STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Valley	300 Old Hook Road Westwood, NJ 07675

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 39885 Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 1 of 21 residents, Resident #69 reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: Reference: According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) on Chapter 2-page 39 . According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023). This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board, and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly. Code 04, Short-Term General Hospital (acute hospital/IPPS): if the resident was discharged to a hospital that is contracted with Medicare to provide acute, inpatient care and accepts a predetermined rate as payment in full. Code 99, Not Listed 1. On 6/06/24 at 9:36 AM, the surveyor reviewed the closed medical record for Resident #69 whose discharge MDS was coded for discharge to an acute hospital. The surveyor reviewed the 3/06/24 progress notes which indicated that Resident #69 was discharged home. Review of Resident #69's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included but were not limited to metabolic encephalopathy, acute kidney failure and diabetes mellitus. Review of the A section of the Discharge MDS for Resident #69 revealed that section A2105 Discharge Status documented, 04. Short-Term General Hospital. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/06/24 at 11:10 AM, the surveyor interviewed the Clinical Reimbursement Coordinator/MDS Coordinator (MDSC) regarding where Resident #69 was discharged to. The MDSC stated that she believed that Resident #69 went home. The surveyor asked the MDSC about Resident #69's Discharge MDS which was coded for discharge to the hospital. The MDSC stated that she thought it was an error in the coding and that she was going to check the medical record. The MDSC then confirmed that the Discharge MDS was coded incorrectly and that Resident #69 was discharged to home and not to a hospital. On 6/06/24 at 01:43 PM, in the presence of the survey team, the surveyor told the Licensed Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, VP of Special Clinical Projects and the Clinical Reimbursement Coordinator (CRC #2) the concern that Resident #69's Discharge MDS was coded incorrectly. CRC #2 confirmed that Resident #69's Discharge MDS was coded incorrectly and added that the facility modified the MDS. The facility did not provide any additional information. A review of the facility provided policy titled, Comprehensive Assessments with a revised date of March 2022 included the following: Policy Interpretation and Implementation 1. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. N.J.A.C. 8:39-11.1, 11.2

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 Based on observation, interview, and review of pertinent medical records, it was determined that the facility failed to follow physician orders related to the use of continuous oxygen (O2) for 1 of 1 resident, Resident #3. This deficient practice was evidenced by the following: On 6/4/24 at 10:45 AM, the surveyor observed Resident #3, who was laying in bed in their room. Resident #3 was receiving O2 delivered through a nasal cannula (NC-plastic prongs attached to a tube, inserted into the nostrils that oxygen flows through) utilizing a concentrator (an oxygen delivery system) at 3.5 Liters per minute (LPM). Resident #3 stated their O2 should be running at 4 LPM. The surveyor reviewed the resident's medical chart which included a review of a paper as well as computerized medical chart. A review of the Admission Record (a summary of important information about the resident) documented the resident was admitted to the facility on [DATE] with diagnoses included but were not limited to Chronic Obstructive Pulmonary Disease, Essential Hypertension, Morbid Obesity, and Obstructive Sleep Apnea. A review of an Annual Minimum Data Set (AMDS, an assessment tool to facilitate care), dated 5/7/24, documented the resident had a Brief Interview for Mental Status (BIMS) and scored a 15 out of 15, indicating that Resident #3 was cognitively intact. The AMDS further revealed Resident #3 is receiving continuous oxygen therapy. A review of the Physician's Orders (PO) and electronic treatment administration record (eTAR) documented a physician's order for, Oxygen at 4 Liters/minute with Humidification VIA: Nasal Cannula (NC) every shift for Acute Respiratory Failure with a start date of 5/20/24. A review of Resident #3's Care Plan (CP) with a revision date of 5/10/24 read, .At risk for respiratory impairment related to Asthma, COPD, morbid obesity, OSA. An intervention for the CP read, Administer oxygen per physician order. On 6/5/24 at 9:42 AM, the surveyor observed Resident #3's O2 concentrator, set at 3 1/2 L/min, second observation of O2 concentrator. On 6/5/24 at 9:45 AM, the surveyor interviewed Licensed Practical Nurse (LPN) caring for Resident #3. The LPN reviewed with the surveyor the PO for the resident's O2 settings. The surveyor informed the LPN of the two observations on 6/4/24 and 6/5/24 in which the resident's O2 setting was at 3 1/2 LPM. The surveyor accompanied the LPN to Resident #3's room to check the O2 settings. The LPN acknowledged the O2 was not set at 4 LPM as ordered by the physician. The LPN could not explain why the resident's O2 setting was at 3 1/2 LPM and adjusted the resident's O2 setting to 4 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 11:00 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled, Oxygen Administration, which had a revised date of October 2010. Under the Preparation portion of the policy it read, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Under the Documentation section of the policy it read, After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record .3. The rate of oxygen flow, route, and rationale. On 6/6/24 at 1:42 PM, the survey team met with the LNHA, Director of Nursing (DON), Assistant Director of Nursing (ADON), [NAME] President of Special Clinical Project (VPSCP), and Clinical Reimbursement coordinator (CRC) The surveyor informed the facility about the concerns of the O2 setting for Resident #3. The DON stated the O2 should be administered according to physicians' orders. There was no further information provided. NJAC 8:39-27.1(a)

