STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 39885 Based on observation, interview, record review and review of pertinent documents obtained from the facility, it was determined that the facility failed to thoroughly investigate an allegation of abuse for 1 of 20 sampled residents (Resident #39). This deficient practice was evidenced by the following: On 11/23/21 at 10:23 AM, Surveyor #1 observed Resident #39 lying in a, low to the ground bed, with his/her eyes closed. There was a floor mat located to the right side of the bed. A review of Resident #39's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to, hypertension, malignant neoplasm (cancer) of skin and major depressive disorder. On 12/01/21 at 8:47 AM, Surveyor #2 reviewed two facility provided fall incident reports for Resident #39. One of Resident #39's fall incident reports, dated 08/10/21 07:10, included the following note: as per CNA (Certified Nursing Assistant), the resident was very restless during final rounds and very confused. [Resident #39] kept stating there was a man trying to hurt [Resident #39] (an allegation of abuse). Further review of the incident report included additional notes on 08/11/21 and 08/16/21 regarding the fall. There was no documented evidence on the incident report that Resident #39's allegation of abuse was investigated. A review of the electronic Progress Note (ePN) dated 08/10/21 07:30, indicated that Resident #39 fell near the TV room and that the resident was alert but confused. Further review of the ePNs for 08/10/21 did not include documentation regarding Resident #39's allegation of a man trying to hurt the resident. At 9:10 AM, Surveyor #2, in the presence of the survey team, received confirmation from the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) that the incident reports that were provided to Surveyor #2 were the only incidents or investigations for Resident #39 for for the prior six months. The facility did not provide an incident report or an investigation for an allegation of abuse. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. Building B. Wing	12/07/2021

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:36 AM, Surveyor #2 via telephone call interviewed the CNA that had stated Resident #39 kept stating there was a man trying to hurt the resident. The CNA stated that she did not think the fall happened on her shift and that she didn't remember Resident #39 stating that someone was hurting the resident. She could not recall making the statement. At 11:59 AM, Surveyor #2 attempted to interview Resident #39 and the resident did not respond to Surveyor #2. At 12:00 PM Surveyor #2 interviewed the Unit Manager (UM) regarding Resident #39's cognition. The UM stated the resident was cognitively intact when admitted but that Resident #39 did not verbalize now. The UM stated that Resident #39 would not be able to be interviewed. At 3:26 PM, Surveyor #2 interviewed the Registered Nurse/Supervisor (RN/S), via telephone. The RN/S had documented the note regarding Resident #39 stating that a man was trying to hurt the resident. The RN/S stated that she vaguely remembered the incident report. She then stated that she did not remember that the CNA stated that Resident #39 had stated someone was trying to hurt the resident. She further stated that if a resident or a staff member would state someone was hurting a resident, she would report it to the DON. On 12/02/21 at 9:36 AM, in the presence of the survey team, Surveyor #2 interviewed the DON regarding the incident report. The DON stated that she spoke with the CNA and that the CNA stated that she [CNA] was frequently in Resident #39's room, and that there was no man around. The DON then stated that if someone is alleging abuse that they would do an internal investigation to substantiate (proved it occurred) or unsubstantiated (unable to prove it occurred) the allegation. She then added that any statement that someone made regarding that someone was hurting them would prompt her to complete an investigation. Surveyor #2 then asked the DON if the statement made by Resident #39 regarding a man trying to hurt [Resident #39] was an allegation of abuse. The DON stated that if she had to do an investigation than it would be an allegation of potential abuse. She then stated that she did not think there would need to be a separate incident report but that there should have been follow-up. She further stated that the nurse checked on Resident #39, and checked the area for any residents that were wandering but that the nurse did not complete an incident report and that nothing was documented. At 9:58 AM, in the presence of the survey team, Surveyor #2 interviewed the Director of Social Services/Abuse Officer (DSS/AO) regarding the incident report. The DSS/AO stated that she was not aware that Resident #39 voiced an allegation of abuse and that she should have been informed. She then stated that if there was an allegation of abuse that a full investigation should have be done. She further stated that she did not have documentation that an investigation was completed regarding Resident #39's allegation of abuse and that she did not know why it was not completed. At 12:02 PM, in the presence of the survey team, Surveyor #2 discussed the concern that an allegation of abuse was not investigated with the LNHA and the DON. The LNHA stated that the RN/S looked into the allegation as a clinical change in Resident #39's status and not abuse. On 12/03/21 at 9:49 AM, in the presence of the survey team, the DON stated that at the time of the incident the staff did a mini investigation that was not documented. At that time, the DON provided Surveyor #2 with a copy of a document titled, Investigation Report which contained an investigative summary, completed after surveyor inquiry, and dated 12/02/21. (continued on next page)

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	315092	A. Building B. Wing	12/07/2021

