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	07/31/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interviews, and facility policy review, the facility failed to ensure initial and weekly weights were implemented for two out three residents (Resident (R) 26 and R92). This lack of monitoring of residents' weight loss/gain can delay in identifying potential nutritional problems.Findings include: Review of a facility policy titled, Weight Assessment and Intervention dated 03/22 indicated .Residents are weighed upon admission and at intervals established by the interdisciplinary team such as: weekly for four weeks, the monthly unless otherwise indicated. The threshold for significant unplanned and undesired weight loss is based on the following criteria.1 month-5 percent weight loss is significant.6 months-10 percent weight loss is significant. Review of R26's EMR titled admission Record located under the Profile tab indicated the resident was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Review of R26's EMR titled Nutritional Evaluation located under the Prog (Progress Notes), dated 04/23/25, indicated the resident's weight during her hospital stay was 180 pounds. There was no documentation the weights were obtain upon R26's admission to the facility. Review of R26's EMR titled 5-day Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 04/28/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which revealed the resident was cognitively impaired. The assessment indicated R26 weighed 180 with no weight gain/loss during the assessment period. Review of R26's EMR titled Weights located under the Wts (Weights)/Vitals tab, dated 06/10/25, indicated the resident's weight was 165.6 pounds. There was no documentation the weights were obtain upon R26's re-admission to the facility. During an interview on 07/29/25 at 12:08 PM, Licensed Practical Nurse (LPN) 1 who was also the second-floor manager stated R26 would frequently refuse to be weighed. A request was made for any records which would reflect this during this interview and there was no information provided by the end of the survey. During an interview on 07/29/25 at 1:56 PM the Director of Nursing (DON) stated that R26 frequently refused to be weighed. A request was made for any records which would reflect this during this interview and there was no information provided by the end of the survey. During an interview on 07/31/2025 at 9:04 AM, the Registered Dietician (RD) stated an initial weight was to be completed within 48 hours after admission. The RD stated it was important to get a baseline weight so the resident can be monitored for loss/gain. The RD stated R26 typically refuses to be weighed, and the refusals were to be documented in the nursing progress notes. During this interview, the RD reviewed R26's EMR and could not identify refusals to be weighed during her time at the facility. 2. Review of R92's (closed record) admission MDS with an ARD of 07/01/24, located in the MDS tab of the electronic medical record (EMR), revealed an admission date of 06/25/24, a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating R92's cognition was severely impaired, and had diagnoses of basal cell carcinoma of skin of nose, type 2 diabetes mellitus without complications, and adult failure to thrive. Review of R92's Care Plan, dated 06/26/24, located in the EMR under the Care Plan tab revealed Nutritional Status as evidenced by therapeutic diet, obese BMI [body mass index] Per MNA [mini nutrition assessment] resident triggers for malnutrition with a goal of Will not experience a significant change in weight through next review. Interventions included Encourage and (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assist as needed to consume foods and/or supplements and fluidsoffered at and between meals, Notify physician and responsible party of significant weight changes, Provide diet/supplements per orders mighty shake QD, prostat [nutritional supplement] QD, and Weights as ordered. Review of R92's Nutrition Evaluation, dated 06/26/24, located in the EMR under the Form tab revealed a diet order of a CCHO [carbohydrate controlled] regular texture, Weight used to calculate resident BMI: 225 lbs [pounds] hospital weight, and Per 6/25 nursing evaluation, edema noted to BIL [bilateral] LE [lower extremities]. Review of R92's weights, located in the EMR under the Vitals tab revealed a 16% weight loss in two months. This included:On 06/26/24 at 225.0 Lbs (hospital records)No admission weight obtained on 06/25/24On 07/02/24 at 190.0 LbsOn 07/06/24 at 190.4 LbsOn 07/07/24 at 190.4 LbsOn 07/08/24 at 190.2 LbsOn 07/17/24 at 187.6 Lbs Review of R92's Nutrition Notes, dated 07/22/25, located in the EMR under the Progress Note, revealed Per calorie count, resident noted with general intake of 0-25% of foods/drinks. Resident continues on CCHO, soft and bite sized texture diet with thin liquids. Skin: per 7/11 wound consult, fungal dermatitis noted to BIL groin and BIL buttocks, stage 2 pressure ulcer notes to sacrum (initial exam). Recommend prostat 30 ml QD [every day] for additional protein for skin healing. Recommend mighty shake 4 oz QD for additional calories and protein. RD [Registered Dietitian] placed call to residents on and discussed current intake/calorie count, and discussed both supplements, and [family member] agreed. RD discussed with resident MDs [physician] as well. RD will continue to remain available and involved in resident care and will continue to monitor and intervene PRN [as needed]. Interview on 07/31/25 at 9:05 AM, RD was asked if an admission weight was obtained for R92. RD stated, No admission weight was obtained. RD confirmed the first weight was obtained one week later. RD stated R92's weight should be taken within the first 48 hours. RD confirmed she used R92's hospital weight of 225 Lbs. RD was asked if R92's weight was 225 Lbs and his last weight at 186.7 Lbs before discharge, did he have a 16% weight loss. RD stated R92 had edema upon admission which could account for his weight loss and had a wound. RD confirmed there was no documentation of the edema and R92 was discharged before supplements were started.NJAC 8:39-27.1(a)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to make choices about their life including interacting with family members in the community for one of 25 sampled residents (Resident (R) 78). Specifically, R78 had an outing in the community scheduled with her son; however, the resident was denied her right to leave the facility with her son. This failure violated the resident's rights, placed the resident at risk for psychosocial decline, and placed the resident at risk for a diminished quality of life.Findings include:Review of R78's undated Face Sheet located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE].Review of R78's admission Minimum Data Set (MDS), with an assessment reference date (ARD) of 06/24/25 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the resident was moderately cognitively impaired.During an observation and interview on 07/28/25 at 10:00 AM, R78 was in her room. R78 stated over the past weekend, her son who lives in another stated came into town to visit her. The resident stated her and her son planned to go out to eat at an Asian restaurant on Sunday afternoon (07/27/25). R78 stated Sunday morning her Nurse Practitioner was in the facility and visited her, and she was aware of the residents plans to go eat with her son. R78 further stated that her assigned Certified Nurse Aide (CNA) assisted her in getting dressed and ready for when her son arrived to pick her up. Continued interview revealed R78's son arrived to the facility to pick her up at approximately 4:00 PM on 07/27/25; however, the nurse on duty stated she could not leave the facility without a physician's order. R78 stated, I didn't know her.maybe an agency nurse. R78 also stated the nurse made no effort to assist in obtaining a verbal order to leave the facility's campus with her son. The resident stated she did not get to go have a meal with her son and he had already returned home to another state. R78 stated she had never had this issue before during her prior admissions at the facility.During an interview on 07/29/25 at 9:35 AM, the Director of Nursing (DON) was asked if there were any policies or standing physician orders for residents who wanted a leave of absence (LOA). The DON stated she was relatively new to this company (three months) and the policy was centered more around issues with residents who leave overnight and medication administration while out of the facility. The DON also stated R78 should have been allowed the choice to leave the facility to have dinner with her son. The DON further stated the nurse who denied the resident leaving the facility was an agency nurse and the nurse should had consulted with one of the facility's regular nursing staff. The DON stated it was completely within R78's right to leave the campus for a family outing and the resident was denied that right. NJAC 8:39-4.1(a)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to protect one of two residents (Resident (R) 93) from misappropriation of property. This failure has the potential to affect all residents who choose to keep money and/or private property in their rooms. Findings include:Review of a facility's policy titled, Abuse and Neglect - Clinical Protocol, dated 03/2018, indicated .All types of resident abuse, neglect, exploitation or misappropriation of resident property are strictly prohibited.Review of R93's electronic medical records (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] with a diagnosis of malignant neoplasm of the frontal lobe. Review of R93's EMR titled Care Plan located under the Care Plan tab, dated 05/26/24, indicated the resident had difficulty with understanding/communicating.Review of R93's EMR titled admission Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 05/30/24 indicted the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed that the resident was cognitively intact. The assessment