Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315485 | A. Building<br>B. Wing | 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Careone at Wall | 2621 Highway 138<br>Wall, NJ 07719 |

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) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>COMPLAINT #2720500 Based on interviews, review of medical records and other pertinent facility documentation on 1/23/26 and 1/28/26, it was determined that the facility failed to notify a resident's representative (RR) regarding a change in the resident's medical condition and or status. This deficient practice was identified for 1 of 3 residents reviewed (Resident #1) and was evidenced by the following:Resident #1 was not at the facility at the time of the survey. A closed record review was conducted. A review of the admission Record revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: type II diabetes, cerebral infarction, chronic obstructive pulmonary disease, and hypertension. A review of Resident #1's Progress Notes (PN) for January 2026 revealed a nursing note dated 1/11/26 at 11:39 PM, created by Registered Nurse (RN #1) which state: [Physician] notified of excoriation to bilateral groins and scrotum, (scraped skin). There was no documented evidence to show that the facility notified the resident's representative about the newly identified scraped areas on the resident's skin. During an interview with RN #1 on 1/23/26 at 4:17 PM, RN #1 stated that a RR was to be notified of any change in a resident's medical condition and that the notification should be documented. In the presence of the surveyor RN #1 reviewed the above-mentioned PN and stated that if the family was notified, they would have documented it. RN #1 further stated that they should have informed the RR. During a joint interview with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) on 1/28/26 at 2:10 PM, they both stated that the expectation was for staff to notify the RR of any new conditions, including excoriation of the skin. They further stated that RN #1 should have informed Resident #1's RR of their change in the resident's skin condition. A review of the facility's Change in a Resident's Condition or Status policy dated February 2021 revealed that the facility would promptly notify an RR of a change in a resident's medical condition. The policy further indicated that notification would occur within twenty-four hours of the change. N.J.A.C. 8:39-27.1(a) |

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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315485 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/28/2026 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Careone at Wall | | STREET ADDRESS, CITY, STATE, ZIP CODE 2621 Highway 138 Wall, NJ 07719 | |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>COMPLAINT #2715780 Based on interviews, review of medical records and other pertinent facility documentation on 1/23/26 and 1/28/26, it was determined that the facility failed to revise care plan interventions for Resident #3 after the resident pushed a bedside table into the abdomen of their roommate (Resident #1). This deficient practice was identified for 1 of 3 residents reviewed (Resident #3) and was evidenced by the following:A review of the admission Record revealed that Resident #3 was admitted to the facility with diagnoses that included but were not limited to: hemiplegia and hemiparesis following cerebral infarction, aphasia (a language disorder that affects the ability to speak and understand what others say), apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked), and speech disturbances. A review of the Facility Reported Event (FRE) dated 1/13/26, revealed that Resident #3 had a Brief Interview of Mental Status (BIMS) of 7 out of 15, which indicated that the resident had severe cognitive impairment. The FRE further stated that an incident of resident-to-resident abuse occurred on 1/10/26 when a verbal argument was overheard in the room of Resident #1 and Resident #3. Registered Nurse (RN #1) stated that she entered the residents' room and observed Resident #3 waving the television remote, and appeared frustrated and ‘pushed [their] bedside table towards [Resident #1] bumping [Resident #1] in the abdomen with the table.' A review of Resident #3's Progress Notes (PN) for January 2026 revealed a change in condition note dated 1/10/26 at 10 AM, created by the Unit Manager (UM #1) which indicated that Resident #3 had a verbal argument with their roommate related to television remote control and that the Resident #3 pushed a bedside table into the abdomen of Resident #1. Another nursing note created by UM #1 on 1/10/26 at 4:58 PM, stated that, .