursing (DON) spoke to the surveyor on 12/22/25 at 11:26 AM stating they had noticed the evaluation was late. The LNHA stated the RD had comprehensively assessed the resident at the time of their admission, however, neglected to enter the assessment into the medical record. The LNHA provided the surveyor with the facility policy titled ?Nutritional Assessment,' revised October 2017. Step #1 indicated the RD in conjunction with the nursing staff and healthcare practitioners will conduct a nutritional assessment within current baseline assessment timeframes. NJAC 8:39-17.2(d); 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** Based on observation, interview, record review of medical records, and pertinent facility documentation, it was determined that the facility failed to ensure that the physician's orders were followed according to the standard of clinical practice. This deficient practice was identified for 2 of 3 of the residents (Resident #18 and #29) who were reviewed for respiratory care.This deficient practice was evidenced by the following: 1. On 12/16/2025 at 11:21 AM, the surveyor observed Resident #18, who was sitting in bed, with oxygen (O2) at 2.5 lpm (liters per minute) via nasal cannula (NC, a plastic prong attached to a tube, inserted into the nostrils through which oxygen flows) attached to the oxygen concentrator (a device that supplies oxygen). Resident #18 stated that they have been using the O2 continuously. On 12/19/25 at 9:34 AM, the surveyor reviewed the electronic medical record and the paper medical record of Resident #18, which revealed the following: A review of the admission record (AR) reflected that Resident #18 was admitted with diagnoses that included, but were not limited to, acute and chronic respiratory failure with hypoxia (low level of O2). A review of the admission MDS (A/MDS), (an assessment tool used to facilitate the management of care), which was dated 12/12/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had intact cognition. Further review of the A/MDS in Section O -Special Treatments, Procedures and Programs revealed that Resident #29 used oxygen while in the facility. A review of the Order Summary Report (OSR) showed an active order for oxygen at 2 lpm via NC every shift for SOB (shortness of breath), with the start date of 12/5/25. A review of the electronic Medication Administration Record revealed that the nurses were signing the order for oxygen at 2 lpm via nasal cannula every shift, with the start date of 12/5/25. A review of the Care Plan (CP) report with an initiated date of 12/7/25, which focused on at-risk for respiratory impairment. The CP interventions included, but were not limited to, administering O2 per physician order. 2. On 12/16/2025 at 11:11 AM, the surveyor observed Resident #29 lying in bed asleep, with O2 at 1.5 lpm via NC attached to the oxygen concentrator. On 12/17/2025 at 10:38 AM, the surveyor observed Resident #29 in bed, asleep. The surveyor observed that the oxygen was at 1.5 lpm via NC attached to the concentrator. On 12/19/25 at 11:02 AM, the surveyor reviewed the electronic medical record and paper medical record of Resident #29, which revealed the following: A review of the AR reflected that Resident #29 was admitted with diagnoses that included, but were not limited to, chronic respiratory failure, unspecified whether with hypoxia or hypercapnia (too much carbon dioxide in the blood). A review of the A/MDS dated [DATE] indicated that the facility assessed the residents' cognitive status using a BIMS score of 9 out of 15, which indicated that the resident had moderately impaired cognition. Further review of the A/MDS in Section O -Special Treatments, Procedures and Programs revealed that Resident #29 used oxygen while in the facility. A review of the OSR showed an active order for oxygen at 2 lpm via NC every shift for SOB, with the start date of 12/2/25. A review of the eMAR revealed that the nurses were signing the order for oxygen at 2 lpm via nasal cannula every shift. A review of the CP report with an initiated date of 10/29/25, which focused on at-risk for respiratory impairment. The CP interventions included, but were not limited to, administering O2 per physician order. On 12/17/2025 at 10:49 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that it was at 2 lpm. The Registered Nurse/MDS Coordinator (RN/MDSC) revealed that Resident #29 O2 is at 1.5 lpm in the presence of the LPN. The RN/MDS adjusted the oxygen to 2 lpm. She added that now it was at 2 lpm. On 12/18/2025 at 10:33 AM, the team of surveyors met with the Licensed Nursing Home Administrator and the Director of Nursing, but did not provide further information. On 12/19/2025 at 10:05 AM, the surveyor reviewed the facility policy titled Oxygen Administration with the revision date of October 2010, stated under Steps in the Procedure: 8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. NJAC 8:39-25.2(c)3, 27.1(a)