STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315502	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Teaneck	544 Teaneck Road Teaneck, NJ 07666

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 34421 Based on the interview and record review, it was determined that the facility failed to code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, accurately for 1 of 21 residents reviewed (Resident # 89). The deficient practice was evidenced by the following: The surveyor reviewed Resident # 89's records. The resident was discharged from the facility and according to the Discharge Return Anticipated MDS, an assessment tool used to facilitate the management of care, dated 11/21/23, the resident was assessed as being discharged to home or lesser care. A review of Resident # 89's progress notes dated 11/21/23 revealed that the resident had a transfer to hospital, as the resident had an increase in respiratory distress, chest congestion which started on 11/20/23 and the symptoms had gotten worse. On 2/21/24 at 10:15 AM, the surveyor interviewed the MDS Coordinator, who stated that the MDS under section A for Resident # 89 should have indicated discharge to the hospital and that it was an error that it indicated discharge to home or lesser care. During an interview on 2/28/24 at 1:00 PM, the surveyor brought the above concerns to the attention of the Director of Nursing and Administrator. A review of the policy regarding accuracy of resident assessment, reviewed 1/2/24, revealed Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. NJAC 8:39-11.2(e)1

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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(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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. 34421 Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of nursing practice for not following physician orders for 3 of 21 residents reviewed (Resident # 19, #197, and #72) and b.) failed to document for accountability of medications and treatments administered for 3 of 21 residents reviewed (Resident #72, #196, and #197). The 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 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. 1. The surveyor reviewed the medical records for Resident #19 and revealed the following: According to the February 2024 Order Summary Report (OSR) for Resident #19 had an order dated 2/2/24 for Midodrine HCl Oral Tablet 5 MG, Give 1 tablet by mouth two times a day for Hypotension, Hold for SBP (Systolic Blood Pressure) > or equal to 110. The February 2024 electronic Medication Administration Records (eMAR) revealed that the order was written without a specified column to check the SBP and there was no proof that SBP was taken at the time that Midodrine was administered. On 2/28/24 at 10:39 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who stated the resident's BP was supposed to be checked prior to administration of midodrine, but after reviewing the eMAR, the LPN stated that nothing had come up which requested the resident's BP was to be taken and she was not able to prove if BP had ever been taken time of administration of the midodrine for Resident #19. 46889 2. The surveyor reviewed the medical records for Resident #72 and revealed the following: According to the January 2024 OSR sheet, Resident #72 had an order dated 1/9/2024 for Midodrine HCl 5 mg two times a day with parameters to hold the medication when the SBP is more than 130. The January 2024 and February 2024 eMAR revealed several dates the nurse gave the Midodrine HCl 5 MG medication when the resident's systolic blood pressure was above 130. Midodrine HCl 5 MG was given when the SBP was above 130 by the 3-11 nurse on 1/11/24, 1/13/24, 1/19/24, and 2/11/24 and by the 7-3 nurse on 1/29/24, 1/30/24, 2/3/24, and 2/16/24. The surveyor interviewed LPN#2 on 2/22/24 at 10:48 AM. LPN#2 stated that the medication should not be given if it is outside of the ordered parameters. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the January 2024 OSR, Resident #72 had physician orders for skin prep to the left great toe, moisture barrier cream to the sacrum, left and right buttocks treatments, and incentive spirometry therapy. The January 2024 electronic Treatment Administration Record (eTAR) revealed that the evening shift nurse did not document the treatment on 1/18/24 of the following: 1. Skin prep wipes are to be applied topically to the left great toe every day and evening shift for redness. 