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:13 AM, in the presence of the survey team, Surveyor #2 asked the DON to clarify the Investigation Report. The DON stated that the Investigation Report is an addendum that was added to the incident report on 12/02/21 which was the written documentation of the abuse investigation. She further stated that the actions were done at the time of the incident but were not documented until 12/02/21. A review of the facility provided policy titled, Abuse, Neglect Exploitation or Misappropriation-Reporting and Investigating with a revised date of April 2021, included the following: Under Policy Statement All reports of resident abuse .are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Under Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities 1. If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations . 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; k. reviews all events leading up to the alleged incident; and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	l. documents the investigation completely and thoroughly . 11. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation A review of the facility provided policy titled, Accidents and Incidents-Investigating and Reporting, with an edited date of 4/24/19, included the following: Under Policy Statement All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Under Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse and/or department director or supervisor shall promptly initiate and document investigation of the accident or incident. A review of the facility provide policy titled, Abuse, Neglect, Misappropriation Prevention Program, with a revised date of April 2021, included the following: Under Policy Interpretation and Implementation 8. Identify and investigate all possible incidents of abuse . N.J.A.C. 8:39-4(a)5

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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. 27193 Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that preventive measures to prevent/ promote healing of pressure sores were in place and staff were consistently following the order. This deficient practice was identified for (Resident #71), 1 of 4 residents reviewed for pressure sores and was evidenced by the following: During the initial tour on 11/23/21 the surveyor observed Resident #71 lying in bed. Resident #71 told the surveyor that he/she needed staff assistance to get out of bed. The surveyor reviewed Resident #71's clinical record on 11/23/21 at 12:55 PM. The Admission Face Sheet revealed that Resident #71 was admitted to the facility with diagnoses which included essential (primary) hypertension, cellulitis of left lower limb, type 2 diabetes mellitus without complication, peripheral vascular disease and acquired absence of left leg below knee. The Admission Minimum Data Set (MDS), an assessment tool, dated 10/31/21 revealed that Resident #71 scored 14 on the Brief Interview for Mental Status (BIMS) Normal score 15. Further review of the clinical record revealed that Resident #71 was at risk for pressure sores. Resident #71 received a 14 score on the Braden Scale (tool used to determine pressure ulcer risk). Also noted was a Physician Order Sheet (POS) with a physician order dated 11/22/21 to cleanse the right heel with Normal saline solution, cover with ABD (abdominal) pad and wrap with kling. Diagnosis: DTI (Deep Tissue Injury) right heel. A review of the clinical record also revealed a care plan initiated on 10/14/21 and revised on 11/28/21 with a focus area of Actual skin breakdown related to Diabetes Mellitus, Peripheral vascular disease, anemia and left below knee amputation. The goal was for Resident #71 to show continued signs of healing. The interventions were to: Administer treatments as per physician orders. Education provided not to use right heel for positioning. Encourage and assist as needed to turn and reposition; use assistive devices as needed. Suspend/float heels as able. On 11/24/21 at 8:59 AM the surveyor observed Resident #71 in bed and the right heel was resting directly on the mattress. On 11/24/21 at 10:42 AM, the surveyor inquired about the POS for the dressing to the right heel. The Licensed Practical Nurse (LPN) assigned to the unit revealed that Resident #71 had an order for skin prep (a protective barrier) to be placed on the right heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/24/21 at 10:46 AM, the surveyor entered the room with the nurse and observed Resident #71 lying in bed. The LPN informed the resident that she needed to check the resident's right heel. The resident agreed to the request. The nurse removed the sheet and observed in the presence of the surveyor, that there was no dressing on the resident's right heel. Resident #71 had a black darkened area to the right heel surrounded by dry skin. The right heel was resting directly on the mattress. The nurse returned covered Resident #71's and left the room. On 11/29/21 at 8:44 AM, the surveyor returned to the room and noted Resident #71 lying in bed and the right heel was resting directly on the mattress. On 11/29/21 at 10:20 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who had cared for Resident #71. The CNA told the surveyor that Resident #71 could assist with care and would get out of bed with the Physical therapy staff. The surveyor asked to see Resident #71's right heel. The CNA removed the cover and it was observed that Resident #71 did not have a dressing to the right heel. The right heel was not off-loaded (was not suspended so there would be no pressure on the heel) but was noted to be resting directly on the mattress. The surveyor interviewed the CNA regarding Resident #71's care. The CNA told the surveyor that Resident #71 did not have an order for a heel protector (device used to off-load heel). The CNA further stated that she never observed Resident #71 with a heel protector on. On 11/29/21 at 11:43 AM, the surveyor returned to the room with the CNA. The CNA checked the dresser and the resident's drawer but could not locate a heel protector. On 11/30/21 at 8:30 AM, the surveyor observed Resident #71 lying in bed and the right heel was resting directly on the mattress. On 11/30/21 at 8:45 AM, an interview with the CNA revealed that Resident #71 did not have a dressing in place, or a heel protector/or a pillow to off-load the heel. That same day at 8:52 AM, the surveyor accompanied the nurse to the room where both observed Resident #71 in bed. There was no dressing on the resident's right heel and, the right heel was resting directly on the mattress. On 11/30/21 at 9:52 AM, the surveyor interviewed the Registered Nurse ADON, covering for the Unit Manager, regarding how Resident #71's Plan of Care was communicated to the CNA. The ADON stated to the surveyor that in the morning the facility did huddles (staff gathered to discuss residents) and all information regarding a residents care was entered and accessible to staff under Task on the Electronic Plan of Care (E-POC). An interview with Resident #71 on 11/30/21 at 9:58 AM, revealed that he/she had not been provided with a heel protector or pillow to off-load the right heel. The surveyor asked the ADON to provide information or documentation regarding Resident #71's refusal to wear a heel protector, and the facility was unable to provide any such documentation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/30/21 at 10:15 AM, the surveyor again interviewed the ADON who was covering for the Unit Manager, regarding the order on the care plan to off-load the resident's right heel. The ADON stated that staff should use a heel protector or pillow if a resident refused to offload the heel. The surveyor asked the ADON to view Resident #71 while in the bed and asked the ADON if the right heel was off-loaded at that time. The ADON confirmed that the right heel was not off-loaded and there was no dressing applied to the right heel. There was no documentation in the clinical record regarding Resident #71's refusal to off-load the right heel at the time of the observation. On 12/01/21 at 9:35 AM, the surveyor accompanied the ADON to the room and both observed Resident #71 lying in bed without a dressing on the right heel. It was also observed that the staff had signed the Treatment Administration record (TAR) on 11/23/21,11/24/21, 11/29/21, 11/30/21 and 12/01/21 which indicated the heel dressing and off-loading of the heels was in place. This documentation occurred on the days when the surveyor had observed Resident #71 in bed without a dressing on the right heel and without a pillow or heel protector in place to off-load the heels. The facility was informed of the above concerns for Resident #71 on 12/02/21 at 12:30 PM. A review of the facility's policy for Charting and Documentation, dated 02/27/18, indicated the following under policy statement: All services provided to the resident, progress toward the care plans goals, or any change in the resident's 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. A review of the facility's policy titled, Prevention of Pressure Injuries last revised 04/2020 revealed the following: Purpose The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation Review the resident's care plan and identify risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The policy was not being followed. Staff failed to review the care plan and implement interventions identified to reduce/prevent pressure ulcer. The policy was not being followed. NJAC 8:39-27.1 (e)

