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 _____	C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE 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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ00167793, NJ00167387, NJ00166908, NJ00166506, NJ00164636, NJ00164205, NJ00162689, NJ00162265, NJ00160759 Survey Date: 1/12/2024 Census: 94 Sample: 23 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		2/8/24

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

Electronically Signed | 02/02/2024

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain [NJ Ex Order 2] during mealtime for a resident who needed assistance with [NJ Ex Order 2]. This deficient practice was observed for 2 of 26 residents observed, Resident #27 and Resident #72 and was evidenced by the following: 1. On 1/4/24 at 12:09 PM, the surveyor observed the [US FOIA (b)(6)] on the [NJ Exec Ord]	F 550	It is the policy of Care One at Highlands to ensure that residents' rights are upheld with respect, dignity, and enhancement of quality of life. CNA#1 was educated on Resident's Rights and to be seated while assisting a resident with meals. CNA#1 educated that personal electronic devices are not to be used in resident	

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F 550	Continued From page 2 Unit, standing and holding a NJ Ex Order 26.4b1 in her right hand while Resident #27 was NJ Ex Order 26.4b1 . The surveyor also observed the US FOIA (b)(6) observing and holding her personal cellphone in her left hand while assisting the resident during NJ Ex Order 26.4b1. The surveyor interviewed the US FOIA (b)(6) on 1/4/23 at 12:14 PM, who stated that she normally stands while NJ Ex Order 26.4b1 the resident because she was also assisting another resident (Resident #27's roommate) at the same time in the same room. A review of the Admission Record for Resident #27 reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4b1 ; NJ Ex Order 26.4b1 ; NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 . A review of the resident's Minimum Data Set, an assessment tool used to facilitate the management of care dated NJ Ex Order 26.4b1, reflected that Resident #27 had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, indicating NJ Ex Order 26.4b1 . A review of the facility's policy and procedure titled, "Assistance with Meals" revealed under Dining Room Residents "#3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example a. not standing over residents while assisting them with meals." On 1/9/24 at 1:48 PM, the US FOIA (b)(6) and the US FOIA (b)(6) were made aware of the surveyor's observation, and both agreed that the US FOIA (b)(6) should be attentive and seated next to the	F 550	areas. CNA#2 was educated on Resident's Rights and to be seated in a chair while assisting a resident with meals. CNA#2 educated on importance of interacting with residents while assisting with meals. All residents requiring staff assistance with meals have the potential to be affected. Resident #27 had NJ Ex Order 26.4b1 related to this interaction. Resident #72 had NJ Ex Order 26.4b1 related to this interaction. Director of Nursing conducted rounds on units during mealtimes to ensure staff were compliant with resident's rights while being assisted with meals. DON/ADON or designee will observe residents utilizing staff with meals twice weekly x 1 month then monthly x 3 months. Findings to be reported to the Administrator as well as QAPI monthly x 3 months.	

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F 550	Continued From page 3	F 550		

resident when NJ Ex Order 26.4b
2. On 1/4/24 at 12:07 PM, the surveyor observed lunch being served on the NJ Exec Or Unit. The surveyor observed CNA #2 sitting at the end of Resident #72's bed in their room. The resident was NJ Ex Order 26.4b1 with the NJ Ex Order 26.4b1 ,NJ Ex Order 26.4b1 ,NJ Ex Order 26.4b1 . The surveyor observed CNA #2 not looking, talking, or attending to Resident #72. CNA #2 was looking down at an electronic device in her hand.

On 1/4/24 at 12:08 PM, the surveyor called the US FOIA (b)(6)) to the doorway of Resident #72's room. The US FOIA (b)(6) observed CNA #2 sitting at the foot of the resident's bed looking at the electronic device in her hands. The US FOIA (b)(6) entered the room and called CNA #2 to the hallway to speak with the surveyor. The US FOIA (b)(6) stated that the device held by CNA#2 was a facility tablet which the CNAs used to complete their resident documentation.

The surveyor interviewed CNA #2, in the presence of the US FOIA (b)(6) CNA #2 acknowledged that she should not have been sitting on the resident's bed. CNA #2 stated she was supervising the resident to provide help with their NJ Ex Ord if needed and that the documentation she was completing on the tablet included the resident's NJ Ex Order 26

The US FOIA (b)(6) acknowledged that CNA #2 should not have been seated on the resident's bed and that it was not an appropriate time for the CNA to complete documentation. The US FOIA (b)(6) acknowledged that CNA #2 should have been interacting with Resident #72.

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According to the Admission Record (an admission summary), Resident #72 had diagnoses that included but were not limited to NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1.

A Comprehensive MDS assessment, dated NJ Ex Order 26.4b1, indicated the facility assessed the resident's cognition using a BIMS test. Resident #72 scored NJ out of 15, which indicated the resident had NJ Ex Order 26.4b1. The MDS further documented the resident required NJ Ex Order 2 or NJ Ex Order 26.4b1 assistance for NJ Ex Order 2.

On 1/9/24 at 1:47 PM, the surveyor informed the regional US FOIA (b)(6) and the US FOIA (b)(6)) of the above concerns during NJ Ex Order 2 observation.

On 1/11/24 at 10:52 AM, the US FOIA (b)(6) and the US FOIA (b)(6) met with the survey team. The US FOIA (b)(6) acknowledged CNA #2 should not have been sitting on Resident #72's bed and should not have used a work tablet at the resident's bedside. The US FOIA (b)(6) further explained CNA #2 should have been interacting with the resident and not on an electronic device.

A review of the facility's policy titled "Resident", last revised in April 2022, under Policy Statement it read: "Employees shall treat all residents with kindness, respect, and dignity." Under Policy Interpretation and Implementation, it read: "1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity including being addressed by the

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F 550	Continued From page 5 resident's chosen name and pronouns ..."	F 550		
F 583 SS=D	N.J.A.C. 8:39-4.1(a)12 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 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	F 583		2/8/24

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F 583	Continued From page 6 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain the confidentiality of the resident information on the Electronic Health Records system. This deficient practice was observed during unit observation and was evidenced by the following: On 1/8/24 at 1:11 PM, the surveyor observed a paper documenting written information placed on top of the medication cart showing resident's photos, resident's names, resident's room numbers, vital signs including blood pressure, heart rate, blood glucose level, and temperature associated with each resident. Further observation revealed other documented notes about the residents next to their names. The surveyor observed two family members passed by the medication cart where the paper was placed having documented information available for viewing by anyone passing by. On 1/8/24 at 1:20 PM, the surveyor observed the US FOIA (b)(6)) walking towards the medication cart. The US FOIA stated to the surveyor that she was assigned to the medication cart. The US FOIA further stated that the piece of paper was referred to as "roster." The US FOIA explained that the roster was a sheet of paper that allows her to document important information about the residents assigned to her. During the interview, the surveyor informed the US FOIA that the paper documented resident's	F 583	It is the policy of Care One at Highlands to ensure that residents' personal privacy and confidentiality of his or her personal and medical records are protected. US FOI was immediately educated on Personal Privacy and Protected Health Information (PHI). All residents with information on the nursing roster have potential to be affected. DON immediately performed rounds to ensure PHI was not left uncovered on medication carts. DON provided re-education to nurses on Personal Privacy and Confidentiality of Records. DON/ADON or designee will conduct rounds to monitor for compliance of Personal Privacy and PHI, daily x 1 week, then weekly x 3 months. Findings to be reported to the Administrator as well as QAPI monthly x 3 months.	