2. Apply moisture barrier cream every shift for protection to the sacrum post-care. 3. Apply moisture barrier cream every shift for protection to the left buttock post-care. 4. Apply moisture barrier cream every shift for protection to the right buttock post-care. 5. Incentive spirometry therapy every shift for lung therapy. According to February 2024 OSR, Resident #72 had physician orders for Celebrex 10 mg capsule by mouth in the evening, Nuplazid 30 mg by mouth in the evening, pain score every shift, anti-depressant and anti-psychotic side effect tracking every shift, and A&D ointment one time a day for dry skin apply to the left and right foot, skin prep wipes are to be applied topically to the left great toe every day shift for wound care, apply moisture barrier cream every shift for protection to the sacrum, left and right buttock post-care, and incentive spirometry therapy. The February 2024 eMAR revealed that on 2/3/24, the evening shift nurse did not document the following medications: 1. Celebrex 100 mg capsule by mouth in the evening. 2. Nuplazid 30 mg capsule by mouth in the evening. 3. Pain score every shift. 4. Anti-depressant side effect tracking every shift. 5. Anti-psychotic side effect tracking every shift. 6. A&D ointment one time a day for dry skin apply to the left foot. 7. A&D ointment one time a day for dry skin apply to the right foot. The February 2024 eTAR revealed that on 2/2/24, the day shift nurse did not document the following treatments: 1. Skin prep wipes are to be applied topically to the left great toe every day shift for wound care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Apply moisture barrier cream every shift for protection to the sacrum post-care. 3. Apply moisture barrier cream every shift for protection to the left buttock post-care. 4. Apply moisture barrier cream every shift for protection to the right buttock post-care. 5. Incentive spirometry therapy every shift for lung therapy. 3. The surveyor reviewed the medical records for Resident #196 and revealed the following: According to the December 2023 OSR, Resident #196 had physician orders for quetiapine fumarate 0.5 mg tablet by mouth at bedtime, disruptive behavior: yelling to the point of exhaustion every shift, pain score every shift, anti-psychotic side effect tracking every shift, vital signs every shift, silver sulfadiazine cream 1 % apply to sacral area topically every day shift for wound care, and incentive spirometry four times a day. The December 2023 eMAR revealed that on 12/15/23, the evening shift nurse did not document the following: 1. Quetiapine fumarate 0.5 mg tablet by mouth at bedtime. 2. Disruptive behavior: yelling to the point of exhaustion every shift. 3. Pain score every shift. 4. Anti-psychotic side effect tracking every shift. 5. Vital signs every shift. The December 2023 eTAR revealed that on 12/21/23 and 12/27/23 respectively, the day and evening shift nurse did not document the following: 1. Silver sulfadiazine cream 1 % is applied topically to the sacral area every day shift for wound care. 2. Incentive spirometry four times a day. 4. The surveyor reviewed the medical records for Resident #197 and revealed the following: According to the April 2023 OSR sheet, Resident #197 had an order dated 4/14/2023 for Midodrine HCl 5 mg every 8 (eight) hours with parameters to hold the medication when the SBP is more than 150. Do not administer after the evening meal or 4 (four) hours from bedtime to avoid supine hypertension. The April 2023 eMAR revealed that on 4/14/23, 4/15/23, 4/16/23, and 4/17/23, the Midodrine HCl 5 mg was given without the blood pressure written in the order. The April 2023 eMAR revealed that on 4/14/23, 4/15/23, 4/16/23, and 4/17/23, the Midodrine HCl 5 mg was given at 2200 (10:00 PM) 4 hours from bedtime. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The April 2023 eMAR revealed that on 4/14/23, 4/15/23, 4/16/23, and 4/17/23, the Midodrine HCl 5 mg was given at 2200 after the evening meal or 4 hours from bedtime. The April 2023 eMAR revealed that the Midodrine HCl 5 mg was not documented on 4/14/23 at 1400 (2:00 PM), 4/15/23 at 0600 (6:00 AM), and 4/17/23 at 1400 (2:00 PM) and 2200. According to the April 2023 OSR sheet, Resident #197 had an order dated 4/18/2023 for Midodrine HCl 2.5 mg every 8 (eight) hours with parameters to hold the medication when the SBP is more than 150. Do not give after 8:00 PM. The April 2023 eMAR revealed that on 4/18/23, 4/19/23, and 4/20/23, the Midodrine HCl 2.5 mg was given at 2200 after 8:00 PM. The April 2023 eMAR revealed that the Midodrine HCl 2.5 mg was not documented on 4/20/23 at 1400. According to the April 2023 OSR sheet, Resident #197 had a physician order of Famotidine 20 mg by mouth two times a day, vital signs every shift, bacitracin ointment to the right lower arm skin tear every day, phytoplex z guard external paste 57-17% apply to sacral region topically every shift, incentive spirometry 4 times a day. The April 2023 eMAR revealed that the incentive spirometry was not documented on 4/13/23 at 1800 (6:00 PM) and 2200. The April 2023 eMAR revealed that on 4/14/23 and 4/20/23, the day shift nurse did not document the vital signs every shift. The April 2023 eTAR revealed that there were several dates that the nurse did not document the treatments was done on the following dates: 1. Bacitracin ointment to the right lower arm skin tear every day on 4/14/23, 4/17/23, and 4/20/23 on day shift. 