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	315092	A. Building B. Wing	12/07/2021

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to apply a positioning device as ordered by the physician for 1 of 1 residents (resident # 453) reviewed for positioning. This deficient practice was evidence of the following: On 11/23/21 at 9:15 am during tour, the surveyor observed Resident #453 lying in bed wearing an abductor pillow (A hip abduction pillow is a device used to prevent your hip from moving out of the joint after hip replacement surgery. The pillow is placed between your thighs and attached to your legs with straps). The resident was observed with garbled speech and was unable to be interviewed. The surveyor reviewed Resident #453 electronic medical record (EMR) revealed the following: The Admission Record (AR) dated November 24, 21, indicated that Resident #453 was admitted with the diagnosis of fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, aphasia (A comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain) following cerebral infarct (stroke), unspecified dementia without behavioral disturbance. According to the admission Minimum Data Set (MDS) an assessment tool dated 11/13/2021, Resident # 453 scored 0 on the Brief Interview for Mental Status (BIMS) which indicated severe cognitive deficits. The MDS also reflected extensive to total of two person assistance with bed mobility, transfers, and activities of daily living (ADL). The Order Summary Report (OSR) dated 11/11/21, indicated that the staff was to ensure that an abductor pillow was in place while the resident was in bed every shift for a right hip fracture. The Treatment Administration Record (TAR) dated on 11/11/21, indicated that the staff was to ensure abductor pillow was in place while the resident was in bed every shift for a right hip fracture. The resident's Care Plan (CP) dated 11/24/21, indicated that the resident was at risk for complications due to musculoskeletal problems related to a fracture. The interventions in place on the CP specified the following: -Hip precautions (posterior approach): Use abductor pillow between legs when lying in bed to prevent leg/foot from rolling in. -Provide support device to site as needed immobilizer when in bed. -knee separator while in wheelchair. On 11/24/21 at 9:34 AM, the surveyor observed the Resident #453 lying in bed not wearing an abduction pillow that was ordered by the physician. (continued on next page)

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	315092	A. Building B. Wing	12/07/2021

