STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315132	A. BUILDING ______ B. WING ______	10/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT THE HIGHLANDS	1350 INMAN AVENUE EDISON, NJ 08820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 10/25/19 CENSUS: 112 SAMPLE SIZE: 23 + 3 closed records The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		11/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/11/2019

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.

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F 583	Continued From page 1 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure a resident's right to receive unopened mail. This deficient practice was identified for 1 of 5 residents (Resident #21) who participated during the Resident Council Meeting and was evidenced by the following: On 10/21/19 at 10:38 AM, during the Resident Council Meeting, Resident #21 stated, " I felt uncomfortable and bothered when I recieved my mail opened the other day." The resident was unable to remember the exact date the mail was delivered opened. Resident #21 further stated that it was the "lady" from the Business Office who handed him/her the opened mail which contained three one-dollar lottery tickets. On that same date and time, Resident #21 informed the surveyor, in the presence of four other residents, that he/she did not want to call the resident's representative (RR) who sent the mail because they did not want the RR to get upset when the mail was delivered opened. A review of the [redacted] Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of [redacted]	F 583	Staff member responsible for opening resident #21's mail was educated on 10/21/19 on facility policy on resident mail not to be opened by staff. If a special request is made by the resident or family, documentation must follow. Residents receiving mail have the potential of being affected. Current residents were interviewed if they receive their mail unopened, they all answered "yes". Staff will be in serviced on mail delivery process. Residents will receive their mail unopened, unless there is a specific request from resident or family to open it, which should be accommodated and documentation must follow. Activities Department will check mail to ensure it is unopened when presented to the resident and will keep a log of residents' mail received and distributed, which will include if mail was intact upon delivery to resident, and submit the log to the Director of Nursing or designee weekly x 4 weeks then monthly x 3 months.	

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F 583	Continued From page 2 [redacted] which reflected that the resident's [redacted] On 10/21/19 at 12:02 PM, the survey team met with the Administrator and the Director of Nursing (DON) and was made aware of the concern. The DON stated that it was "unacceptable" for the resident to receive mail tht had been opened and the facility would "get to the bottom of it and investigate what had happened." She further stated that Resident #21 was [redacted] On 10/22/19 at 12:06 PM, the survey team met with the Administrator and the DON. The DON stated that upon investigation, it was the Business Office Staff (BOS) who opened and handed the opened mail to Resident #21. The DON further stated that the BOS should not have opened the mail because of the resident's right to privacy and it was the facility policy to deliver the mail unopened. She indicated that it was the first time she knew about it and it was not communicated to the facility team and it should have been care planned. On that same date and time, the BOS stated in the presence of the surveyors, Administrator and the DON that she verbally received an endorsement from the previous Office Manager who left the facility, that the RR requested that all resident's mail be open and checked by the Business Office because the resident had a tendency to give away money to anyone. The BOS further stated that she was the only one who knew about the RRs request and did not inform the facility team about it. On 10/25/19 at 10:00 AM, there was no additional	F 583	Director of Nursing or designee will report findings to the Quality Assurance Committee quarterly for one quarter.	

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F 583	Continued From page 3 information provided by the facility. A review of the facility Mail and Electronic Communication Policy provided by the DON with a revised date of 5/2017 indicated, "Mail will be delivered to the resident unopened; staff members of this facility will not open mail for the resident unless the resident requests them to do so; such request will be documented in the resident's care plan of care." NJAC 8:39-4.1 (a)(19)	F 583		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that [redacted] for	F 688	Resident #56 had their [redacted] applied as per the order.	11/8/19

