STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Moorestown	895 Westfield Road Moorestown, NJ 08057

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Complaint NJ #: 175738 Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) obtain weekly weights as ordered; and b.) obtain a physician's order to hold a tube feeding (therapeutic nutrition) in accordance with professional standards of practices. This deficient practice was identified for 2 of 18 residents reviewed for professional standards of practice (Resident #103 and Resident #301). 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. The deficient practice was evidenced by the following: 1. On 9/23/24 at 7:24 PM, the surveyor reviewed the closed medical record for Resident #103. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but not limited to; fracture of left femur (thigh bone), left knee osteoarthritis, generalized muscle weakness, and anemia (low iron). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 5/28/24, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated a moderately impaired cognition. (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	A review of the Order Summary Report dated active orders as of 5/21/24, included a physician's order (PO) dated 5/21/24, for weekly weights every Tuesday. A review of the corresponding May and June 2024 Medication Administration Records (MAR) revealed the weekly weights were blank on 5/28/24 and 6/6/24. A review of the Weights and Vitals Summary included one weight for 5/22/24, of 195 pounds. On 9/26/24 at 11:49 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN), who stated when a resident was admitted to the facility, their weight was taken upon admission, then a weekly weight was obtained. The IP/RN stated that the Certified Nursing Aides (CNA) obtained the weight, wrote the weight on a list and gave it to the nurse to enter the weight in the Electronic Health Record (EHR). The IP/RN stated that the weight was either recorded in the Weights and Vitals or on the MAR. On 9/26/24 at 12:06 PM, the surveyor interviewed the Registered Dietitian (RD), who stated that orders were put in for weekly weights, and the staff was expected to obtain weekly weights and document on the MAR. The RD stated that the facility was aware that the nurses were either not obtaining or not documenting weekly weights for residents, since there were blanks on the MAR. On 9/27/24 at 10:23 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the IP/RN, [NAME] President of Operations Bridge Care (VPO), and survey team, confirmed that Resident #103's weights were not obtained weekly as ordered. The LNHA acknowledged that the weights should have been obtained weekly as ordered. A review of the facility provided Weight Assessment and Intervention policy dated revised March 2022, included residents are weighed upon admission and at intervals established by the interdisciplinary team such as: weekly for four, then weekly for four weeks, then monthly unless otherwise indicated, or as ordered . weights are recorded in each individual's medical record . 49094 2. On 9/23/24 at 7:05 PM, during initial tour of the facility, the surveyor observed Resident #301 sleeping in bed with the Resident Representative (RR) by their bed side. The RR stated that the resident had not been eating well and a feeding tube (a tube surgically inserted into the stomach to provide nutrition; FT) was inserted to provide supplemental nutrition. The surveyor observed the FT pump located on a pole near the resident's bed. There was no formula being administered at that time. On 9/24/24 at 11:10 AM, the surveyor reviewed the medical record for Resident #301. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses including but not limited to; dysphagia (difficulty with swallowing), gastrostomy (FT) malfunction, and adult failure to thrive (weight loss, decreased appetite, poor nutrition, and inactivity). A review of the most recent MDS dated [DATE], reflected the resident had a BIMS score of 6 of out of 15, indicating a severe impairment in cognition. A review of Section K indicated Resident #301 had a FT and received mechanically altered diet. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Physician Order Summary Report reflected a physician's order (PO) with a start date of 9/19/24, for Osmolite 1.5 calorie (nutrition formula) with a start start time of 6:00 PM (6 PM), to administer 40 milliliters (ml) per hour until 800 ml has been infused. There was also a PO with a start date of 9/14/24, to administer water flushes every six hours 150 ml every shift for water flushes. On 9/24/24 at 11:40 AM, the surveyor observed Resident #301 lying in bed awake. The surveyor asked the resident if they ate breakfast that morning, and the resident, who seemed confused, replied yes. The surveyor observed a 1000 ml bottle of Osmolite 1.5 calorie and a water flush bag hanging on the FT pole near the resident's bed. The pump was turned off and the tube feeding was not connected to the resident. The bottle of Osmolite had 600 ml remaining in the bottle, and was dated for 9/23/24, and timed for 10:00 PM. On 9/24/24 at 11:53 AM, the surveyor observed Resident #301 in their wheelchair being escorted by the Certified Nursing Aide (CNA) to a common area where Resident #301 started watching television. Resident #301 was not receiving any tube feeding at that time. On 9/24/24 at 12:01 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that Resident #301's tube feeding started at 6 PM, and ran until the resident received a total volume of 800 ml. The LPN and surveyor proceeded to the resident's room where the LPN confirmed that the tube feeding was hanging on the feeding pole and not being infused at that time. The LPN confirmed that there was only 400 ml missing from the Osmolite. The LPN acknowledged that the resident's tube feeding at a rate of 40 ml per hour would take until 2:00 PM (2 PM) to reach a total volume of 800 ml infused. The LPN then stated that they may be holding the tube feeding because Resident #301 was scheduled for a kidney, ureter, and bladder (KUB) X-ray (imaging test that examines the urinary and gastrointestinal system) today. The LPN stated there should be an order to hold the tube feeding. At that time, the surveyor and LPN reviewed the resident's EHR, and the LPN confirmed there was no physician's order to hold the tube feeding and said she was going to call Resident #301's physician to clarify if the tube feeding should be held. On 9/24/24 at 12:36 PM, the surveyor interviewed the LPN, who stated that she spoke with the resident's Nurse Practitioner (NP) who was aware of the tube feeding being held due to the KUB X-ray scheduled for today. The LPN stated that the NP was going to put in an order to hold the tube feeding. On 9/26/24 at 9:57 AM, the surveyor reviewed the physician order's which revealed a PO dated 9/24/24 at 12:41 PM, to hold tube feeding until KUB results. On 9/26/24 at 10:09 AM, the surveyor reviewed the Progress Notes which included a Physician/Practitioner Progress Note created on 9/24/24 at 3:21 PM, that documented the KUB X-ray was ordered and the tube feeding was on hold until KUB was obtained. The LPN created a progress note on 9/24/24 at 4:28 PM, which indicated that the tube feeding was on hold until KUB results were returned. The doctor and nutritionist were notified. On 9/26/24 at 10:40 AM, the surveyor interviewed the Charge Nurse (CN), who acknowledged that there should have been a physician's order to hold the tube feeding. The CN also stated the physician's order should have been obtained prior to holding the resident's feeding. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 10:24 AM, the IP/RN in the presence of the LNHA, VPO, and survey team, stated there should have been a physician's order to hold the tube feeding. The IP/RN acknowledged that the physician's order to hold the tube feeding should have been obtained at the time the KUB X-ray was ordered to ensure the nurses were aware to hold the tube feeding. A review of the facility's Licensed Practical (Vocational) Nurse (LPN)/(LVN) job description with a revision date of May 2022, included to transcribe telephone, verbal, and telemedicine orders from providers as appropriate . A review of the facility's Charting and Documentation policy with a revision date of 2001, included all services provided to the resident, progress toward the care plan goals, or any changes in the residents medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . NJAC 8:39-27.1(a)