indicated R93 had impairments on both sides of the resident's upper and lower extremities. The assessment indicated that the resident required substantial/maximum assistance with all activities of daily living.Review of a document provided by the facility titled Reportable Event Record/Report dated 07/19/24, indicated R93 was transferred to the hospital for a change in her condition and was eventually placed on hospice and passed away. On 07/19/24, the facility received a call from the resident's family member (F)1 who alleged that on the evening shift Certified Nurse Aide (CNA)1 transferred $100 from R93's cash app on 06/11/24. According to the facility's investigation, the police were called and arrived at the facility. The facility reported that the police would not proceed with the investigation since there was no longer a victim. CNA1 was suspended immediately. Per the facility investigation CNA1 claimed she gave R93 her cash app and the resident transferred $100 to CNA1. The investigation revealed CNA1 claimed she was out of work for a few days and when she returned back to the facility, R93 was excited to see CNA1. During this time CNA1 shared it was her birthday, and the resident wanted to give her a gift. According to the investigation, CNA1 rejected the resident's offer several times but then accepted the offer. The facility stated they were unable to substantiate abuse, neglect, or mistreatment of the resident. There was no evidence that the facility decided that misappropriation happened when CNA1 received money from R93.During an interview on 07/29/2025 4:22 PM F1 stated after the death of R93, she went through the resident's bank statement and identified a transaction of $100 and stated this was on 06/11/24 around 3:00 AM. F1 stated the money transaction should never have happened whether or not it was consensual from the resident or not. F1 stated the resident was ill and the transaction should never have happened.During an interview on 07/30/2025 at 3:32 PM, the Director of Nursing (DON) stated the money transaction between R93 and CNA1 since CNA1 had a paid position and there should have been no sharing of gifts from the resident to the staff. The DON stated CNA1 should have alerted her supervisor to be able to provide some direction to the staff member.During an interview on 07/31/25 at 12:00 PM, the Administrator stated the staff were not to accept gifts from any resident. NJAC 8:39-4.1(a)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, it was determined that the facility failed to include in the physician's order a 14-day limit for an as needed psychotropic medication for one (Resident (R)1) of five residents reviewed for unnecessary medication. This had the potential to place the resident at a higher risk for falls, injury, and confusion.Findings include: Review of the facility's policy titled, Psychotropic Medication Use, revised 02/25, provided by the facility revealed .3. PRN [as needed] orders for psychotropic medications are limited to 14 days. a. For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order.Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 07/01/25, located in the MDS tab of the electronic medical record (EMR), revealed an admission date of 06/18/25, a Brief Interview for Mental Status (BIMS) score of two out of 15 indicating R1's cognition was severely impaired, was prescribed an antianxiety medication, and had diagnoses of anxiety disorder, depression, and schizophrenia.Review of R1's Care Plan, located in the EMR under the Care Plan tab revealed no care plan for anxiety, Lorazepam or what non-pharmacological interventions (NPI) were used.Review of R1's July 2025 Medication Administration Record (MAR) located in the EMR under the Order tab revealed Lorazepam Oral Tablet 0.5 MG [milligram] Give 1 tablet by mouth every 6 hours as needed for Anxiety, Start Date 07/05/25. Lorazepam was administered every day between 07/5/25 through 07/29/25 except for 07/18/25, 07/26/25, and 07/27/25.On 07/28/25 at 4:45 PM, R1 was observed sitting on her bed dressed and groomed and eating supper. R1 was asked about her medications, and she stated no problems. During an interview 07/30/25 at 3:02 PM, Licensed Practical Nurse (LPN)3 was asked who put R1's order for Lorazepam in the EMR and should there be an end date. LPN3 reviewed the EMR and stated she was the nurse who put the order in, but she didn't know about an end date. LPN3 stated she would have to ask. At 3:13 PM, LPN3 stated she documented in the Progress Notes the medication was for 14 days but confirmed the 14-days wasn't included in the order. LPN3 was asked if the Lorazepam order was only supposed to be for 14 days, then why was the medication administered beyond the 14 days. LPN3 reviewed the MAR and acknowledged the medication went beyond 14 days. Clinical Service Coordinator (CSC) also reviewed the MAR and confirmed the order did not include an end date.During an interview on 07/30/25 at 3:28 PM, Director of Nursing (DON) was asked if she was aware there was no end