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F 583	Continued From page 7 personal medical information. The [redacted] responded that there were no HIPPA (Health Insurance Portability and Accountability Act, a 1996 Federal law that restricts individual's private medical information) violations that referred to this because it only listed the resident's names and room numbers. On 1/9/24 at 1:48 PM, the surveyor discussed the above concern with the facility's[redacted] and [redacted] who both agreed that the nurse revealed private medical information that should have been covered from view. NJAC 8:39-4.1 (a) 18	F 583		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the	F 640		2/8/24

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F 640	Continued From page 8 CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) - Discharge Assessment in accordance with federal guidelines. This deficient practice was identified for 1 of 26 residents reviewed for resident assessment, Resident #84.	F 640	It is the policy of Care One at Highlands that the discharge Minimum Data Set (MDS) is completed and transmitted timely. Resident #84 was discharged from the facility. Discharge MDS was completed and	

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F 640	Continued From page 9 This deficient practice was evidenced by: On 1/9/24 at 11:22 AM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. The MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. After transition of the MDS, a quality measure will be transmitted to enable a facility to monitor the residents decline or progress. On 1/9/24 at 11:30 AM, the surveyor reviewed Resident #84's electronic medical record.. Review of the record revealed that the resident was discharged to the community on NJ Ex Order 26.4b1. The surveyor reviewed the resident's MDS 3.0 Assessment History assessment tool, including all the completed MDS's. The MDS assessment history revealed that there was no Discharge Assessment MDS completed for the resident's discharge date of NJ Ex Order 26.4b1. According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) page 2-11 "Discharge refers to the date a resident leaves the facility..." There are two types of OBRA required discharges: return anticipated and return not anticipated. A Discharge assessment is required with all types of discharges. The manual revealed on Page 2-17 "A Discharge Assessment - return not anticipated MDS must be completed not later	F 640	transmitted NJ Exec Order 26.4b1. Resident #84 had NJ Ex Order 26.4b1 related to this practice. All residents requiring a Discharge Assessment have potential for being affected. Clinical Reimbursement Coordinator (CRC) conducted an audit of residents discharged in the last 60 days to ensure completion and submission of the Discharge Assessment. CRC or designee will track census activity including discharges daily, and open Discharge Assessment directly into Point Click Care (Emar). DON/ADON or designee will conduct audits to ensure Discharge Assessments are completed within 14 days of discharge. Audits will be weekly x 4 weeks, monthly x 3 months. Findings to be reported to the Administrator as well as QAPI monthly x 3 months.	

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F 640	Continued From page 10 than discharge date + 14 days. The assessment must also be transmitted to the QIES ASAP system not later than the MDS completion + 14 days." On 1/10/24 at 12:33 PM, the surveyor interviewed the facility's US FOIA (b)(6) responsible for completing MDS assessments, who stated to the surveyor that the Discharge MDS for Resident #84's assessment was missed. On 1/11/24 at 11:07 AM, the facility's US FOIA (b)(6) [redacted] and US FOIA (b)(6) was informed regarding the above concern. There was no further information provided. NJAC 8:39 - 11.2	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: 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 2 of 26 residents, Resident #105 and Resident #47, reviewed for accuracy of MDS coding. This deficient practice was evidenced by the following:	F 641	It is the policy of Care one at Highlands that the MDS is completed timely and accurately. Resident #105 was discharged to NJ Ex Order. MDS was modified for resident #105 on NJ Exec Order 26.4b1. Resident #105 had NJ Ex Order 26.4b1 related to this practice. Resident #47 was discharged to NJ Ex Order. MDS was modified for resident #47 on	2/8/24

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F 641	Continued From page 11 1. On 1/11/24 at 2:18 PM, the surveyor reviewed the closed hybrid (paper and electronic) medical records for Resident #105. A review of the Admission Record (a summary of important information about the resident) documented Resident #105 with diagnoses that included but were not limited to NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , NJ Ex Order 26.4 , and NJ Ex Order 26 . A review of a discharge MDS for the resident, dated NJ Ex Order 26.4 , under section A documented it was a "Discharge assessment-return not anticipated ...Planned discharge ..." to a "NJ Ex Order 26.4b1 ." A review of the Patient Discharge Summary/Instructions form dated NJ Ex Order 26.4 documented that Resident #105 was discharged NJ Ex Order . On 1/11/24 at 10:51 AM, the surveyor informed the US FOIA (b)(6) and US FOIA (b)(6) about the above concerns. The US FOIA (b)(6) stated all MDS coding should be accurate. There was no further information provided. On 1/12/24 at 8:47 AM, the surveyor reviewed the Discharge MDS of Resident #105 with the US FOIA (b) . The US FOIA (b)(6) stated that the identified coding on the Discharge MDS was an error. The US FOIA (b)(6) confirmed that the resident was discharged NJ Ex Order and not to a NJ Ex Order 26.4b1 . 2. On 1/8/24 at 1:04 PM, the surveyor observed Resident #47 in the day room seated in their	F 641	1-12-2024. Resident #47 had NJ Ex Order 26.4b1 related to this practice. All residents who require an MDS assessment have potential for being affected. Clinical Reimbursement Coordinator (CRC) conducted an audit of residents who were discharged in the last 30 days to ensure accuracy of coding. Clinical Reimbursement Coordinator (CRC) conducted an audit of residents who had falls in the last 30 days to ensure accuracy of coding. DON/ADON or designee will conduct audits to ensure accuracy of coding for residents who are discharged weekly x 4 weeks, monthly x 3 months. Findings to be reported to the Administrator as well as QAPI monthly x 3 months. DON/ADON or designee will conduct audits to ensure accuracy of coding for residents who have had falls with major injury weekly x 4 weeks, monthly x 3 months. Findings to be reported to the Administrator as well as QAPI monthly x 3 months.	

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[redacted] wheelchair in the dayroom.

The surveyor reviewed Resident #47's hybrid medical records.

The admission record (AR) reflected that Resident #47 was admitted to the facility with medical diagnoses that included but were not limited to NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 .

A review of the NJ Exec Order 26.4b1 [redacted] an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1 documented that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 indicating that the resident had NJ Ex Order 26.4b [redacted] .

Further review of the NJ Exec Order 26.4b1 under Section NJ Exec Orde documenting the number of NJ Exec O since admission/entry or reentry to the facility revealed that Resident #47 had NJ Ex Order 26.4 with NJ Ex Order 26.4b1 and another NJ Ex with a NJ Ex Order 26.4b1 .

The surveyor interviewed the facility's US FOIA (b) [redacted] who was responsible of completing the MDS assessments. The US FOIA (b)(6) stated that the MDS section NJ Ex Order 2 for NJ Ex Or was coded in error. The US FOIA (b)(6) further stated that Resident #47 did not have a NJ Ex with NJ Ex Order 26.4b1 , only the NJ Ex Order 26.4 with NJ Ex Order 26.4b1 .

On 1/9/24 at 1:48 PM, the surveyor discussed the above concern with the facility's US FOIA (b)(6) and US FOIA (b)(6) [redacted] There was no further information provided.

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F 658 SS=D	NJAC 8:39-11.1, 11.2(e)(1) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #NJ00154940 Complaint #NJ 00153394 Based on observation, interview, and record review it was determined that the facility failed to accurately document and clarify the administration of medication for 3 of 36 residents, Resident #39, #43 and #21. This deficient practice was evidenced by the following: 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."	F 658	It is the policy of Care One at Highlands that services provided as outlined by the care plan, meet professional standards of quality. Resident #39 orders were clarified for the use of NJ Ex Order 26.4b1, to be worn 6 hours per day, on at 4:00pm and off at 10:00pm. Resident #39 had NJ Ex Order 26.4b1 related to this practice. Resident #43 orders were clarified for use of the NJ Ex Order 26.4b1 daily. Resident #43 orders for NJ Ex Order 26.4b1 were discontinued. Resident #43 had NJ Ex Order 26.4b1 related to this practice. Resident #21's orders for NJ Ex Order 26.4b1 were clarified with physician. Resident #21 had NJ Ex Order 26.4b1 related to this practice. All residents with use of splints have	2/8/24