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Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/24/21 at 9:55 AM, the surveyor interviewed a Certified Nursing Assistant (CNA) who completed morning care for Resident #453. The CNA indicated that morning care consisted of complete bathing and dressing of the resident, while resident was in bed. The CNA revealed that she did not know why the resident was here and that she did not get report from the nurse that morning before she provided care to Resident #453. She further added that the resident was confused and did not know how to communicate. On 11/24/21 at 9:57 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated Resident #453 was in the facility for rehabilitation from hip surgery. She also added that Resident #453 received Physical Therapy (PT) and according to the physician orders, Resident #453 should be wearing an abductor pillow while in bed. The LPN indicated that she gave report to the CNA this morning and that she told the CNA to wash and dress the resident. She did confirm that she did not relay to the CNA that Resident #453 was on hip precautions. The LPN explained to the surveyor that hip precautions required that an abduction pillow be worn while in bed to prevent the residents hip from being dislocated. The LPN did not give the surveyor an explanation as to why she did not explain these precautions to the CNA who provided morning care. The surveyor then asked the LPN why the resident was not wearing the abduction pillow at this time. The LPN accompanied two surveyors to the room and admitted that the resident was not wearing an abduction pillow that was ordered by the physician. The LPN then proceeded to look for the abduction pillow and found it in a hamper underneath clothing. The LPN then explained that the resident had a room change and was transferred from room [ROOM NUMBER] to room [ROOM NUMBER] the evening on 11/23/21. The LPN then took the abductor pillow out of the hamper and placed it on the resident. The LPN could not explain as to how long the resident #453 was without the abductor pillow. On 11/24/21 at 10:13 AM, the surveyor interviewed the CNA who has been who employed in the facility for 3 years. The CNA indicated that she was assigned to provide care to Resident #453. She revealed that she usually got report from the nurse in the morning about her assignment and what care she was to provide to her residents, but did not receive report today. She stated that Resident #453 was confused and unable to communicate his/her needs or wants. The CNA stated that the resident's speech was garbled and jumbled up and that he/she was difficult to understand. The CNA also added that when she provided morning care to Resident #453 that the resident was not wearing an abduction pillow in-between his/her legs. She stated that Resident #453 required complete care with all aspects of activities of daily living and that when she provided care to the resident she washed and dressed him/her and turning the resident side to side without wearing the abduction pillow. She explained that she was not told that the resident required one. On 11/24/21 at 11:01 AM, the surveyor interviewed the Physical Therapist, who stated that she has worked in the facility for 4 and 1/2 years. She stated that Resident #453 was admitted to the facility for rehabilitation after hip replacement surgery. She added that the resident was ordered to have an abductor pillow in place while in bed. She revealed that the abduction pillow was to prevent internal rotation of the hip and to prevent dislocation. She further stated that if the hip did become dislocated it could cause severe pain to the resident which would require radiological tests and possible revision surgery. She explained that if the resident was in bed then the large wedge should be used and if the resident was in a wheelchair, a smaller wedge could be used if ordered by a physician. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/29/21 at 9:51 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that it was the nurse's responsibility to report if a resident required hip precautions and abductor pillows to the CNAs. She explained that it was also added to the Care Plan and MDS. The ADON further added that she was not sure why the CNA was not given report on 11/24/21 but that she would investigate it. She explained that an abductor pillow was used to prevent the hip from popping out and that the nurse should have noticed that the abductor pillow was not in place during morning rounds first thing in the morning. The facility form titled, Occupational Therapy Plan of Care (OTPOC) dated 11/10/21, indicated that Resident #453 was admitted for right hip fracture. Precautions that were listed on the OTPOC included the following: fall risk, hip precautions, hip abductor pillow when in bed, full weight bearing to right lower leg, aphasia. The facility form titled, Physical Therapy Plan of Care (PTPOC) dated 11/10/21, indicated that Resident #453 was admitted for right hip fracture. Precautions that were listed on PTPOC included the following: fall risk, hip precautions, hip abductor pillow when in bed, full weight bearing to right lower leg, aphasia. The facility policy titled, Resident Mobility and Range of Motion (ROM) with a revised date of July 2017 indicated that residents with limited ROM would receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility was unavoidable. The policy also indicated that interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. NJAC 8:39-27.1(a) 45208

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	315092	A. Building B. Wing	12/07/2021