date for R1's Lorazepam. DON stated she was not aware. DON was asked how staff would know to add an end date for Lorazepam and DON stated, Staff were in-serviced on the PRN antipsychotics. DON was also asked if there should be non-pharmacological interventions (NPI) in the care plan for the use of Lorazepam. DON stated, Yes there should be. After reviewing R1's EMR, DON agreed there was no end date, anxiety care plan or NPI for R1's Lorazepam. During a telephone interview on 07/31/25 at 11:30 AM, Pharmacist (RPh) was asked about R1's PRN Lorazepam order not having a time limit of 14-days and was administered for 21 days. RPh was asked it there should be a limit. RPh stated, Generally yes there should be a limit. RPh was asked if there should be NPI used and documented. RPh stated, Generally, yes. NJAC 8:39-4.1(a)6

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy, the facility failed to complete a thorough investigation of an allegation of misappropriation for one (Resident (R) 93) of two residents reviewed for abuse out of 40 sampled residents. The facility's failure to complete a thorough investigation placed residents at risk of being unprotected from misappropriation. Findings include: Review of a facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 09/22 indicated . All allegations are thoroughly investigated. The administrator initiates investigations. interviews the resident (as medically appropriate) or the resident's representative. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. interviews the resident's roommate, family members. documents the investigation completely and thoroughly. Review of R93's electronic medical records (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of a document provided by the facility titled Reportable Event Record/Report, dated 07/19/24, indicated a family member (F) 1 reported that Certified Nurse Aide (CNA) 1 received $100 from R93's cash app on 06/11/24. The facility investigation failed to show that a statement was collected from the resident. There were no other interviews, such as other residents and staff, other than from CNA1 who admitted R93 sent her $100 via a cash app as a gift. During an interview on 07/30/25 at 3:32 PM the Director of Nursing (DON) stated she investigates an allegation of abuse/neglect or misappropriation she would attempt to obtain a statement from the resident involved, other residents, and staff who were on the same shift. The DON confirmed she read the facility investigation which involved R93 and CNA1 and confirmed the investigation was not complete. During an interview on 07/30/25 at 3:56 PM, the Social Services Director (SSD) stated that when she completes an abuse/neglect or misappropriation investigation, she would interview the resident, the person accused, and any other residents and staff who worked at the time of the allegation. NJAC 8:39-9.4(f)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to obtain wound treatment orders, upon admission, to provide treatment for one of two residents (Resident (R) 93) and failed to implement wound prevention measures upon admission. This failure had the potential to lead to infection and worsen the pressure ulcer.Findings include: Review of a facility policy titled, Prevention of Pressure Injuries, dated 04/20, indicated . Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Review of R93's electronic medical records (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R93's EMR titled Resident Evaluation located under the Forms tab, dated 05/25/24, indicated the resident had a stage II pressure ulcer upon admission. Review of a document provided by the facility titled Resident Evaluation, dated 05/25/24, indicated the resident that R93 had sacral redness early signs of pressure ulcer. Review of R93's EMR titled, physician Orders located under the Orders tab, dated 05/28/24, indicated orders for zinc oxide external ointment 20 percent to be applied to the resident's sacral per shift three days after the resident's admission. Review of R93's EMR titled admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/30/35 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident was at risk for the development of pressure ulcers and had a stage II pressure ulcer upon admission. Under the Care Area Assessment (CAA) indicated that the resident triggered pressure ulcers and directed the staff to develop a care plan. Review of R93's EMR titled Care Plan located under the Care Plan tab, dated 05/25/24, that the resident was at risk for alteration in skin integrity related to impaired mobility. The care plan was updated on 06/03/24 and revealed that the resident was provided with wound consultation and care and an air mattress An attempt was made to call the wound doctor but there was no return call. During an interview conducted on 07/30/2025 at 2:24 PM, Licensed Practical Nurse (LPN)1 who was the second-floor supervisor, stated currently when a resident was admitted with a stage II pressure ulcer, air mattresses were implemented. During