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F 658	Continued From page 14 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." 1. On 1/4/24 at 11:47 AM, the surveyor observed Resident #39 seated in their NJ Ex Order 26.4b1 in their NJ Ex Order 26.4b1 in their room. Resident #39 was noted with NJ Ex Order 26.4b1 as well as NJ Ex Order 26.4b1. Resident #39 was NJ Ex Order 26.4b or NJ Ex Order 26.4b and NJ Ex Order 26.4b1 when NJ Ex Order 26.4b1 On 1/9/24 at 11:10 AM, the surveyor observed Resident #39 seated in their NJ Ex Order 26.4b1 in their NJ Ex Order 26.4b1 in their room. Resident #39 had NJ Ex Order 26.4b1 as well as NJ Ex Orde. On 1/10/24 at 12:15 PM, the surveyor observed Resident #39 seated in their NJ Ex Order 26.4b1 in their NJ Ex Order 26.4b1 in their room. Resident #39 had NJ Ex Order 26.4b1 as well as NJ Ex Orde. On 1/11/24 at 11:56 AM, the surveyor observed Resident #39 seated in their NJ Ex Order 26.4b1 in their NJ Ex Order 26.4b1 in their room. Resident #39 had NJ Ex Order 26.4b1 as well as NJ Ex Orde	F 658	potential to be affected. All residents with use of lidocaine patches have potential to be affected. All new admissions have potential to be affected. The Director of Rehab conducted an audit of residents utilizing splints to ensure accurate orders for use. The Director of Nursing conducted an audit of residents with orders for lidocaine patches to ensure accuracy of orders. The Director of Nursing conducted an audit of new admissions in the last 14 days to ensure accuracy of medication orders when compared to hospital discharge orders. Director of rehab or designee will perform audits for residents utilizing splints weekly x 4 weeks, monthly x 3 months. Findings to be reported to the Administrator as well as QAPI monthly x 3 months. DON or designee will perform audits for residents with lidocaine patch orders to ensure accuracy of the order weekly x 4 weeks, monthly x 3 months. Findings to be reported to the Administrator as well as QAPI monthly x 3 months. DON/Pharmacy Consultant/designee will reconcile new admission orders daily x 7 days, weekly x 4 weeks, then monthly x 3 months with findings reported to the	

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F 658	Continued From page 15 NJ Ex Order 26.4b1. At this time, the surveyor noted the US FOIA (b)(6) in the room. The surveyor interviewed the US FO who informed the surveyor that the NJ Ex Order 26.4b1 are applied to Resident #39 between 11:30 and 12:00 PM. A review of Resident #39's electronic health record (EHR) revealed the following: According to Resident #39's Admission Record (an admission summary), Resident #39 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. Review of the resident's Quarterly Minimum Data Set (QDS) assessment, a tool used to facilitate management of care, dated NJ Ex Order 26.4b1, indicated that the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #39 scored a NJ out of 15, which indicated the resident had NJ Ex Order 26.4b1. On 1/11/24 at 12:10 PM, the surveyor reviewed the NJ Ex Order 26.4b1 Emar for Resident #39. The surveyor reviewed two physician's orders on the NJ Ex Order 26.4b1 Emar. The first physician's order with a start date of NJ Ex Order 26.4 read, "Apply NJ Ex Order 26.4b1 in the afternoon for NJ Ex Order 26.4b1. Please do NJ Ex Order 26.4b1 before NJ Ex Order 26.4b1 and remove per schedule." The Emar had documentations that the NJ Ex Order 2 were being donned (applying) NJ Ex Order 26.4b1 at 12:00 PM and Doffed (removing) at 4:00 PM daily.	F 658	Administrator and QAPI monthly x 3 months.	

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The second physician's order with a start date of [NJ Ex Order 2], found on the [NJ Ex Order 26.4b1] Emar for Resident #39 documented, "Wear [NJ Ex Order 26.4b1] for 6 hours during day don at afternoon, doff in evening." The documentation on the Emar revealed that it was applied daily at 4:00 PM and removed at 10:00 PM from [NJ Ex Order 2] to [NJ Ex Order 26.4].

On 1/11/24 at 1:56 PM, the surveyor informed the [US FOIA (b)(6)] and [US FOIA (b)(6)] of the conflicting orders for the [NJ Ex Order 26.4].

On 1/12/24 at 11:56 AM, the R[US FOIA (b)(6)] could not explain why there were two orders for the [NJ Ex Order 26.4b1] application. He did clarify that the [NJ Ex Order 26.4b1] should be applied on Resident #39 for only 6 hours per day, on at 4:00 and off at 10:00 PM.

On 1/12/24 at 11:58 AM, the surveyor along with the [US FOIA (b)(6)] and [US FOIA (b)(6)] observed Resident #39 seated in their [NJ Ex Order 26.4b1] in their [NJ Ex Order 26.4b1] in their room. Resident #39 had [NJ Ex Order 26.4b1] as well as [NJ Ex Order 26.4b1].

2. On 1/5/24 at 12:33 PM, the surveyor interviewed Resident #43 who was seated in a wheelchair in their room. The resident was [NJ Ex Ord], [NJ Ex Order 26.4b] and [NJ Ex Order 26.4b1]. Resident #43 informed the surveyor tha[NJ Ex Order 26.4b1] was supposed to be applied every morning, but the nurses have informed the resident that it was not available.

A review of Resident #43's electronic health record (EHR) revealed the following:

According to Resident #43's Admission Record

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(an admission summary), Resident #43 was admitted with diagnoses that included but were not limited to, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1.

Review of the resident's Quarterly Minimum Data Set (QDS) assessment, a tool used to facilitate management of care, dated NJ Ex Order 26.4b1, indicated that the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #43 scored a NJ Ex out of 15, which indicated the resident had NJ Ex Order 26.4b1.

A physician's order dated NJ Ex Order 26.4b1 and noted on the electronic medical administration record (Emar) read: NJ Ex Order 26.4b1 Apply to NJ Ex Or one time a day for NJ Ex Ord . Apply for only 12 hours in a 24 hour period. External use only. And remove per schedule." The documentation on the Emar for NJ Ex Order 26.4b1 revealed application at 9:00 AM and removal at 9:00 PM.

Review of the application documentation by nursing for NJ Ex Order 26.4b1 was documented as applied at 9:00 AM and removed at 9:00 PM from NJ Ex Order 2 to NJ Ex Order 2.

On 1/5/24 at 1:21 PM, the surveyor discussed Resident #43's NJ Ex Order 26.4b1 with the US FOIA (b)(6) responsible for administering the resident's medication. The US FOIA stated that the NJ Ex Order was applied in the morning.

The surveyor along with the US FOIA approached Resident #43 and with their permission, inspected the resident's NJ Ex Order 26.4b1. There was no evidence that NJ Ex Order 26.4b1 was applied to the NJ Ex Or

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of Resident #43.

The US FOIA could not explain why the NJ Ex Order 26.4b1 was documented as applied when there was no evidence that it was applied on Resident #43.

On 1/5/24 at 1:24 PM, the US FOIA in the presence of the surveyor inspected her medication cart where there was no NJ Ex Order 26.4b1 available.

On 1/9/24 at 11:41 AM, the surveyor called the provider pharmacy and spoke with the US FOIA (b)(6) who stated that the NJ Ex Order 26.4b1 was never sent by the pharmacy. It was ordered as a profile medication only and therefore was only printed on the Emar.

3. On 1/9/24 at 11:41 PM, the surveyor interviewed Resident #43 who was seated in a wheelchair in their room. The resident was NJ Ex Ord, NJ Ex Order 26.4b and NJ Ex Order 26.4b1 Resident #43 informed the surveyor that NJ Ex Order 26.4b1 was another medication that was supposed to be applied every morning, but the nurses informed the resident that it was not available until today. Resident #43 presented the bottle of NJ Ex Order 26.4b1 with a delivery date of NJ Ex Order 2. Resident #43 stated that it was delivered NJ Ex Order 26.4b1 and lasts about 3 weeks.