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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. 31656 Based on observation, interview, and record review, it was determined that the facility failed to properly store a controlled and noncontrolled medications in a secure manner. This deficient practice was identified for one (1) of 3 units inspected and involved two Residents, Resident #123 and #122. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The deficient practice was evidenced by the following: On 6/4/24 at 11:55 AM, the surveyor inspected the medication cart located on Unit 2 of the facility in the presence of the Licensed Practical Nurse (LPN). The surveyor opened the top drawer of the medication cart and noted that there was a medication cup that contained 2 pharmacy wrapped unit dose medications. The surveyor inspected the 2 medications which were found to be Doxycycline 100mg Capsule (an antibiotic) and Oxycodone IR 5 mg tablet (Schedule II Opioid analgesic). The surveyor discussed the storage of the two medications, Doxycycline 100mg Capsule and Oxycodone IR 5 mg tablet in the medication cup with the LPN, who stated that he was not made aware by the previous shift that the unit dose Doxycycline 100mg Capsule and Oxycodone IR 5 mg tablet were in his cart. The LPN stated that he did not know which resident this belonged to. The LPN explained that if he was aware he would have questioned why they were there because the Oxycodone 5 mg should be stored in the locked narcotic box of the medication cart. On 6/4/24 at 12:00 PM, the Assistant Director of Nursing (ADON) joined the surveyor in investigating the Doxycycline 100mg Capsule and Oxycodone IR 5 mg tablet found in a medication cup in the top drawer of the medication cart. The ADON could not identify which resident the medications belonged to and The ADON stated that she was not aware of the medication left in the top drawer. The ADON added that she needed to investigate how and why these medications were left not properly secured in the medication cart, especially a Class II control substance. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 12:09 PM, the surveyor and ADON reviewed the medication back up System (Omnicell) printout for history of Doxycycline 100mg Capsule and Oxycodone IR 5 mg tablet activity. The Omnicell printout showed that on 6/1/24 at 16:11 (4:11 PM), 1 capsule of Doxycycline 100mg was removed for the Resident #123 as well as on 6/3/24 at 17:21 (5:21 PM), the printout showed that 2 tablets of Oxycodone IR 5 mg tablets were removed for Resident #122. The physical count for the Class II Controlled Substance Oxycodone IR 5 mg was shown to be correct in the Omnicell. On 6/4/24 at 12:15 PM, the surveyor interviewed the ADON who stated that when a medication is not administered, it needs to be destroyed, relating to the Doxycylcine 100mg and the Oxycodone 5 mg. She added that a control substance (Oxycodone 5 mg) should be stored separated in a double locked area and that the destruction of a control substance should be carried out by two nurses. The surveyor reviewed the medical record for Resident #123. A review of the Admission Record for Resident #123 reveals that the resident was admitted with diagnosis that include but are not limited to Fracture of Superior Rim of Left Pubis, Type 2 Diabetes Mellitus, Unspecified Protein-Calorie Malnutrition, and Primary Generalized Osteoarthritis. Review of the June 2024 electronic medication administration record (eMAR) documents a physician's order dated 6/1/24 for Doxycycline Hydrate 100 mg to be administered twice daily for skin/soft tissue infection for 10 days. The June eMAR documents the administration of the Doxycycline 100mg twice daily with no missed doses. Review of the Admission Record for Resident #122 reveals that the resident was admitted with diagnosis that include but are not limited to Spinal Stenosis, Lumbar Region without Neurogenic Claudication, Type 1 Diabetes Mellitus and Anxiety Disorder. Review of the June 2024 eMAR documents a physician's order dated 5/31/24 for Oxycodone 10 mg every 6 hours as needed for severe pain (8-10) and Oxycodone 5 mg every 6 hours as needed for moderate pain (5-7). Documentation for administration for the Oxycodone 5 mg reveals that it was administered as (1) tablet on 6/3/24 at 17:35 (5:35 PM) even though (2) tablets were removed from the Omnicell at 17:21 (5:21 PM). The Director of Nursing presented an interview with LPN#2 who administered the Oxycodone 5 mg to Resident #122 on 6/3/24. This interview revealed that Resident #123 was going to therapy and requested pain medication. LPN#2 continued that the nursing supervisor went to the Omnicell and removed 2 tablets of Oxycodone 5 mg (logged into the Omnicell) but that Resident #122 only requested 1 tablet of Oxycodone 5 mg. LPN#2 stated that she forgot to destroy the extra Oxycodone 5 mg that was not administered. On 6/6/24 at 1:30 PM, the surveyor telephoned the Provider Pharmacy and spoke to a Pharmacy Technician who revealed that #30 tablets of Oxycodone IR 5 mg and #30 tablets of Oxycodone IR 10 mg were delivered to the facility for Resident #123 on 6/4/24 at 3:50 PM. The Pharmacy Technician explained that a Class II control substance does not automatically get transmitted, the pharmacy needs a physician's written and signed order. The Pharmacy Technician continued by stating that this is the reason that the facility has a back up medication unit, Omnicell so that there is no delay in treatment if medication is needed prior to the pharmacy delivery. The Pharmacy Technician stated that the order was received from the facility on 6/4/24 at 7:00 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pharmacy Technician stated that the Doxycycline 100mg was ordered and delivered on 6/1/24. Review of the Controlled Substances policy section Storing Controlled Substances, 1. Controlled substances are separately locked in permanently affixed compartments,. Documented under Dispensing and Reconciling Controlled Substances, 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. And 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. On 6/6/24 at 1:51 PM, the surveyor met with facility staff Clinical Reimbursement Coordinator, ADON, Director of Nursing, and [NAME] President of Special Clinical Projects who did not provide any further information. NJAC 8:39-11.2(b), 29.2 (a)(d)