an interview on 07/30/2025 at 3:14 PM the Director of Nursing (DON) stated she would expect that the admitting physician be notified if there were no orders for skin care from the hospital. The DON stated she also expected that staff would place the resident on an air mattress upon admission if the resident had a stage II pressure ulcer. The DON read R93's EMR and verified that there were no orders for wound care upon admission and were not ordered until 05/28/24. NJAC 8:39-27.1(e)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication orders were followed and administered through a feeding tube according to standard of practice for one (Resident (R)103) of five residents reviewed for medication administration. This practice had the potential to alter the drug release, absorption, and/or effectiveness as well as causing discomfort.Findings include: Review of the facility policy titled Administering Medications through an Enteral Tube, revised 11/18, provided by the facility revealed The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. 3. Administer each medication separately and flush between medications. 4. Do not crush or split medications for administration through an enteral tube unless first checking with the pharmacy or facility approved Do Not Crush Medication List. a. Tablets that must be crushed prior to administration through an enteral tube require a specific order related to crushing.b. Do not crush enteric coated, sustained release, buccal, sub-lingual, or enzyme-specific medications. Review of R103's admission Record, located in the electronic medical record (EMR) under the Profile tab revealed R103 was admitted on [DATE] and had diagnosis of non-st [KB1] elevation (nstemi) myocardial infarction, hypertensive heart disease with heart failure, unspecified atrial fibrillation and gastrostomy status. Review of R103's 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 07/27/25, located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R103's cognition was intact. Review of R103's Orders, located in the EMR under the Order tab revealed Metoprolol Succinate ER [extended release] Tablet Extended Release 24 Hour 50 MG [milligram] Give 1 tablet via PEG [percutaneous endoscopic gastrostomy]-Tube one time a day for HTN [hypertension] Take with or immediately following meals. Do not crush. Hold if the SBP [Systolic Blood Pressure] is less than 110 and HR [heart rate] < 60, Start Date- 07/22/25, Aspirin EC [enteric coated] Tablet Delayed Release 81 MG (Aspirin) Give 1 tablet via PEG-Tube one time a day for CAD [coronary artery disease] Take with full glass of water, do not crush. Monitor for bleeding, bruising, and black tarry stools. Give with food to minimize GI [gastrointestinal] irritation, Start Date 07/22/25, and May crush meds [medications] where manufacturer permits, revised dated 07/21/25. Review of R103's evaluations, dated 07/21/25 to 07/27/25, located in the EMR under the Forms tab revealed no evaluation for administering crushed medications to ensure there were no drug interactions. Review of R103's Care Plan, revised 07/24/25, located in the EMR under the Care Plan tab revealed Cardiac disease related to HTN, hyperlipidemia. An intervention included Administer medication per physician orders. Review of R103's Nursing/Clinical Note, dated 07/27/25, located in the EMR under the Progress Note revealed Residents peg tube is clogged, tube was checked, unable to flush medications hs [bedtime]. Review of R103's Physician/Practitioner Progress Note, dated 07/28/25, located in the EMR under the Progress Note tab revealed Pt [patient] seen and examined at bedside, returned from hospital from this AM [morning] for clogged PEG tube. Review of R103's July 2025 Medication Administration Record (MAR), located in the EMR under the Order tab revealed on 07/31/25 Aspirin EC Tablet Delayed Release 81 MG (Aspirin) Give 1 tablet via PEG-Tube one time a day for CAD Take with full glass of water, do not crush and Metoprolol Succinate ER Tablet Extended Release 24 Hour 50 MG Give 1 tablet via PEG-Tube one time a day for HTN Take with or immediately following meals. Do not crush. Hold if the SBP is less than 110 and HR < 60 were administered.On 07/29/2025 at 8:46 AM, R103 was awake in bed and responded to the surveyor's greeting. R103 confirmed he was sent to the hospital and came back the same day 07/28/25 due to his feeding tube being clogged. During an interview on 07/31/25 at 8:18 AM, Registered Nurse (RN)1 was asked about R103's medication administration. RN1 stated he already administered R103's medications. RN1 listed the medications R103 received which included aspirin and Metoprolol. RN1 (continued on next page)

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	315502	A. Building B. Wing	07/31/2025