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Based on observations, interviews, record review, and review of pertinent facility documents, the facility failed to ensure that the Foley urinary catheter drainage bag was stored in a manner to prevent Urinary Tract Infection (UTI) for 1 of 3 residents reviewed for urinary catheter care (Resident #18). The deficient practice was evidenced by the following: Resident #18 was readmitted to the facility with diagnoses which included Urinary Tract Infection, muscle weakness, adult failure to thrive and urinary retention. A care area assessment (CAA) associated with an admission Minimum Data Set (MDS), an assessment tool, dated 03/15/21, specified Resident #18 had a diagnosis of urinary retention and Resident #18 used a urinary catheter (tube inserted into the urethra to facilitate urinary drainage). A care plan dated 03/12/21, identified Resident #18 at risk for UTI due to a history of UTI and the need for a Foley catheter due to urinary retention related to obstructive uropathy. The care plan goal specified the resident would have no acute complications of urinary catheter use. Interventions included: Administer medications per physician order. Change catheter per physician order. Change urinary collection bag as needed. Evaluate as needed for possible removal of catheter and bladder retraining or toileting plan. Maintain catheter drainage bag below bladder level. Provide catheter care per protocol and change catheter per physician's orders. A review of Resident #18's medical record revealed that Resident #18 was last treated for a UTI on 06/27/21 and the organism involved was ESBL (Extended Spectrum Beta Lactamase). An Admission MDS dated [DATE], indicated Resident #18's was awake, alert and confused at times. The MDS coded the resident required some assistance with bed mobility and transfers. The MDS specified the resident had an indwelling urinary catheter and used a wheelchair for locomotion. An observation on 11/23/21 at 12:30 PM revealed Resident #18 laying in bed. The surveyor observed the Foley catheter drainage bag stored in a plastic bag, hung on the rails in the bathroom. The drainage port was not capped. A urinal dated 11/10/21 was also noted next to the bag. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional observation on 11/24/21 at 1:15 PM, revealed Resident #18 lying in bed and a leg bag on. The Foley catheter drainage bag was not in the bathroom. An interview was conducted on 11/24/21 with the Certified Nursing Assistant (CNA) who cared for Resident #18. The CNA revealed that Resident #18 was dependent on staff for care, had a Foley catheter, and wore a leg bag during the day to facilitate ease with therapy. The CNA further stated that the leg bag was changed to a Foley catheter drainage bag at night. The surveyor then inquired about the storage of the Foley catheter drainage bag. The CNA went to the room and pulled a plastic bag out from the resident's drawer. The CNA opened the plastic bag and showed to the surveyor the Foley catheter drainage bag stored with residual urine and the drainage port was not capped. The surveyor left the room and observed another surveyor in the hallway. The surveyor shared the observed practice with the other surveyor. The two surveyors went to the room and the CNA again showed how the Foley catheter drainage bag was stored with residual urine and the drainage port was not capped. The CNA then tied the plastic bag and returned the bag in the resident's drawer. The surveyor returned to the unit on 11/29/21 at 9:15 AM and observed Resident #18 in bed. A second interview with the CNA on 11/29/21 at 9:22 AM who cared for Resident #18 revealed that in the morning he assisted Resident #18 to the bathroom for care and switched the Foley catheter drainage bag to the leg bag and stored the bag in a secure plastic bag. The surveyor inquired twice about the process, the CNA did not mentioned any cleaning or disinfecting of the drainage port prior to applying the leg bag. The CNA then informed the surveyor that he shared the conversation with the Unit Manager on 11/24/21 (UM) and he was told to discard the drainage bag. An interview with the Registered Nurse (RN) assigned to the unit on 11/29/21 at 9:40 AM, revealed that the Foley catheter was changed monthly. The surveyor reviewed with the nurse the order for catheter care. The RN indicated that she had to make sure that the catheter was not kinked and the catheter was not clogged. The RN indicated that CNA's were responsible to switch the Foley drainage bag to the leg bag in the morning and at bedtime. On 11/30/21 at 9:05 AM, an interview with the CNA who had cared for Resident #18, revealed that he had been in-serviced on storage of the Foley catheter drainage bag but could not recall the date. Regarding the process, he indicated that he assisted the resident to the bathroom and switched the drainage bag to the leg bag and that the leg bag was changed daily. The CNA did not mentioned the use of a disinfectant to wipe the drainage port prior to applying the leg bag. On 11/30/21 at 9:50 AM, an interview with the Infection Control Preventionist (IP) revealed that the facility initiated some in services about storage of the Foley catheter drainage bag on 11/24/21. The IP provided the in-service education with the attached policy. The IP commented on the process. She indicated that the Foley catheter drainage bag should be rinsed of residual urine, capped, and stored in a plastic bag. When inquired about the rationale for the above statement, the IP indicated that was to prevent infection. On 11/30/21 at 9:42 AM, a review of the lab result dated 06/24/21 revealed a urine culture positive for a UTI. The organism involved was ESBL with a colony count greater than 100, 000. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/01/21 at 9:46 AM, the surveyor observed another CNA switching the Foley catheter drainage bag to the leg bag. The CNA went to the pantry, obtained a leg bag and took it to the resident's room. The CNA entered the room, donned (applied) gloves and went to the bedside to switch the Foley catheter drainage bag to the leg bag. The CNA returned to the bathroom to obtain the urinal. The CNA did not wash her hands or change gloves. The CNA returned to the bedside to start the process. The CNA removed the cap from the leg bag and threw the cap in the receptacle bin next to the bed. The CNA was about to disconnect the Foley drainage bag when the surveyor questioned the process. The surveyor referred the CNA to the Unit Manager for clarification with the process. Upon further inquiry, the CNA told the surveyor that she had been working at the facility for the last 4 months and did not receive any in-service on Foley catheter care. The CNA further stated, This is the way I always do it. A second interview with the CNA on 12/01/21 at 12:20 PM, revealed that she informed the Assistant Director of Nursing (ADON) of the process. The CNA stated that she recognized the problem. She went on to state she did not perform hand hygiene and did not have a wipe to cleanse the Foley catheter drainage port. Review of the facility's policy's for, Urinary Leg Drainage Bags undated and revised 10/2010 indicated the following: Purpose: The purpose of this provide guidelines to decrease the likelihood of nosocomial urinary tract infections associated with the intermittent use of leg drainage bags with Foley catheters. General guidelines: Every attempt should be made to maintain a closed urinary drainage system. Leg drainage bags should be used only after careful consideration and after a decision has been made that the benefits of use of the leg bag outweigh the potential increased of urinary tract infection. The resident should be informed that there is increased risk of infection when the integrity of the closed drainage system is compromised. A new sterile drainage bag should be used every time the regular straight drainage tubing is disconnected and the leg bag is used. The regular straight drainage bag may be reconnected only if it appears that the integrity of the system has been maintained. Aseptic technique must be used when handling urinary drainage systems. Do not wash or disinfect leg bags in an attempt to reuse them. Steps in the procedure. Place the clean equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached. (continued on next page)