A review of Resident #43's electronic health record (EHR) revealed the following:

Review of the Emar dated NJ Ex Order 26 documented a physician's order for NJ Ex Order 26.4b1 Apply to NJ Ex Orde every shift for NJ Ex Order 2 with a start date of

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NJ Ex Order 26.4.

Review of the documentation on the NJ Ex Order 26 Emar showed that the NJ Ex Order 26.4b1 was applied from NJ Ex Order 2 to NJ Ex Order 2 every shift (3 times daily).

On 1/9/24 at 11:41 AM, the surveyor called the provider pharmacy and spoke with the US FOIA (b)(6) who stated that the NJ Ex Order 26.4b1 was last delivered to the facility on NJ Ex Order 26.4.

4. On 1/4/24 at 11:16 AM, the surveyor interviewed Resident #21 in the resident's room. The resident stated that they NJ Ex Order 26.4b1 and take NJ Ex Order 26.4b1 to treat the NJ Ex Order 26. Resident #21 informed the surveyor that previous to their admission to the facility they were treated with NJ Ex Order 26.4b1 but have been receiving NJ Ex Order 2 daily since admission to the facility. The resident stated they noticed this about NJ Ex Order 26.4b1 alerted a staff member, but has not heard anything since.

A review of Resident #21's Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26, NJ Ex Order 26.4b1, NJ Ex Order 26, and NJ Ex Order 26.4.

The Comprehensive Minimum Data Set (MDS), an assessment tool used for the management of care dated NJ Ex Order 26.4b1, revealed a BIMS score of NJ Ex out of 15 which indicated that the resident had an NJ Ex Order 26.4b1.

The surveyor reviewed the NJ Ex Order 26.4b1 Physician Orders (PO), which revealed an order dated NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1,

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F 658	Continued From page 20 Give 1 tablet by mouth one time a day for [NJ Ex Order 26.4b] May cause [NJ Ex Order 26.4b1]. The surveyor reviewed the hospital "After Visit Summary," a summary of medication administered to Resident #21 during the resident's hospital stay from [NJ Ex Order 26.4] - [NJ Ex Order 26.4b]. The "After Visit Summary" (AVS) documented that Resident #21 was treated with '[NJ Ex Order 26.4b1] tablet, dose: [NJ Ex Order] daily for [NJ Ex Order 26.4b1]. The surveyor reviewed the Nursing Admission Assessment and Physician Initial Assessment for documentation related to a reduction in dosage from [NJ Ex Order 26.4b1] to [NJ Ex Order 2]. Neither the Nursing Admission Assessment or the Physician Initial Assessment addressed a change in [NJ Ex Order 26.4b1] dosage. Multiple attempts were made by the surveyor to interview the Physician and nurse who documented Resident #21's medication orders from the hospital. Both were unable to be reached. Voicemail messages were left by the surveyor. On 1/5/24 at 1:00 PM, the [US FOIA (b)(6)] provided the surveyor with facility policies titled, "Psychotropic Medication Use" with an edited date 2/2/2023 and "Medication and Treatment Orders" with a revised date of July 2016. The Psychotropic Medication Use policy states under the Policy Interpretation and Implementation, 3. "Residents, families and/or representative are involved in the medication management process ...Psychotropic medication management includes ...b. dose." The Medication and Treatment Orders policy	F 658		

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F 658	Continued From page 21 states under the Policy Interpretation and Implementation, 3. "Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis." On 1/11/24 at 10:53 AM, the surveyor met with the US FOIA (b)(6) and US FOIA (b)(6) The US FOIA (b)(6) stated, "with regards to the process for new admission and medication review, upon admission, orders are reconciled with the resident and physician. Transcribed as physician's orders on Point Click Care. US FOIA (b)(6) unable to state why the medication dosage occurred. No further comments were provided. NJAC 8:39-11.2 (b); 29.2(d)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: 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 NJ Ex Order 26.4b1 for 1 of 1 resident, Resident #15, reviewed for NJ Ex Order 26.4b1.	F 695	It is the policy of Care One at Highlands that resident who needs respiratory care; tracheostomy care and tracheal suctioning are cared for with professional standards of practice and the residents'	2/8/24

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F 695	Continued From page 22 This deficient practice was evidenced by the following: On 1/4/24 at 11:00 AM, the surveyor observed Resident #15 seated in a wheelchair in their room. Resident #15 was receiving NJ Ex Order 26.4b1 through NJ Ex Order 26.4b1 utilizing a NJ Ex Order 26.4b1 at NJ Ex Order 26.4b1 . The surveyor reviewed the resident's paper and electronic medical chart. A review of the Admission Record (a summary of important information about the resident) documented the resident's diagnoses included but were not limited to NJ Ex Order 26.4b1 , NJ Ex Order 26.4 , NJ Ex Order 26.4b1 , and NJ Ex Order 26.4b1 . A review of a comprehensive Minimum Data Set (an assessment tool to facilitate care) dated NJ Ex Order 26.4b1 , documented the resident had a Brief Interview for Mental Status (BIMS) and scored a NJ Ex out of 15, indicating that Resident #15 had NJ Ex Order 26.4b1 . A review of the Physician's Orders (PO) and electronic treatment administration record (eTAR) documented a physician's order for, " NJ Ex Order 26.4b1 continuous at NJ Ex Order 2 " with a start date of NJ Ex Order 26.4 at 3:00 PM. A review of Resident #15's Care Plan (CP) with an effective date of NJ Ex Order 26.4b1 read, " ...Has/At risk	F 695	goals and preferences. Resident #15's NJ Ex Order 26.4b1 was adjusted to NJ Ex Order 26.4b1 as per physician's orders. Resident #15 had NJ Ex Order 26.4b1 from this practice. All residents with use of oxygen have potential to be affected. The DON conducted an audit of residents with oxygen therapy to ensure oxygen delivery coincided with physician order. All nurses were educated to ensure oxygen administration according to physician order. DON or designee will conduct audits for 100% of residents on oxygen therapy to ensure oxygen administration is according to physician's orders weekly x 4 weeks, monthly x 3 months. Findings to be reported to the Administrator as well as QAPI monthly x 3 months.	

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F 695	Continued From page 23	F 695		

for NJ Ex Order 26.4b1 related to [redacted]. An intervention for the CP read, "Administer [redacted] per physician order."

On 1/4/24 at 12:20 PM, the surveyor observed Resident #15 seated in a wheelchair in their room. The resident was NJ Ex Order 26.4b1 delivered through [redacted] utilizing a NJ Ex Order 26.4b1 at [redacted].

On 1/4/24 at 12:25 PM, the surveyor interviewed the US FOIA (b)(6)) caring for Resident #15. The [redacted] and surveyor reviewed the PO for the resident's [redacted] settings.

The surveyor informed the [redacted] of the two observations on [redacted] in which the resident's [redacted] was at [redacted]. The surveyor accompanied the [redacted] to Resident #15's room to check the [redacted] settings. The [redacted] acknowledged the [redacted] was not set at [redacted] as ordered by the physician. The [redacted] could not explain why the resident's [redacted] was set at [redacted].