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was asked about crushing the medications and how he administered them. RN1 stated he crushed all the medications and placed them in the same cup and flushed them through R103's gastrostomy tube. RN1 then demonstrated how he did it, comparing the medications with the orders, taking the medications out of the package, placing it in a small plastic bag and placing the bag in the crushing device on his medication cart. Then RN1 picked up a small cup and stated he poured the crushed medications into the same cup. RN1 was asked for clarification if he administered R103's medications that morning one by one, flushing in between each medication. RN1 said, No, but they used to do it that way. RN1 was asked to show the surveyor the aspirin he crushed for R103 that morning. RN1 picked up a bottle from his medication cart that was labeled chewable. RN1 was asked if R103's order for the aspirin was enteric coated (EC). RN1 checked the order in the EMR and RN1 confirmed the order was for EC. RN1 stated EC could not be crushed so that was why he used chewable. RN1 was asked if the order should have been changed before administering the aspirin and RN1 said, Yes. On 07/31/25 at 9:55 AM, R103 was awake in bed with his gastrostomy feeding in progress. Family Member (FM)2 was present at the bedside. R103 was asked if his medications were administered all at once into his gastrostomy tube the morning of 07/31/25 and then flushed with water. R103 stated, Yes. FM2 stated sometimes some of the nurses will administer the medications individually and others don't. R103 stated he sometimes experienced abdominal pain but he didn't know what to associate it with, medications or feedings. During a follow up interview on 07/31/25 at 10:01 AM, RN1 was asked about crushing Metoprolol the morning of 07/31/25, and if it should have been crushed. RN1 reviewed the EMR and confirmed Metoprolol was extended release (ER) and should not be crushed. RN1 stated he just noticed it and will call the MD for an alternative medication right now. During a telephone interview on 07/31/25 at 11:30 AM, the Pharmacist (RPh) stated he wasn't the usual pharmacist, but he was the manager as the regular pharmacist was on leave. RPh was asked about R103's medications and was it okay for RN1 to crush the medications and administer them together the morning of 07/31/25, through R103's gastrostomy tube. RPh stated generally they like to separate the medications. RPh was asked if it was expected to have an evaluation before administering the medications together. RPh stated, there should be something if they go outside their policy. RPh was asked if it was okay for RN1 to crush R103's Metoprolol ER the morning of 07/31/25. RPh stated the manufacture recommends not crushing Metoprolol. RPh was informed R103's' gastrostomy tube was clogged earlier this week and could administer all the crushed medications together cause that. RPh stated he wasn't sure. During an interview on 07/31/25 at 12:10 PM, the Director of Nursing (DON) was asked if R103's medications should be crushed and administered together through his gastrostomy tube. DON stated, No. DON was asked if she was aware R103's medications were crushed and all administered together the morning of 07/31/25. DON stated, No. DON was asked if R103's Metoprolol ER should be crushed. DON stated, No, it shouldn't be crushed. DON was asked if she was aware R103's Metoprolol ER was crushed when administered the morning of 07/31/25 and DON stated, No. DON was informed that R103's order for aspirin was EC but RN1 used chewable. DON was asked if there should be an order for the chewable aspirin. DON stated, Yes. DON stated the nurses were just in-serviced on Thursday on this topic. NJAC 8:39-27.1(a)NJAC 8:39-29.2(d)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that food preferences were honored for one out of two sampled residents (Resident (R) 26). The facility failed to ensure the resident was given dinner that she had ordered and strawberry ice cream. Findings include: Review of a facility policy titled Menu, dated 10/2017 indicated . Menus are developed and prepared to meet resident choices. Review of R26's electronic medical records (EMR) titled admission Record dated 04/22/25 initially and was readmitted to the facility on [DATE]. During an observation conducted on 07/28/25 at 11:32 AM, R26 pointed to a tray and gave permission to lift the lid to her meal. Observed a beef and Asian noodle dish. R26 explained that she had saved her dinner meal from the night before since it was not what she had ordered. The resident stated she ordered a grilled steak. During this interview the resident presented a menu titled Selection Sheet, dated 07/27/25, for the dinner meal. The resident stated she selected the grilled steak on the menu. During an observation on 07/29/25 at 12:27 PM, Certified Nurse Aide (CNA) 3 brought in R26's noon meal. On the tray was chocolate ice cream. The resident stated she had ordered strawberry ice cream and presented her menu. The resident had handwritten two strawberry ice creams. CNA3 verified the chocolate ice cream on the resident's tray. During an interview on 07/31/25 at 8:39 AM, the Dietary Manager (DM) stated there were two choices for residents on the menu. The DM stated in addition, the resident could write items that they might want, and the kitchen would attempt to accommodate them. The DM stated it may have been a mistake if R26 was sent chocolate ice cream instead of strawberry. The DM stated he was here on 07/27/25 and thought that he was accommodating the resident with beef lo Mein instead of the grilled steak since it was the same meat. The DM stated R26 required small bites of food, and this was why he sent the beef lo Mein to the resident instead of the grilled steak. During an interview on 07/31/25 at 12:00 PM, the Director of Nursing (DON) stated residents were provided with an alternate meal so they can select, and we can accommodate what they want. NJAC 8:39-17.4