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	315092	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wash and dry your hands thoroughly. Put on gloves. Wipe the Foley catheter/ drainage tubing junction with alcohol wipe before disconnecting. Disconnect the catheter from the tubing. If the drainage system has a tamper-proof seal, the seal will have to be broken. (Note: If the system has been previously opened, remove the tape.) Carefully remove sterile cover over connection tip of the urinary leg drainage bag. Place the cover over the connection tip of the straight drainage bag. Connect the Foley catheter with the urinary leg drainage bag. Anchor as needed. Empty straight drainage bag and measure urine, as indicated. Keep the drainage bag in a safe place where it will not be mishandled. Continue to keep drainage bag beneath the drainage tubing to prevent contamination. When the urinary leg drainage bag is no longer needed, wipe the catheter/ drainage bag junction alcohol wipe. Wipe connection tip of straight drainage tubing with alcohol wipe. If there is reason to believe the integrity of the system has not been maintained, obtain a new drainage bag. Reconnect system. Secure the junction with tape. Measure urine in urinary leg drainage bag into designated container. Discard all disposable items into designated containers. Remove gloves and discard in designated containers. An interview with the Director of Nursing (DON) on 12/03/2021 at 9:24 AM, revealed her expectation was to ensure that the care was being delivered properly. The DON indicated that going forward the facility will do audits to ensure that staff were in compliance. NJAC 8:39-27.1 (a)

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	315092	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34033 Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation on 11/24/21, the surveyor observed three (3) nurses administer medications to five (5) residents. There were 32 opportunities, and three (3) errors were observed which calculated to a medication administration error rate of 9.38 %. This deficient practice was identified for two (2) of five (5) residents, (Resident #87 and #454), that were administered medications by two (2) of three (3) nurses. The deficient practice was evidenced as follows: 1. On 11/24/21 at 8:57 AM, the surveyor observed the Licensed Practical Nurse (LPN) preparing to administer medications to Resident #87. The LPN stated that she was going to administer the resident's insulin first and then return to the medication cart and prepare the resident's oral medications. The LPN removed the resident's Lantus (a long-acting insulin-a medication used to treat high blood sugar/diabetes) SoloStar 100 units (U)/milliliter (ML) solution pen-injector (a disposable single-patient-use prefilled insulin pen) from the medication cart and explained that the resident had a physician's order (PO) on the electronic medication administration record (eMAR) for 15 units. The LPN showed the surveyor the resident's Lantus pen-injector and indicated on the pen in the dose window that 15 units had been selected. On 11/24/21 at 9:02 AM, the surveyor observed the LPN inject the resident's right arm subcutaneously (SC) with the Lantus pen injector. The surveyor reviewed the medical records for Resident #87. A review of the resident's Admission Record reflected that the resident was admitted on [DATE] with diagnoses which included Diabetes (high blood sugar) and cerebral infarction (stroke). According to the quarterly Minimum Data Set (MDS) (an assessment tool), dated 11/3/21, reflected that the resident had a Brief Interview of Mental Status (BIMS) score of 3 out of 15 which indicated that the resident had a moderately impaired cognition. A review of the resident's Order Summary Report reflected a PO dated 8/27/21 for Lantus SoloStar 100 U/ML solution pen-injector, inject 15 units SC one time a day for Diabetes. On 11/24/21 at 12:34 PM, the surveyor interviewed the LPN regarding the technique for administering insulin with the pen-injector. The LPN stated that she had put a new needle on the pen-injector and selected the right dose of 15 units and when she had injected the insulin had held the pen-injector button in for more than five (5) seconds. The LPN stated that she thought that was the correct procedure. The surveyor asked the LPN if there was any procedure for priming the insulin pen-injector before administering a dose. The LPN stated that the pen-injectors did not need to be primed. (ERROR#1) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/24/21 at 11:44 AM, the Director of Nursing (DON) provided the surveyor with the insulin pen-injector administration instructions titled Using Insulin Pens and Pen Needles that the facility used to instruct the nurses on the proper technique. The instructions revealed Always prime your insulin pen before each injection. The instructions also included to Dial two units on your pen and then press the button to shoot some insulin into the air to make sure it works. Further review included that If you do not see at least two drops of insulin after repeated priming, do not use the pen. At that time, the DON also provided the surveyor with a form that the facility educator completed when observing the nurses for medication observations titled Medication Administration Observation Quality Improvement Program. The form included that when a medication observation was being completed the nurse was reviewed for the proper technique when administering injections. On 11/30/21 at 9:30 AM, the surveyor interviewed the DON who stated that all insulin pen-injectors including Lantus SoloStar were required to be primed before each injection. The DON also stated that she was unsure the reason the insulin pen-injectors required priming but had received a handout of information from the Consultant Pharmacist (CP) regarding the proper technique and thought the reason would be included. A review of the Insulin Pen Injections handout of information provided by the CP reflected that the steps required to properly administer an insulin pen included Always prime your insulin pen before each injection. The information also revealed to Dial two units on your pen and then press the button to shoot some insulin into the air to make sure it works. In addition, Priming means removing air bubbles from the needle, and ensures that the needle is open and working. The pen must be primed before each injection On 11/30/21 at 12:26 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON who stated that she had already started in-services regarding the proper technique for insulin pen-injectors with the nurses. The DON also stated that the nurses were observed for medication administration after orientation and usually on a yearly basis. The DON stated that she would have to check for a completed medication observation and in-servicing for the LPN. On 11/30/21 at 12:37 PM, the survey team met with the CP and the Consultant Pharmacist Director of Operations (DCP). The DCP acknowledged that information was provided to the facility regarding proper insulin pen technique. The DCP and CP also acknowledged that insulin pen-injectors must be primed before each dose and by not priming the insulin pen could cause an inaccurate dose to be administered. The DCP stated that she had provided the facility with the Medication Administration Observation Quality Improvement Program form that was used during a medication administration observation. The CP stated that medication observations were performed by her upon request by the facility and there was no specific frequency. The CP stated that the DON or nurse educator would let her know which nurse required a medication pass. The DCP added that the facility educator also performed medication observations with the nurses. The DON provided the survey team with a Preventing Medication Errors Inservice Record for the LPN dated 2/2/20 indicating that the LPN had completed the in-service. The DON had not provided a Medication Administration Observation Quality Improvement Program form for the LPN. (continued on next page)