On 1/10/24 at 10:30 AM, the US FOIA (b)(6) [redacted] 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 1/11/24 at 10:53 AM, the survey team met with the US FOIA (b)(6) [redacted]

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F 695	Continued From page 24 ([redacted] and [redacted] The surveyor informed the [redacted] and [redacted] about the concerns of the [redacted] setting for Resident #15. The [redacted] stated the [redacted] should be administered according to physicians' orders. There was no further information provided by the facility. NJAC 8:39-27.1(a)	F 695		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the residents' primary physician signed and dated monthly physician orders (PO) to ensure that the residents' current medical regimen was current and accurate. This deficient practice was observed for 4 of 46 residents reviewed, Resident #76, Resident #51, Resident #47, and Resident	F 711	It is the policy of Care One at Highlands that Physician review care/notes/orders at each visit. Residents #76, #51, #27, and #47 physicians' orders were reviewed and signed in wet ink by their attending physicians.	2/8/24

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F 711	Continued From page 25 #27 and was evidenced by the following: 1. On 1/4/24 at 11:27 AM, the surveyor observed Resident #76 in bed [NJ Ex Ord] and [NJ Ex Order 26.4b1] The surveyor reviewed the Admission Record (one page summary of important information about a resident) (AR) for Resident #76. The resident was admitted to the facility with diagnoses that included but was not limited to [NJ Ex Order 26.4b1] ;[NJ Ex Order 26.4b1] ;[NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1]. A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated [NJ Ex Order 26.4b1], reflected that Resident #76 had a Brief Interview for Mental Status (BIMS) score of [NJ Ex] out of 15, indicating [NJ Ex Order 26.4b1]. On 1/9/24 at 12:35 PM, the surveyor reviewed the resident's PO in the electronic medical chart which revealed in red print indicating, "Next Order Review: [NJ Ex Order 26.4] - [NJ Ex] days overdue." On 1/10/24 at 12:10 PM, the surveyor interviewed the [US FOIA (b)(6)] who worked in collaboration with the physician via a telephone call who stated that the PO must be reviewed and signed electronically every month. The [US FOI] further stated that she had not reviewed and signed Resident #76's PO. 2. On 1/4/24 at 11:27 AM, the surveyor observed Resident #51 seated in the wheelchair right outside their room. The resident was [NJ Ex Ord] and [NJ Ex Order 26.4b1].	F 711	Residents #76, #51, #27, and #47 had [NJ Ex] related to this practice. All residents have the potential to be affected. The DON printed monthly physicians' orders for all residents, to be signed in wet ink by physicians. Facility to implement Practitioner Engagement whereby physicians will sign monthly orders electronically. All nurses were educated with regards to physician's visits and signing of monthly orders. DON or designee will perform audits of 10% of the residents on each unit to ensure monthly physicians orders are signed. Audits will be conducted monthly x 3 months and quarterly x 3 quarters. Findings to be reported to the Administrator as well as QAPI quarterly x 3 quarters.	

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F 711	Continued From page 26	F 711		

The surveyor reviewed the AR for Resident #51. The resident was admitted to the facility with diagnoses that included but was not limited to NJ Ex Order 26.4b1; NJ Ex Order 26.4b1; NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

A review of the MDS, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1, reflected that Resident #51 had a BIMS score of NJ out of 15, indicating NJ Ex Order 26.4b1.

On 1/9/24 at 12:35 PM, the surveyor reviewed the resident's PO in the electronic medical chart which revealed in red print indicating, "Next Order Review: NJ Ex Order 26.4 - NJ Ex days overdue".

3. On 1/8/24 at 1:04 PM, the surveyor observed Resident #47 in the day room seated in their NJ Ex Order 26.4 wheelchair. The resident was NJ Ex Ord and NJ Ex Order 26.4b1.

The surveyor reviewed Resident #47's hybrid medical records. The AR reflected that Resident #47 was admitted to the facility with medical diagnoses which included but were not limited to NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

A review of the Significant Change in Status Assessment Minimum Data Set, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1 reflected that the resident had a BIMS score of NJ Ex out of 15 indicating that the resident had NJ Ex Order 26.4b1.

On 1/9/24 at 12:35 PM, the surveyor reviewed the

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F 711	Continued From page 27	F 711		

resident's PO in the electronic medical chart which revealed in red print indicating, "Next Order Review: [redacted] - [redacted] days overdue".

4. On 1/4/24 at 12:09 PM, the surveyor observed Resident #27 in bed with [redacted].

A review of the AR for Resident #27 reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted].

A review of the resident's MDS, an assessment tool used to facilitate the management of care dated [redacted], reflected that Resident #27 had a BIMS score of [redacted] out of 15, indicating [redacted].

On 1/9/24 at 12:35 PM, the surveyor reviewed the resident's PO in the electronic medical chart which revealed in red print indicating, "Next Order Review: [redacted] - [redacted] days overdue".

The surveyor reviewed the hybrid medical records (paper and electronic) for the residents listed above which revealed the resident's primary physician had not signed the Order Summary Reports (monthly physician's orders) located in the residents' chart. To clarify the documentation, there were no electronic or handwritten signatures under the PO.

On 1/10/24 at 1:30 PM, the surveyor interviewed the facility's [redacted] who stated that the physician must review and sign the PO electronically every month.

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F 711	Continued From page 28 On 1/10/24 at 2:15 PM, the surveyor discussed the above concern with the facility's Licensed [redacted]. The [redacted] stated that the physician's must electronically review and sign the PO monthly. There was no further information provided.	F 711		
F 712 SS=D	NJAC 8:39- 23.2 (b) Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to ensure that the responsible physician supervising the care of residents conducted face to face visits and wrote	F 712	It is the policy of CareOne at the Highlands for physicians to conduct face-to-face visits with residents, at least once every 30 days for the first 90 days	2/8/24

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F 712	Continued From page 29 progress notes at least once every sixty days. This deficient practice was identified for 1 of 26, Resident #76, reviewed for physician visits and was evidenced by the following: 1. On 1/4/24 at 11:27 AM, the surveyor observed Resident #76 in bed. When interviewed, Resident #76 was noted NJ Ex Orc and NJ Ex Order 26.4b1 The surveyor reviewed the Admission Record (one page summary of important information about a resident) for Resident #76. The resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 ; NJ Ex Order 26.4b1 ; NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 . A review of the Quarterly Minimum Data Set , an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1, reflected that Resident #76 had a Brief Interview for Mental Status score of NJ Ex out of 15, indicating NJ Ex Order 26.4b1 . A review of the Physician's progress notes reflected the following: NJ Ex Order 2 Physician progress notes completed by US FOIA (b)(6) NJ Ex Order 26.4 Physician progress notes completed by US FOIA (b NJ Ex Order 26.4 Physician progress notes completed by US FOIA (b NJ Ex Order 26.4 Physician progress notes completed by US FOIA (b NJ Ex Order 26.4b1 Physician progress notes completed by US FOIA (b NJ Ex Order 26.4b1 Physician progress notes completed by US FOIA (b NJ Ex Order 26.4b1 Physician progress notes completed by	F 712	after admission, and at least once every 60 days thereafter. Resident #76 was examined by the primary care physician with a progress note made. There were NJ Ex Order 26.4b1 to resident #76 with regards to this practice. All residents have the potential to be affected. The DON conducted an audit of 10% of long term residents to ensure the facility's practice was being followed. Nurses were educated on the practice for physicians to conduct face-to-face visits at least every 60 days. Medical Director to provide Physician re-education of the regulation to conduct face-to-face visits at least every 60 days. DON or designee will perform audits of 10% of the residents on each unit to ensure physicians are providing face-to-face visits at least every 60 days. Audits will be conducted monthly x 3 months and quarterly x 3 quarters. Findings to be reported to the Administrator as well as QAPI quarterly x 3 quarters.	

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F 712	Continued From page 30 US FOIA (b) There was no documented evidence that the physician visited and examined Resident #76 at least every [redacted] days. On 1/10/24 at 12:10 PM, the surveyor interviewed the [redacted] who worked in collaboration with the physician via a telephone call. The [redacted] informed the surveyor that the PO must be reviewed and signed electronically every month. The [redacted] further stated that she had not reviewed and signed Resident #76's PO. On 1/10/24 at 2:15 PM, the surveyor discussed the above concern with the facility' US FOIA (b)(6) [redacted] who both stated that the Physician failed to conduct a face-to-face visit at least every 60 days.	F 712		
F 755 SS=D	NJAC 8:39 - 23.2 (d) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		2/8/24

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F 755	Continued From page 31 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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 expired and discontinued medications were removed from active inventory after it had expired and/or had been discontinued by the physician in accordance with professional standards of clinical practice. This deficient practice was identified for 2 of 2 units inspected involving Resident #6, #28, #36, #49, #66, #90, #260, #263, #265, #266, #268, #269 and #270, This deficient practice was evidence by the following: 1. On 1/4/2024 at 11:47 AM, the surveyor inspected the [redacted] Unit Nursing Station. Inspection of the [redacted] Unit Nursing Station resulted in the absence of an Emergency Kit (designed to help nursing facilities provide	F 755	It is the policy of CareOne at the Highlands to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The expired medications, Humalog and mucomyst were immediately discarded in the appropriate manner. The expired Enteric Coated Aspirin bottles were removed and appropriately disposed of, from medications carts 1 and 3 on the West Unit. The Emergency Kit was immediately replaced on the West Wing Unit.	