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure one of one resident (Resident (R) 26) reviewed for assistive devices during dining out of a total sample of 40. This had the potential to cause a decrease in the resident's dietary intake. Findings include: Review of a facility policy titled, Assistance with Meals dated 03/22, indicated .Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles. Review of R26's electronic medical records (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] with a diagnosis of Parkinson's disease. Review of R26's EMR titled admission Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date of 06/10/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which revealed the resident was cognitively intact. Review of a document provided by R26 titled Selection Sheet, dated 07/27/25, indicated the resident used specialized handled utensils. An observation was conducted on 07/28/25 at 12:26 PM, and Certified Nurse Aide (CNA) 3 assisted R26 with her meal tray and verified that the resident did not receive her built up eating utensils. During an interview on 07/31/25 at 8:39 AM, the Dietary Manager (DM) stated the built-up utensils were written by the computer system to include on R26's meal trays. The DM stated for R26 not receiving them was a mistake and that the resident typically will have a set of built-up utensils available in her room. During an interview on 07/31/25 at 12:00 PM, Director of Nursing (DON) stated it was important to provide R26 with built up utensils so she could properly feed herself. NJAC 8:39-27.5(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure the clinical records were complete for one of three residents (Resident (R) 26) reviewed for tube feeding orders out of a total sample of 40 residents. This had the potential for the resident not to receive accurate care.Findings include: Review of a facility policy titled Medication Orders dated 11/14 indicated .The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Review of R26's electronic medical records (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R26's EMR titled physician Orders located under the Orders tab, dated 06/04/25, indicated the resident was to receive Jevity (nutritional feeding) 1.2 rate 237 mL (milliliter) five times a day via bolus/gravity via a gastrostomy-tube (g-tube). This order continued until it was discontinued on 07/18/25. Review of R26's EMR titled Medication Administration Record (MAR) located under the Orders tab for 06/25 revealed the resident did not receive Jevity bolus on the following dates: 06/09/25 at 4:00 PM and 7:00 PM; 06/10/25 at 8:00 AM, 11:00 AM, and 2:00 PM; and 06/24/25 at 11:00 AM and 2:00 PM. There were no corresponding nursing progress notes which would indicate the resident missed these doses of tube feeding. Review of R26's EMR titled physician Orders located under the Orders tab, dated 07/18/25, indicated the resident was to receive Jevity 1.2, rate 237 mL five days a day via bolus/gravity via a g-tube. Review of R26's EMR titled MAR located under the Orders tab for 07/25 revealed the resident did not receive Jevity bolus on the following dates: 07/24/25 at 2:00 PM and 07/27/25 at 8:00 am, 11:00 AM, and 2:00 PM. During an interview on 07/31/25 at 12:00 PM, both the Administrator and the Director of Nursing (DON) were present. The DON stated the Jevity needed to be documented to ensure the resident received care. NJAC 8:39-4.1(a)NJAC 8:39-35.2

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to ensure residents' care equipment was maintained in safe operating condition for one of 25 sampled residents (Resident (R) 107). Upon admission, R107 was provided a bed that was broken and in need of repair or replacement. This failure placed the resident at risk of a diminished quality of life from not having a homelike environment and placed the resident at risk for accidents and hazards to occur.Findings include: Review of R107's Face Sheet located in the resident's Electronic Medical Record (EMR) under the Profile tab documented R107 was admitted to the facility on [DATE] with diagnoses including schizophrenia, bipolar disorder, and orthopedic aftercare for physical therapy following a right knee replacement. Review of R107's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/29/25 