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	315092	A. Building B. Wing	12/07/2021

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Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the manufacturer's specifications for How to use your Lantus SoloStar pen in 6 steps revealed that a safety test was to be performed before each injection. The safety test entailed dialing a test dose of 2 units, pointing the needle up and injecting the dose to see that the insulin came out of the needle and that would help ensure the most accurate dose. 2. On 11/24/21 at 9:15 AM, the surveyor observed the LPN preparing to administer eight (8) oral medications to Resident #87 which included one tablet of Senna (Sennosides 8.6 milligram (MG)) (a laxative medication used to relieve constipation). The LPN stated that Senna was an over the counter (OTC) medication and was obtained by the facility as a house stock product and was stored in the original container in the medication cart. The LPN also stated that according to the eMAR for Resident #87, Senna was the OTC medication ordered by the physician. The LPN poured one (1) brown colored tablet into a medication cup from the bottle labeled Senna. On 11/24/21 at 9:31 AM, the surveyor observed the LPN administer the eight (8) oral medications which included the one (1) tablet of Senna to Resident #87. Upon returning to the medication cart, the surveyor reviewed the eMAR with the LPN. The eMAR revealed a PO dated 2/9/21 for Senna-Docusate Sodium tablet 8.6-50 MG (Sennosides-Docusate Sodium) (a combination laxative and stool softener medication used to relieve constipation). The LPN stated that she thought that Senna was the correct medication. The surveyor, with the LPN, reviewed the OTC medications in the medication cart which revealed a bottle labeled Senna Plus with the ingredients listed as Sennosides 8. 6 MG and Docusate Sodium 50 MG. The LPN stated that she thought the Senna Plus was a more concentrated product and did not think that Senna Plus should have been administered for the PO. The LPN was unable to speak to the ingredients of Senna Plus matching the PO. (ERROR#2) On 11/24/21 at 10:23 AM, the surveyor with the Unit Manager/LPN (UM/LPN) reviewed the facility OTC house stock medications which included Senna (Sennosides 8.6 MG) tablets and Senna Plus (Sennosides 8. 6 MG-Docusate Sodium 50 MG) tablets. The UM/LPN stated that the two (2) medications were not the same and the Senna Plus was a combination product that contained both Senna and Docusate Sodium. The UM/LPN added that the PO would specify Senna 8.6 MG or Senna-Docusate Sodium 8.6-50 MG for Senna Plus. On 11/24/21 at 10:27 AM, the surveyor, with the UM/LPN, reviewed the PO for Resident #87. The UM/LPN stated that Senna Plus should have been administered for the PO for Senna-Docusate Sodium tablet 8.6 -50 MG, (Sennosides-Docusate Sodium). The surveyor reviewed the medical record for Resident #87. A review of the resident's Admission Record reflected that the resident was admitted on [DATE] with diagnoses which included Diabetes (high blood sugar) and cerebral infarction (stroke). According to the quarterly Minimum Data Set (MDS) (an assessment tool) dated 11/3/21 reflected that the resident had a Brief Interview of Mental Status (BIMS) score of 3 out of 15 which indicated that the resident had a moderately impaired cognition. A review of the resident's Order Summary Report reflected a PO dated 8/27/21 for Senna-Docusate Sodium tablet 8.6 -50 MG, (Sennosides-Docusate Sodium), give one tablet by mouth two times a day for constipation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/30/21 at 12:26 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON who stated that the nurses were observed for medication administration after orientation and usually on a yearly basis. The DON stated that she would have to check for a completed medication observation and in-servicing for the LPN. On 11/30/21 at 12:37 PM, the survey team met with the CP and the Consultant Pharmacist Director of Operations (DCP). The DCP stated that the facility decided which OTC products the facility purchased, and that the CP was not involved in the decision. The CP and DCP acknowledged that the nurses were to administer the correct OTC medication which correlated with the PO. The DCP stated that she had provided the facility with the Medication Administration Observation Quality Improvement Program form that was completed during a medication observation. The CP stated that medication observations were performed by her upon request by the facility and there was no specific frequency. The CP stated that the DON or nurse educator would let her know which nurse required a medication pass. The DCP added that the facility educator also performed medication observations with the nurses. The DON provided the survey team with a Preventing Medication Errors Inservice Record for the LPN dated 2/2/20 indicating that the LPN had completed the in-service. The DON had not provided a Medication Administration Observation Quality Improvement Program form for the LPN. A review of the facility policy, provided by the DON, dated as edited 5/21/19, reflected that medications were administered in accordance with prescriber orders. In addition, the policy reflected that the nurse administering the medications was to check the label three times to verify the right medication. 3. On 11/24/21 at 9:49 AM, the surveyor observed the Registered Nurse (RN) preparing to administer six (6) medications to Resident #454. On 11/24/21 at 10:03 AM, the surveyor observed the RN return to the medication cart after administering the six (6) medications and reviewed the resident's eMAR and explained that she had to administer two (2) additional medications which included Vitamin C (Ascorbic Acid) (a vitamin supplement). The RN stated that Vitamin C (Ascorbic Acid) was an OTC medication and was obtained by the facility as a house stock product and was stored in the original container in the medication cart. The RN prepared one (1) 250 MG tablet of Vitamin C (Ascorbic Acid). At that time, the surveyor, with the RN, reviewed the eMAR for the PO for Vitamin C (Ascorbic Acid). The RN stated that she had the correct OTC medication. On 11/24/21 at 10:07 AM, the surveyor observed the RN administer one (1) 250 MG tablet of Vitamin C (Ascorbic Acid) to Resident #454. (continued on next page)