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F 755	Continued From page 32 medication to their residents during emergency situations). The [redacted] Unit US FOIA (b)(6) and Licensed Practical Nurse (LPN1) on the unit could not locate or explain why there was no required Emergency Kit on the unit when interviewed. 2. On 1/4/2024 at 11:55 AM, the surveyor inspected the medication cart 3 (MC3) on the [redacted] Unit. The surveyor found an opened, actively used Humalog Kwik pen 100 units/ml delivered by the pharmacy on 11/21/23 and opened on 11/26/23. As per manufacturers recommendation, once opened the Humalog Kwik pen should be discarded after 28 days, 12/24/23. The surveyor inspected the [redacted] Unit refrigerator located in the medication room. The refrigerator thermometer read 28 degrees. A medication refrigerator should provide a stable temperature of between 36 and 46 degrees F. Within the refrigerator, the surveyor found an actively used and open bottle of Mucomyst/Acetylcysteine 20% Solution documented as opened on 12/21/23. The Mucomyst had a warning label from the pharmacy, "Warning Discard Opened container after 96 hours." The documentation on the bottle did not include an opening time, only a date which meant that the Mucomyst had to be discarded sometime on 12/25/23. 3. On 1/4/2024 at 12:07 PM, the surveyor noticed the [redacted] Unit LPN 2 on the unit holding a large plastic bag filled with medications. The surveyor approached LPN2 and asked about the large plastic bag filled with medication. At that point the	F 755	Resident #6 transferred to a new room. Medications were transferred to the new medication cart. Resident #28 was discharged from the facility. Medications were disposed of in the appropriate manner. Resident #36 was transferred to a new room. Medications were transferred to the new medication cart. Resident #49 was discharged from the facility. Medications were disposed of in the appropriate manner. Resident #66 was discharged from the facility. Medications were disposed of in the appropriate manner. Resident #90 was discharged. Medications were disposed of in the appropriate manner. Resident #260 was discharged. Medications were disposed of in the appropriate manner. Resident #263 was discharged. Mediations were disposed of in the appropriate manner. Resident #265 was discharged. Medications were disposed of in the appropriate manner. Resident #266 was discharged. Medications were disposed of in the	

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F 755	Continued From page 33 US FOIA (b)(6) responded by explaining that LPN2 was removing discontinued medications from the medication cart. The surveyor inspected the medications in the plastic bag in the presence of the (US FO and found: a. Medication for Resident #6 found in the plastic bag was NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 . Review of the facility medical records documented that Resident #6 was moved to NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1 and the medication was not moved but new medication was ordered from the pharmacy. b. Medication for Resident #28 found in the plastic bag was NJ Ex Order 26.4b1 . Review of the facility medical records documented that Resident #28 was discharged from the facility on NJ Ex Order 26.4b1. c. Medication for Resident #36 found in the plastic bag was NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , and NJ Ex Order 26.4b1 . Review of the facility medical records documented that Resident #36 was moved to another room on NJ Ex Order 26.4b1 and the medication was not moved but new medication was ordered from the pharmacy. d. Medication for Resident #49 found in the plastic bag was NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , and NJ Ex Order 26.4b1 .	F 755	appropriate manner. Resident #268 was discharged. Medications were disposed of in the appropriate manner. Resident #269 was transferred to another room. Medications were moved to the new medication cart. Resident #270 was transferred to a new room. Medications were moved to the new medication cart. Residents #6, #28, #36, #49, #66, #90, #260, #263, #265, #266, #268, #269, #270 had NJ Ex Order 26.4b1 related to this practice. All residents have the potential to be affected. The DON and Pharmacy Consultant performed an inspection of 100% of the medication carts to ensure no expired medications were present. The medication refrigerator had the temperature adjusted to maintain a temperature between 36- and 46-degrees F. Over-the-counter stock medication was reviewed by the DON to ensure no expired medications were stored. Education provided to the US FOIA (b)(6) to ensure rotation of over-the-counter medication / house stock. Nurse education provided on the storage	

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F 755	Continued From page 34 Review of the facility medical records documented that Resident #49 was discharged from the facility on [redacted]. e. Medication for Resident #66 found in the plastic bag was [redacted], and [redacted]. Review of the facility medical records documented that Resident #49 was discharged from the facility on [redacted]. f. Medication for Resident #90 found in the plastic bag was [redacted]. Review of the facility medical records documented that Resident #90 was discharged from the facility on [redacted]. g. Medication for Resident #260 found in the plastic bag was [redacted] and [redacted] (both [redacted]). Review of the facility medical records documented that Resident #260 was discharged from the facility on [redacted]. h. Medication for Resident #263 found in the plastic bag was [redacted]. Review of the facility medical records documented that Resident #263 was discharged from the facility on [redacted]. i. Medication for Resident #265 found in the plastic bag was [redacted]. Review of the facility medical records documented that Resident #265 was discharged from the facility on [redacted].	F 755	of biologicals including but not limited to the timely removal of expired medication, as well as medication of discharged residents. LPN#2 received education on the importance of prompt removal of expired medications as well as medications of discharged residents. RN#2 received education on the prompt identification and removal of expired medications. DON/pharmacy consultant or designee will perform audits of 100% of the medication carts monthly to ensure no expired medications are stored. Audits will be conducted monthly x 3 months and quarterly x 3 quarters. Findings to be reported to the Administrator as well as QAPI monthly on an on-going basis.	

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j. Medication for Resident #266 found in the plastic bag was NJ Ex Order 26.4b1 [redacted] tablets.
Review of the facility medical records documented that Resident #266 was discharged from the facility on NJ Ex Order 26.4 [redacted].

k. Medication for Resident #268 found in the plastic bag was NJ Ex Order 26.4b1 [redacted].
Review of the facility medical records documented that Resident #268 was discharged from the facility on NJ Ex Order 26.4b1 [redacted].

l. Medication for Resident #269 found in the plastic bag was NJ Ex Order 26.4b1 [redacted].
Review of the facility medical records documented that Resident #269 was moved to another room and the medication was not moved but new medication was ordered from the pharmacy.

m. Medication for Resident #270 found in the plastic bag was NJ Ex Order 26.4b1 [redacted].
Review of the facility medical records documented that Resident #270 was moved to another room and the medication was not moved but new medication was ordered from the pharmacy.

4. On 1/5/24 at 9:47 AM, the surveyor observed the NJ Exec Ord [redacted] Unit RN2 prepare medications for administration. The surveyor noticed a bottle of Aspirin Enteric Coated 81 mg which had an expiration date of 5/2023 located in Medication Cart 3.

The surveyor then inspected Cart 1 located on the NJ Exec Ord [redacted] Unit and found another bottle of Aspirin

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Enteric Coated 81 mg which had the expiration date crossed out with a black magic marker.

The surveyor interviewed the RN2 who could not explain why these expired medications were in Cart 1 and Cart 3.

Review of the monthly Consultant Pharmacist Unit Inspection Reports from June 7, 2023, to December 20, 2023, provided evidence that many medications were found expired or with discrepancies in labeling and removed from stock.

Review of the Medication Labeling and Storage Policy documents, "3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items." The policy adds, "Multi-dose that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial."