2. Phytoplex z guard external paste 57-17% apply to the sacral region topically every shift on 4/14/23 on the day shift. 3. Incentive spirometry 4 (four) times a day on 4/13/23 at 1800 and 2200, on 4/14/23 at 1000 (8:00 AM) and 1400, and on 4/17/23 at 1000 and 1400. On 2/28/24 at 12:56 PM, the surveyors discussed the above concerns with the Administrator, Director of Nursing (DON), and interim DON. There was no information provided. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled Documentation of Medication Administration with a revised date of November 2022 indicated under Policy Interpretation and Implementation 1. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR). The medication administration record may be a paper record or an electronic equivalent. 2. Administration of medication is documented immediately after it is given. 3. Documentation of medication administration includes, as a minimum: f. reason(s) why a medication was withheld, not administered, or refused (as applicable); g. initials, signature, and title of the person administering the medication. NJAC 8:39-27.1(a)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48781 Based on interview, and record review, it was determined the facility failed to follow professional standards and practices to accurately document in the medical record the status of a resident's progress or changes in his/her condition. The resident was transferred from the facility to the hospital. The concern was cited for 1 (Resident #199) of 21 residents reviewed and is evidenced by the following: Resident #199 is not in the facility and will investigate the closed record and conduct interviews. S483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are (ii) accurately documented. The medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions. A review of the 5 Day 5/1/23 Minimum Data Set (MDS), a facility assessment tool, revealed the resident's Brief Interview for Mental Status (BIMS) 15 out of 15 indicating intact cognition. The admission record indicated the resident was admitted to the facility with diagnoses that included but were not limited to hypertension, chronic kidney disease, diabetic nephropathy, gout, anemia, bladder cancer, atrial fibrillation, benign prosthetic hypertrophy, hyperlipidemia, diabetes mellitus II. A review of the nursing progress notes revealed missing nursing documentations for 4/29/23, 4/30/23, 5/1/23, 5/4/23, and 5/5/23, the day the resident was transferred to the hospital. On 2/20/23 at 1:50 PM, the surveyor discussed the concerns of lack of nursing documentation for Resident #199 on the day of change in condition 5/5/23, with Director of Nursing (DON) in training, sitting DON/Regional Clinical Services, and the Licensed Nursing Home Administration (LNHA). The surveyor requested from the facility for any additional documentations, grievances, or investigations during the resident's stay. On 2/22/24 at 10:00AM, the DON and LNHA provided documentation of the timeline on the day resident was transferred to the hospital. The timeline revealed that on 5/5/23 the resident was transferred on 5/5/23 at 7:30 AM via 911 ambulance for complaint of chest pain. The resident was admitted with atrial fibrillation and pneumonia. The timeline provided was not documented in the resident's EHR. On 2/23/24 at 9:50 AM, interviewed the sitting DON regarding nursing documentation and the DON stated, It is the expectation that nursing will document every shift in the EHR under the progress notes. The surveyor reviewed with the DON and the LNHA, the missing nursing documentations on 4/29/23, 4/30/23, 5/1/23, 5/4/23, and 5/5/23. The professional standards of practices S483.70(i)(1), mentioned above was also reviewed with the DON and the LNHA. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/28/24 at 10:40 AM, interviewed the LPN on the 3rd floor, the LPN stated, "We do skilled nursing notes, we should document on residents that has something going on. I document on residents that go out, when the doctor was notified and of course the family and who I spoke to. I document on how the resident was transported, the reason that they're going out. I try to document on all the residents daily. The surveyor reviewed the current facility policy and procedures titled Charting and Documentation revised 5/27/22 and Acute Condition Changes revised 3/2018, which revealed The following information is to be documented in the resident medical record: Changes in the resident's condition. NJAC 8:39-35.2(d)