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	315092	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon returning to the medication cart, the surveyor asked the RN to further review the eMAR which revealed that the PO dated 9/13/21 was for Vitamin C (Ascorbic Acid) 500 MG, give one tablet by mouth two times a day for supplement. The RN stated that she thought she had administered the correct dose but had administered Vitamin C 250 MG one tablet. (ERROR #3) The RN added that she should have administered two (2) tablets of the 250 MG to make the dose of 500 MG. The RN was unsure if the facility had the 500 MG tablets of Vitamin C and was unable to find a bottle of the Vitamin C 500 MG tablets on her medication cart. On 11/24/21 at 10:12 AM, the RN#2 stated that she was the nurse in charge at the desk of the North Unit for the day and thought the facility had Vitamin C (Ascorbic Acid) 500 MG tablets as an OTC house stock medication. The UM/RN further stated that the PO should be followed as ordered. The RN#2 explained that if the PO indicated to administer 500 MG then a 500 MG tablet should be administered. The RN#2 added that if the facility had Vitamin C 250 MG then the PO would indicate to administer two (2) 250 MG tablets to make the dose of 500 MG. On 11/24/21 at 10/16/21, the surveyor interviewed LPN#2, who stated that she had Vitamin C (Ascorbic Acid) 500 MG tablets on her medication cart. The LPN#2 also stated that she followed the PO as to whether she administered the 250 MG tablets or the 500 MG tablets. The surveyor reviewed the medical record for Resident #454. A review of the resident's Admission Record reflected that the resident was admitted on [DATE] with diagnoses which included Diabetes (high blood sugar) and pressure ulcer of the left buttock. According to the admission Minimum Data Set (MDS) (an assessment tool), dated 9/19/21, reflected that the resident had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated an intact cognition. A review of the resident's Order Summary Report reflected a PO dated 9/13/21 for Vitamin C (Ascorbic Acid) 500 MG, give one tablet by mouth two times a day for supplement. A review of the list of house stock medications provided by the DON reflected that Vitamin C (Ascorbic Acid) 250 MG and 500 MG tablets were ordered by the facility. On 11/30/21 at 12:26 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON who stated that the nurses were observed for medication administration after orientation and usually on a yearly basis. On 11/30/21 at 12:37 PM, the survey team met with the CP and the Consultant Pharmacist Director of Operations (DCP). The DCP stated that the facility decided which OTC products the facility purchased, and that the CP was not involved in the decision. The CP and DCP acknowledged that the nurses were to administer the correct dosage of the OTC medication which correlated with the PO. The DCP stated that she had provided the facility with the Medication Administration Observation Quality Improvement Program form that was completed during a medication observation. The CP stated that medication observations were performed by her upon request by the facility and there was no specific frequency. The CP stated that the DON or nurse educator would let her know which nurse required a medication pass. The DCP added that the facility educator also performed medication observations with the nurses. (continued on next page)

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	315092	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Holmdel	188 Highway 34 Holmdel, NJ 07733

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON provided a completed Medication Administration Observation Quality Improvement Program form dated 11/22/21 by the nurse educator indicating the RN had no errors. A review of the facility policy dated as edited 5/21/19 reflected that medications were administered in accordance with prescriber orders. In addition, the policy reflected that the nurse administering the medications was to check the label three times to verify the right dosage. NJAC 8:39-11.2(b), 29.2(d)