and located in the iQIES MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated the resident was moderately cognitively impaired; however. During an observation and interview on 07/29/25 at 8:20 AM, R107 and her roommate (R78) were visited in their room. R107 was in bed, and the bed was observed to be in need of repair. The foot of the bed frame and mattress were pointed downward at an approximate 90-degree angle, with the frame and mattress resting on the floor. R107 stated she had not slept well because her bed was broken. R107 stated .couldn't sleep with my bad leg hanging down like that. With the beds condition, the resident could not elevate her right leg/knee that she recently had surgery on. R78 stated, She asked the nurse to switch the bed out when she (R107) got here, but nobody did anything about it. R107 nodded in agreement with R78's statement. Observation on 07/29/25 at 8:35 AM, Certified Nuse Aide (CNA) 5 entered R107's room and delivered the resident's breakfast tray. When CNA5 as shown and asked about R107's bed, looked at the resident's bed, shrugged her shoulders, and left the room. CNA5 did not respond to the resident's concern about the bed being broken and did not report the issue to any other staff member. During an interview on 07/28/25 at 11:35 AM, the Director of Nursing (DON) was asked if there were empty beds in the facility since the census was down. The DON stated, Yes I think so. When advised about R107's bed issue, the DON stated she was unaware of the situation before now, but she was going to investigate it and she would get back to the surveyor. During an interview on 07/28/25 at 12:45 PM, the DON stated she had maintenance staff replace the broken bed with a working bed from an empty room. The DON stated she apologized to R107 for the delay, and she assured R107 was now comfortable in a bed that functioned as it should. The DON confirmed R107 had the right to have her needs accommodated in a comfortable environment as possible from the moment she was admitted . She confirmed that the situation should have been corrected at any of the instances when the two residents reported the issue to staff over the past two days.NJAC 8:39-31.2

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on record review, observations, and interviews the facility failed to ensure one Certified Nursing Assistant (CNA) 1 was effectively trained in understanding misappropriation. As a result, money was exchanged from one of one resident (Resident (R) 93) to CNA1. This had the potential for staff not to recognize a gift could be viewed as misappropriation, when a resident was dependent on the caregiver for personal needs. Findings include: Review of a document provided by the facility titled Certificate of Completion for CNA1, dated 04/01/24, indicated CNA1 completed training abuse, neglect, and exploitation. Review of a document provided by the facility titled, Certified Nursing Assistant, dated 07/2024 indicated the job description for a CNA was to .Attend and participate in facility in-service training programs as instructed including resident rights, prevention of abuse and neglect, dementia care, behavioral management and competencies for Certified Nursing Assistants. Review of a document provided by the facility titled, Facility Assessment, dated 07/18/25, indicated .Facility resources needed to provide competent support and care for our resident population every day and during emergencies.Staff training/education and competencies. During an interview on 07/30/25 at 3:32 PM, the Director of Nursing (DON) stated the abuse prevention training that CNA1 took included misappropriation and that gifts/money were not to be taken from residents even if it was a gift since the staff were paid to do a job. NJAC 8:39-13.4(c)2

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on document review, interview, and review of facility policy, the facility failed to ensure that the quality assessment and assurance (QAA) committee met at least quarterly. This had the potential to affect the care and services for each of the 83 residents in the facility.Findings include: Review of a facility policy titled Quality Assurance and Performance improvement (QAPI) Program- Governance and Leadership dated 03/20 indicated . The committee meets at least quarterly (or more often as necessary). Committee members are reminded of meeting day, time and location via e-mail at least two business days prior to the meeting. Review of documents provided by the facility titled Quality Assurance & Performance indicated the quarterly QAA meetings were held on 07/30/24, 11/19/24, 01/16/25 and on 04/24/25. There was no evidence there was a quarterly QAA meeting held on 10/24. During an interview on 07/29/25 at 5:14 PM, the Administrator stated the QAA meeting was held in 11/24 instead of 10/24 since the Infection Preventionist (IP) was out on vacation therefore if the QAA meeting was held in 10/24 the required members would not fulfill the federal requirement. NJAC 8:39-33.1