On 1/5/24 at 3:24 PM, the surveyor discussed the issues that related to expired and discontinued medications with the US FOIA (b)(6) and US FOIA (b)(6) who could not explain or provide any further information related to the discrepancies found. The US FOIA (b)(6) did explain that all medications should be removed from active use in the medication cart as soon as the medication is discontinued or the resident is discharged. She added that all expired medications should be removed from active use

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F 755	Continued From page 37 in the medication cart prior to their expiration date. NJAC 8:39-29.4(g)	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		2/8/24

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F 756	Continued From page 38 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the US FOIA (b)(6) [redacted]) failed to clarify medication dosage for a newly admitted resident to the facility during the initial medication review for 1 of 1 Residents, Resident #21. The deficient practice was evidenced by the following: On 1/4/24 at 11:16 AM, the surveyor interviewed Resident # 21 in the resident's room. The resident stated they had NJ Ex Order 26. which they took the medication NJ Ex Order 26.4b1 and they had been receiving the incorrect dose. Resident #21 explained that prior to admission to the facility they were receiving NJ Ex Order 26.4b1 of NJ Ex Order 26.4b1 and since admission to the facility had been receiving NJ Ex Order daily. The resident stated they noticed this about NJ Ex Order 26. ago. Resident #21 reported to a staff member and had not heard anything since that time. The surveyor reviewed Resident #21's paper and electronic medical records which revealed the following: A review of the resident's Admission Record (an admission summary) documented that the resident was admitted to the facility with diagnoses that included but were not limited to:	F 756	It is the policy of CareOne at the Highlands that the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. US FOIA (b)(6) reviewed medication and dose for resident #21. Dose clarified for NJ Ex Order 26.4b1 with provider. Resident #21 had NJ Ex Order 26.4b1 related to this practice. All residents have the potential to be affected. New admission orders will be faxed to the pharmacy consultant. These will include hospital orders. Pharmacy consultant will re-review all new admission orders with monthly visit. Nurse education on medication reconciliation for new admission orders. DON or designee will perform audits of 10% of new admission orders to ensure medication reconciliation has been completed. Audits will be conducted weekly x 3 weeks	

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F 756	Continued From page 39 NJ Ex Order 2, NJ Ex Order 26, and NJ Ex Order 26.4b1. A Quarterly Minimum Data Set (an assessment tool used for the management of care) dated NJ Ex Order 26.4b1, documented the resident had a Brief Interview for Mental Status (BIMS) and scored a NJ Ex out of 15, indicating that Resident #21 was NJ Ex Order 26.4b1. A review of the NJ Ex Order 26.4b1 Physician Orders (PO) included a PO dated NJ Ex Order 26.4b1 that read, "NJ Ex Order 26.4b1, Give 1 tablet by mouth one time a day for NJ Ex Order 26.". A review of the hospital records indicated the resident was receiving NJ Ex Order 26.4b1 during their hospital stay. An "After Visit Summary" a summary of Resident #21's hospital stay, included medication administered to the resident during the hospital stay and a discharge medication list. The After Visit summary documented that Resident #21 received "NJ Ex Order 26.4b1 tablet, dose: NJ Ex Order daily for NJ Ex Order 26.4b1". A review of the initial medication review for Resident #21 by the US FO read under Recommendations, "1. This [electronic CP] review is based on the information provided by the POS [Physician Order Summary], MAR [Medication administration Record]. Transfer Orders/ Medication discharge List not available at time of review." There was no documentation found of the NJ Ex Order 26.4b1 medication. On 1/5/24 at 1:00 PM, the US FOIA (b)(6) provided the surveyor with the CP Service Agreement and the facility policy titled, "Psychotropic Medication Use"	F 756	and monthly x 3 months. Findings to be reported to the Administrator as well as QAPI.	

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F 756	Continued From page 40	F 756		

with an edited date of 2/2/2023.

A review of the CP Service Agreement dated 12/11/08 read, " ...The Consultant shall be responsible for the guidance of the Facility's pharmaceutical care as follows: a. General supervision of the facility's procedures for the control and accountability for all medications and biologicals throughout the facility and that such medications and biologicals shall be approved and dispensed in compliance with federal and state laws and the facility's own policy and procedures." The agreement further documented, " ...The Facility shall be responsible for the following ...c. Assure complete access by the Consultant to any and all records and supplies necessary to perform pharmaceutical care."

A review of the "Psychotropic Medication Use" with an edited date of 2/2/2023 under the Policy Interpretation and Implementation read: "3. Residents, families and/or representative are involved in the medication management process ...Psychotropic medication management includes ...b. dose."

On 1/09/24 at 11:45 AM, the surveyor interviewed the [US FO] over the phone. The [US FO] stated that a remote pharmacist would review the medications sent by the facility for new admissions if the [US FO] is unable to come to the facility within 48 hours of admission. For new admissions, The [US FO] explained the remote pharmacist reviews the hospital discharge medication list with medication dosages to make sure the medication from the hospital match what is order in the facility. The [US FO] stated she would conduct on-site visits to review the resident's medications to ensure the

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physician orders and medications, including dosages, were correct. "I look at the hospital transfer forms which includes the medication list as well." The [US FO] further stated, "if a discrepancy with the medication dosage was found, it would be reported to the nursing supervisor."

The surveyor informed the [US FO] about the concerns found with Resident #21's [NJ Ex Order 26.4b1] medication dosage. The [US FO] stated she was not aware of the differing dosages and that the resident's discharge medication list was not available to the [US FOIA]. The [US FO] stated she only reviewed Resident #21's medications that were entered in the electronic medical record because the hospital discharge medication list was not available. The [US FO] further stated in [NJ Exec Order 26.4b1] of [NJ Exec Orde] "I saw the patient was evaluated by the [NJ Exec Order 26.4b1] and observed an ordered for [NJ Ex Order] [NJ Ex Order 26.4b1] and I did not question the order." The [US FO] in cases where the hospital medication list is not available, I just look at the medications entered by the [US FOIA] and nurse.

On 1/9/24 at 12:30PM, the surveyor made multiple attempts to interview the [US FOIA] and Licensed Nurse Practitioner (LPN #1) who entered Resident #21's medication from the hospital. Both were unable to be reached. Voicemail messages were left by the surveyor. The surveyor did not receive a call back from the [US FOIA] or [US FOIA (b)(6)].

On 1/11/24 at 10:53 AM, the surveyor met with the US FOIA (b)(6) and the [US FOIA (b)(6)]. The [US FOIA (b)(6)] acknowledged the resident's [NJ Ex Order 26.4b1] medication dosage was incorrect. The [US FOIA (b)(6)] stated the process upon admission, was for a resident's medication

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F 756	Continued From page 42 regimen to be reviewed with the resident and physician. The physician's orders for medication were to be entered into the electronic medical record. The PO summary and the hospital medication list were to be faxed to the US FO group to be reviewed. The US FOIA (b)(6) could not explain why the US FO did not receive the resident's hospital discharge medication record. There was no further information provided by the facility. NJAC 8:39- 29.3 (a)	F 756		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation	F 812	It is the policy of CareOne at the Highlands to procure food from sources approved or considered satisfactory by	2/8/24