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F 688	Continued From page 4 [redacted] management were consistently applied for 1 of 24 residents, (Resident #56) reviewed for [redacted] This deficient practice was evidenced by the following: On 10/17/19 at 11:00 AM, the surveyor observed Resident #56 in bed sleeping. There were no visitor(s) present. The surveyor observed that the resident's [redacted]. There was no [redacted] noted on the resident's [redacted]. On 10/18/19 at 10:01 AM, the surveyor observed the resident in bed with the head of the bed elevated. The resident was awake and [redacted] There were no visitor(s) present. There was no [redacted] in use. On that same day at 10:15 AM, the surveyor observed the Certified Nursing Assistant (CNA) providing morning care to Resident #56. Later, that same day at 12:02 PM, the surveyor observed the resident in bed without the [redacted] in use. There were no visitor(s) present. Review of the Face Sheet (an admission record) indicated Resident # 56 was admitted to the facility on [redacted] and had diagnoses which included but not limited to [redacted] Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated that the resident's cognitive skills for daily	F 688	Residents with [redacted] have the potential for being affected. An audit was conducted on 10/20/19 and it was noted that all orders and care plans were in place according to rehab recommendations and al[redacted]were in place as ordered. Director of Nursing or designee will in service nursing and rehab staff on rehab recommendations process. Director of Nursing or designee will in service nurses on proper and timely documentation of refusal of [redacted] Director of Nursing or designee will audit records of patients with [redacted] to ensure orders, care plan and POC task are in place weekly x 4 weeks then monthly x 2 months. Director of Nursing or designee will report findings of the audits to the Quality Assurance Committee quarterly for one quarter.	

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F 688	Continued From page 5 decision making was [redacted]. Further review of the MDS indicated the resident had no [redacted]. Review of the October 2019 Treatment Administration Record (TAR) revealed a physician's order dated 10/11/19 for [redacted] apply in am remove at HS [bedtime] every day and evening shift. [redacted] -apply at HS remove in am every day and evening shift." Further review of the October 2019 TAR revealed that on 10/17/19 and 10/18/19 the order for the for [redacted] apply in am remove at HS [bedtime] every day and evening shift was signed by the nurses as applied. There was no documentation in the nurses note that the resident refused the [redacted]. Review of the resident's comprehensive individualized care plans with the revision date of 10/08/19 did not address the resident [redacted], nor did it address the use of the (1) [redacted] to be applied at bedtime and removed in the morning and (2) [redacted] to be applied in the morning and removed at bedtime. On 10/21/19 at 9:30 AM, the surveyor observed the resident in bed with no [redacted] in use. At that same time, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that the nurses were responsible for applying the [redacted]. " I did apply the [redacted] but the family came and they removed the [redacted] so that they can rub the resident's [redacted]." The surveyor asked the LPN what time the family visited with the resident. The LPN stated, the resident's spouse	F 688		

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F 688	Continued From page 6	F 688		

comes at varied times everyday.

The surveyor asked the LPN where the [redacted] was kept. The LPN stated, the [redacted] should be kept in the resident's room. At that same time, the surveyor and the LPN entered the resident's room, the LPN opened the closet door and removed [redacted]. One of the [redacted] was inside a plastic bag which was under the resident's clothing inside the closet.

On that same day at 9:40 AM, the surveyor interviewed the CNA who stated, the CNAs are responsible for applying the [redacted] after morning care. The CNA stated, " I did not put it on him/her because he/she does not like it, he/she pushes it away." The surveyor asked the CNA if she reported the resident's refusal to wear the [redacted] to the nurse. The CNA stated that she did not report the resident's refusal to the nurse because everybody knows the resident refuses everything."

On that same day at 9:45 AM, the surveyor interviewed the Assistant Director of Nursing #2 (ADON #2) who stated, the nurse assigned to the resident was responsible for applying the [redacted] and signing the TAR. ADON #2, also said that the [redacted] should have been careplanned. She further stated that the unit manager (UM) was responsible for care planning but the unit had no UM at the time.

On 10/21/19 at 9:53 AM, the surveyor interviewed the Occupational Therapist (OT) in the presence of the survey team. The OT stated that she provided OT services to the resident from 7/16/19 through 8/30/19 and recommended [redacted]

