STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING _____ B. WING _____	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

(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 Complaint #: NJ144696, NJ140329, NJ143836 Census: 47 Sample Size: 8 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities based on this complaint survey.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ143836 Based on the facility policy, record review, and interviews, it was determined that the facility failed to ensure a resident received care according to professional standards of practice by failing to promptly notify the physician of abnormal [redacted] results for a resident with a [redacted], potentially delaying treatment and [redacted] interventions. A nurse reported to the physician and family that the [redacted] results were negative, however, the [redacted] results showed that the resident had a [redacted]. This affected 1 (Resident #3) of 3 residents reviewed for [redacted].	F 684	1 What corrective action(s) will be accomplished for those residents affected by the deficient practice? Resident's immediate transfer was initiated to acute care hospital for further evaluation and treatment. 2 How will you identify those residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who receive [redacted] testing	8/20/21

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

Electronically Signed | 08/13/2021

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F 684	Continued From page 1 Findings included: 1. Resident #3 was admitted to the facility on [redacted] with diagnoses of [redacted], and [redacted]. A review of the admission Minimum Data Set (MDS) dated [redacted] revealed the resident was severely [redacted]. The resident required extensive assistance with activities of daily living (ADLs). A review of the care plan dated [redacted], and revised on [redacted] due to a [redacted], revealed the resident was at risk for [redacted] to [redacted] and [redacted]. An intervention noted on [redacted] indicated that a bed and chair alarm were initiated. A review of the progress notes dated [redacted] revealed Resident #3 was found lying on the floor on the right side near the wall next to the bathroom. The physician was notified and assessed the resident. A review of the physician's notes dated [redacted] revealed the resident had a fall and complained of [redacted]. The resident was assessed for injuries and was able to move [redacted] with no shortening observed and no [redacted] seen. A [redacted] was ordered to rule out a [redacted] and [redacted] was given for [redacted] A review of the treatment administration record (TAR) for [redacted] revealed the resident did not complain [redacted]. A review of the medication administration record (MAR) physician's order for [redacted] of [redacted] milligrams (mg) order for [redacted] tabs every [redacted] hours	F 684	have the potential to be affected. Other [redacted] tests performed for other residents were reviewed and no other residents were affected. 3 What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? DON or designee shall provide additional training to nurses related to review of reports and reporting results to the physician. [redacted] vendor to reformat report when more than [redacted] is completed on the patient. 4 How the corrective actions will be monitored to ensure the deficient practice will not recur? Administrator or designee will audit [redacted] results daily for 1 week, three times a week for 2 weeks, and monthly for 2 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for 3 months.	

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F 684	Continued From page 2	F 684		

revealed the resident received [redacted] one time on [redacted], twice on [redacted], zero on [redacted], one time on [redacted], and one time on [redacted].

A review of the occupational therapy treatment note dated [redacted] revealed the resident completed [redacted] strength therapeutic exercises. Dynamic sitting balance was completed. The resident was deferred from standing balance until [redacted] results were completed.

A review of the [redacted] results of the [redacted] dated [redacted] revealed a [redacted] with [redacted] with the [redacted]. The [redacted] had no [redacted].

A review of the progress notes dated [redacted] revealed the unit nurse reported to the physician and the responsible party that the [redacted] results were negative.

A review of the progress notes dated [redacted] revealed the resident had [redacted] with no impairment, with range of motion on both the [redacted].

A review of the progress notes dated [redacted] revealed the resident's [redacted] level was [redacted] and range of motion performed indicated the resident was able to move all [redacted]

A review of the physician's progress notes dated [redacted] revealed the physician indicated the resident's [redacted] of the [redacted] and [redacted] indicated [redacted]. The family was notified, and the resident was sent out

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F 684	Continued From page 3 to the ER for an evaluation and admitted to the hospital with a [redacted]. During an interview on [redacted] at 3:30 PM, Registered Nurse (RN) #1 revealed he found Resident #3 on the floor and assessed the resident after the [redacted]. RN #1 revealed Resident #3 moved all [redacted] without any [redacted] and had no [redacted] or [redacted] RN #1 further revealed the physician was at the facility and immediately assessed the resident with [redacted] of [redacted], with no [redacted] observed and no [redacted] seen. RN #1 revealed the resident did complain of [redacted] and was given [redacted], and a [redacted] was ordered on [redacted]. RN #1 revealed he was assigned on second shift to care for Resident #3 throughout the weekend. The resident was assessed and moved [redacted], and nothing was [redacted]. RN #1 further revealed the resident was assisted up in the wheelchair to go to the bathroom and did not complain of [redacted]. During an interview on 07/28/2021 at 12:41 PM, Licensed Practical Nurse (LPN) #1 revealed she cared for the resident on first shift during the weekend. LPN #1 further revealed she assessed the resident first thing in the morning, and there was no [redacted] of the [redacted]. The resident had no [redacted] or yelling out and no indicator [redacted]. LPN #1 revealed after the resident finished occupational therapy, the therapist let her know the resident was having [redacted] and was given [redacted]. During an interview on 07/28/2021 at 1:15 PM, the Occupational Therapist (OT) revealed she worked with the resident after the [redacted] The OT further revealed Resident #3 had gotten up on the	F 684		

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F 684	Continued From page 4	F 684		

side of the bed and seemed to be in [redacted] on [redacted]. The OT revealed the resident was observed without any [redacted] and was able to sit on the side of the bed without [redacted] and only complained of [redacted] The OT further revealed the resident's nurse was notified, and the resident received [redacted].

During an interview on 07/28/2021 at 3:24 PM, the Medical Director revealed the charge nurse should have looked at the entire [redacted] results and reported it to the physician. The Medical Director was aware of the situation and the delay did not cause the resident harm. The resident's pain was managed, and the resident had range of motion. When the physician saw the resident after the [redacted] there was no [redacted] After the physician was aware Resident #3 had a [redacted], the resident was sent to the hospital and was admitted to the hospital with a [redacted]

During an interview on 07/28/2021 at 4:00 PM, the Director of Nursing (DON) revealed the charge nurse no longer worked at the facility, and the physician was unavailable for interview. The DON revealed the procedure for reporting [redacted] results was to notify the physician of the complete results. The DON further revealed the results of the [redacted] were received at the facility on [redacted], and the unit manager reported to the physician and the [redacted] the results of the [redacted] with [redacted] but failed to report the [redacted].

A review of the facility policy, dated April 2007, titled, "Test Results," read in part: 1. Results of laboratory, radiological, and diagnostic tests shall be reported to the resident's Attending Physician or to the facility. 2. Should the test results be

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F 684	Continued From page 5 provided to the facility, the Attending Physician shall be promptly notified of the results. New Jersey Administrative Code § 8:39-27.1(a)	F 684		