[Resident #3] became frustrated and pushed table at their roommate (Resident #1). A review of Resident #3's care plan (CP) revealed a focus which indicated that Resident #3 had difficulty expressing themselves due to expressive aphasia (difficulty getting their words out). A review of interventions initiated on 1/10/26 included the following: Emotional Support provided, time given to express feelings. There was no information on the care plan regarding how they facility would ensure the resident's roommate would be protected when resident #3 gets frustrated again and staff are not in the room to provide emotional support and allow time for resident to express their feelings. The care plan failed to include adequate interventions to ensure other residents are protected from Resident #3, given their risk to physically act out towards others. On 1/23/26 at 11:43 AM, surveyor attempted to contact RN #1 via telephone without success. On 1/23/26 at 12:57 PM, surveyor attempted to contact UM #1 via telephone without success. During a joint interview with the Director of Nursing (DON) and the Licensed Nursing Home Administrator on 1/23/26 at 5:14 PM, the surveyor asked if Resident #3's CP had been updated after the incident to which they stated that Resident #3's CP was updated and referenced the above intervention. When asked how this intervention would prevent Resident #3 from becoming frustrated and physically acting out towards another resident again when staff were not around, both the DON and the LNHA stated that their updated interventions would not stop Resident #3 from another altercation with another resident. A review of the facility's Care Plans, Comprehensive Person-Centered policy dated March 2022 revealed that the purpose was to include person-centered measures that would meet a resident's physical, psychosocial and functional needs that would be developed and implemented. The policy further indicated that interventions were to address the underlying source of a problem. N.J.A.C. 8:39-11.2(e)2, 27.1(a) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>COMPLAINT #2720500 Based on interviews, review of medical records and other pertinent facility documentation on 1/23/26 and 1/26/26, it was determined that the facility failed to maintain an accurate and complete medical record in accordance with acceptable professional standards of practice. This deficient practice was identified for 1 of 3 residents reviewed (Resident #1) and was evidenced by the following:A review of the admission Record revealed that Resident #3 was admitted to the facility with diagnoses that included but were not limited to: hemiplegia and hemiparesis following cerebral infarction, aphasia (a language disorder that affects the ability to speak and understand what others say), apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked), and speech disturbances. The comprehensive Minimum Data Set (MDS), an assessment tool, dated 1/12/26, revealed a Brief Interview of Mental Status (BIMS) of 14 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS indicated that Resident #1 required substantial assistance with toileting and bathing, and that the resident was at risk of developing pressure ulcers/injuries. A review of Resident #1's care plan (CP), revealed a focus related to the resident being at risk of having alteration in skin integrity. Further review revealed an intervention, initiated on 1/6/26, that indicated that the resident's skin was to be observed during daily [Activities of Daily Living] (ADL) care and that abnormalities were to be reported. A review of Resident #1's Task list for January 2026 included the following areas facility stated should be documented during each shift. There was no evidence of documentation on the following dates and shifts: -Bladder continence and toilet use:1/6 Night1/7 Day, Evening & Night1/8 Day, Evening & Night1/9 Day, Evening & Night1/10 Day & Night1/11 Evening & Night1/12 Day, Evening & Night -Bowel movement and toilet use1/7 Evening & Night1/8 Day, Evening & Night1/9 Day, Evening & Night1/10 Day1/11 Evening & Night1/12 Day, Evening & Night -Hygiene1/6 Evening and Night1/7 Day & Night1/8 Day, Evening & Night1/9 Day, Evening & Night1/10 Day & Night1/11 Evening & Night1/12 Day, Evening & Night A review of Resident #1's Progress Notes (PN) for the corresponding dates did not reveal any documentation related to the above tasks on the stated dates. During an interview with the Certified Nursing Assistant (CNA #1) on 1/28/26 at 10:47 AM, CNA #1 stated that CNA's were primarily responsible for assisting residents with Activities of Daily Living (ADL) care. CNA #1 further stated that all care provided was to be documented in each resident's electronic medical record (EMR). CNA #1 further stated that documentation was important because it verified that residents were being monitored and that care was provided. During a joint interview with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) on 1/28/26 at 2:10 PM, they both stated that CNAs were responsible for providing ADL care and that they were expected to enter all care provided into each residents EMR. They further stated that documentation was important to prove that that care was provided. They further stated that nurses and unit managers were responsible for not only ensuring that the appropriate care was provided, but that the CNAs are documented the care they provided. A review of the facility's Charting and Documentation policy dated July 2017 revealed that all services provided to residents should be documented and that documentation would be complete and accurate. The policy listed what information was to be documented and included, .Treatment or services performed. N.J.A.C. 8:39-27.1(a) |