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F 688	Continued From page 7 for [redacted] to be applied to the [redacted] at bedtime and [redacted] in the morning for Resident # 56. She stated the resident was discharged from OT services on 8/30/19 and she educated staff to follow the [redacted] application schedule for [redacted]. She also stated that the resident was re-evaluated on [redacted] status post hospitalization for the continued use of the [redacted]. The surveyor reviewed the OT notes dated 10/9/19 which revealed "prior Occupational Therapy received on 7/16/19 - 8/30/19 for [redacted] and caregiver education." On 10/21/19 at 10:55 AM, the surveyor interviewed the resident's family representative who stated the resident had [redacted] and the last [redacted] greatly affected him/her and he/she can [redacted]. She added that OT gave the resident a [redacted] to keep on his/her [redacted] but the [redacted] are not on the resident whenever she visits. She said she usually visits in the evening. The family representative stated a family member took the [redacted] off one time in the past before the resident went to the hospital. On 10/21/19 at 12:23 PM, the surveyor discussed the above observations and concerns with the Administrator and the Director of Nursing (DON). The DON stated, "I put the care plan today [10/21/19] after we realized that there was no care plan for the [redacted] " On 10/22/19 at 12:23 PM, the DON stated she reviewed the OT notes and there was no decline in the resident's [redacted] from 8/30/19 through	F 688		

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F 688	Continued From page 8 10/9/19 when a re-evaluation was done. The DON further stated that the nurse who cared for the resident on 10/17 and 10/18/19 stated that the resident became [redacted] so they removed the [redacted] but they did not document the refusal. On 10/22/19 at 1:00 PM, the surveyor reviewed the facility policy for [redacted] dated 5/2007 and revised 10/25/07 provided by the DON. Procedure #4 indicated, "the therapist will establish a wearing schedule for the [redacted] It is recommended that the wearing period is gradually increased to the full amount of time prescribed." Procedure #5 indicated, "the nurse/C N A/care giver and or patient/resident are instructed by the therapist in the use and maintenance of the [redacted]." Procedure #6 indicated "The use of the [redacted] is incorporated into the resident's/patient's plan of care." NJAC 8:39-27.1(a):27.2(m)	F 688		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		11/8/19

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F 761	Continued From page 9 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure the expired medications were disposed of for 1 of 1 medication (med) storage rooms. This deficient practice was evidenced by the following: On 10/18/19 at 10:38 AM, two surveyors in the presence of the Assistant Director of Nursing #1 and #2 (ADON#1 and #2) inspected the Nursing Office med storage area. The surveyors observed the two ADONs perform a manual count of the controlled medications by counting the actual meds and checking and updating the expiration date. The surveyors also observed there were 5 of 19 expired (exp. date 7/6/19) [redacted] tablets (a med used to [redacted] At that same time, ADON #2 informed the surveyors that the expired [redacted] should have been disposed of. The ADON #2 had no answer as to why the expired [redacted] was still in the med	F 761	The 5 expired [redacted] were immediately removed from Omnicell and were wasted appropriately on 10/18/19. No residents received expired [redacted] Patients/ residents receiving medications from Omnicell have the potential for being affected. All medications in Omnicell checked for expiration dates on 10/18/19, no other expired meds found. Narcotic cycle count accountability sheet was edited on 10/18/19 to include: cycle count completed, any discrepancies, any expired meds. Director of Nursing or designee will in service staff on narcotic cycle count which is to be completed daily to include checking the expiration dates on all narcotic meds in Omnicell, removing and appropriately wasting any expired meds immediately.	

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F 761	Continued From page 10 storage area. On that same date and time, both ADONs informed the surveyors that the Cycle Count for the controlled medications should be done at least once a day and the expiration dates should be checked. At that time, the surveyor observed ADON #1 and #2 remove the expired [redacted] from the med storage, dispose of it in the drug buster and documented as disposed in the Controlled Drug Administration Record. On 10/22/19 at 12:05 PM, the DON stated that the [redacted] "should have been identified and removed" from the med storage. A review of the facility's Policy titled Storage of Medications with a revised date of 4/20/19 provided by the DON indicated that "Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed." NJAC 8:39-29.4 (g)	F 761	Director of Nursing or designee will complete a check of narcotic count in Omnicell weekly x 4 weeks then monthly x 3 months to ensure there are no expired narcotic medications in Omnicell. Director of Nursing or Designee will report findings of the Omnicell narcotic counts to the Quality Assurance Committee quarterly for one quarter.	