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F 812	Continued From page 43 practices as well as discard potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 1/04/24 09:17 AM, the surveyor in the presence of the US FOIA (b)(6) observed the following during the kitchen tour: 1. On a storage shelf below Chef Preparation Table #3, the surveyor observed an opened one (1) gallon bottle of molasses with a label that read, "use by 12/10/23". 2. In the food preparation area, the surveyor observed dietary aide (DA) #1 with hair not fully restrained under their hairnet and DA #2 wore large, hooped earrings. The US FOIA stated, all dietary staff need to have their hair fully restrained under the hairnets and large hooped earrings were not allowed to be worn in the kitchen. The US FOI stated the bottle of molasses should have been discarded on 12/10/23. On 1/10/24 at 10:30 AM, the US FOIA provided the surveyor facility policies titled, "Food and Nutrition Services Department Employee Uniform Policy", with a revision date on 4/15/15 and "Food Receiving and Storage", with a revised date of July 2014. The "Food and Nutrition Services Department Employee Uniform Policy" revealed under the Process section, "2. Jewelry will be kept to a minimum of wedding bands a non-dangling earring. This is to prevent contamination of the food hazards to employees during food	F 812	federal, state or local authorities. The (1) gallon bottle of molasses was immediately discarded. DA#1 adjusted the hairnet to fully restrain her hair. DA#2 immediately removed the hoop earrings. No residents were negatively impacted by this practice. All residents have the potential to be affected. Food Service Director conducted inspection of all opened food items to ensure they are within expiration date. Dietary Aides received re-education on the Food and Nutrition Services Department Employee Uniform Policy. Food Service Director to monitor food in dry storage to ensure they are used or discarded by “use-by” date. Food Service Director/designee will perform audits of 100% of storage food items weekly to ensure they are within expiration date. Audits will be conducted weekly x 3 weeks, then monthly x 3 months. Findings to be reported to the Administrator as well as QAPI monthly on an on-going basis. The Administrator/designee will perform weekly checks in the Kitchen area to ensure staff are compliant with dressing.	

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F 812	Continued From page 44 preparation." The "Food Receiving and Storage" policy revealed under Dry Storage, "foods are labeled, dated, and monitored so they are used by their "use-by" date or discarded." On 1/11/24 at 10:53 AM, the survey team met with the[redacted] and [redacted] The [redacted] acknowledged dietary staff should not wear large, hooped earrings and hair should be completely covered by a hairnet. The [redacted] also acknowledged the expired molasses found should have been discarded based on the use by date. NJAC 8:39-17.2(g)	F 812	Audits will be conducted weekly * 3 weeks, then monthly x 3 months. Findings to be reported to QAPI monthly on an ongoing basis.	
F 836 SS=D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet	F 836		2/8/24

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F 836	Continued From page 45 the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Complaint #NJ00154940 Complaint #NJ00150195 Complaint #NJ00151010 Refer to deficiencies F658, F755 Based on observation, interview, record review, and review of facility provided documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	F 836	Nursing leadership met and continues to meet on an on-going basis to identify staffing challenges and areas of improvement and recruitment for certified nursing assistants necessary to maintain the required minimum direct care to ratio as required. No residents were negatively impacted by this practice. All residents have the potential to be affected. To ensure the problem of staffing does not recur: Potential candidates are interviewed for Hospitality Aide positions. Facility will place them in the 5-week Certified Nurse Aide program provided every 6 weeks by CareOne. Nursing agency usage as needed to assist in filling open positions.	

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F 836	Continued From page 46 nursing homes. The following ratio(s) were effective on 2/01/21: Nurse Staffing Reports were completed by the facility for 4 distinct periods of time equaling 8 weeks in total. The weeks of 09/12/2021 ending 09/25/2021; 12/19/2021 and ending 01/01/2022 and 5/14/23 ending 5/27/23 were reviewed due to complaints filed for low staffing during these 2 periods. A third period was reviewed for the 2 weeks of staffing prior to the standard recertification survey from 12/17/23 ending 12/30/23. Staffing had been calculated for the following time frames and revealed the following: 1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 09/12/2021 and ending 09/25/2021 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 8 of 14 day shifts and 2 of 14 evening shifts. The facility was deficient in CNA staffing for residents on 8 of 14 day shifts and 2 of 14 evening shifts as follows: -09/12/21 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs. -09/12/21 had 6 CNAs to 15 total staff on the evening shift, required at least 7 CNAs. -09/13/21 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/17/21 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs. -09/17/21 had 8 CNAs to 18 total staff on the	F 836	The facility is offering incentives for new hires, such as sign on bonuses and referral bonuses. Director of Nursing or designee and Administrator (or designee) will review staffing practices daily and document a weekly review of the daily staff x 4 weeks, then twice monthly x 3 months. Findings to be reported to QAPI.	

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evening shift, required at least 9 CNAs.
-09/18/21 had 9 CNAs for 94 residents on the day shift, required at least 12 CNAs.
-09/21/21 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-09/22/21 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-09/23/21 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.
-09/25/21 had 7 CNAs for 91 residents on the day shift, required at least 11 CNAs.

2. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 12/19/2021 and ending 01/01/2022 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 13 of 14 day shifts and 9 of 14 evening shifts.

The facility was deficient in CNA staffing for residents on 13 of 14 day shifts and 9 of 14 evening shifts as follows:

-12/19/21 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-12/20/21 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-12/20/21 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.
-12/22/21 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-12/23/21 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-12/23/21 had 7 CNAs to 18 total staff on the evening shift, required at least 8 CNAs.
-12/24/21 had 8 CNAs for 99 residents on the day

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shift, required at least 12 CNAs.
-12/25/21 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-12/25/21 had 7 CNAs to 17 total staff on the evening shift, required at least 8 CNAs.
-12/26/21 had 3 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-12/26/21 had 3 CNAs to 15 total staff on the evening shift, required at least 7 CNAs.
-12/27/21 had 1 CNA for 97 residents on the day shift, required at least 12 CNAs.
-12/27/21 had 5 CNAs to 14 total staff on the evening shift, required at least 7 CNAs.
-12/28/21 had 1 CNA for 97 residents on the day shift, required at least 12 CNAs.
-12/29/21 had 2 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-12/29/21 had 5 CNAs to 15 total staff on the evening shift, required at least 7 CNAs.
-12/30/21 had 1 CNA for 103 residents on the day shift, required at least 13 CNAs.
-12/30/21 had 5 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.
-12/31/21 had 1 CNA for 103 residents on the day shift, required at least 13 CNAs.
-12/31/21 had 6 CNAs to 17 total staff on the evening shift, required at least 8 CNAs.
-01/01/22 had 3 CNAs for 103 residents on the day shift, required at least 13 CNAs.
-01/01/22 had 4 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.

3. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 5/14/23 and ending 5/27/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 10 of 14 day shifts.

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The facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows:
-05/14/23 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -05/15/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs
-05/16/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -05/18/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-05/20/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-05/21/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-05/23/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-05/25/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-05/26/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.
-05/27/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs.

4. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 12/17/23 and ending 12/30/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 12 of 14 day shifts.
The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows:

-12/17/23 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-12/18/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.
-12/19/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.

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F 836	Continued From page 50 -12/20/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/21/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/22/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/23/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -12/24/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/25/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/26/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/28/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/29/23 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. On 1/11/23 at 11:24 AM , the surveyor discussed the lack of required staff with the US FOIA (b)(6) and US FOIA (b)(6) who did not provide any further information. NJAC 8:39-5.1(a) NJAC 8:39-27.1(a)	F 836		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		2/8/24

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to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 52 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for 1 of 22 residents reviewed (Resident #42). This deficient practice was evidenced by the following: On 1/5/24 at 11:02 AM, the surveyor observed Resident #42 in their room sitting in a reclining chair, watching television. The resident was NJ Ex Order 26 NJ Ex Orde and NJ Ex Order 26.4b1 . On 1/11/24 at 12:20 PM, the surveyor reviewed the hybrid (paper and electronic) medical records of Resident #42. According to the Admission Record (an	F 842	Physician's progress notes were obtained for resident #42 and placed in the resident's chart. There were NJ Ex Order 26.4b1 to the resident, related to this practice. All residents have the potential to be affected. An audit was conducted by the DON, on 10% of the charts on the East and West Wing to ensure physician's notes were included with the medical record. Physician outreach to re-educate providers on the importance of documenting in the electronic medical record (Emar), Point Click Care. DON or designee will audit 10% of resident records to ensure physician's	

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F 842	Continued From page 53 admission summary), Resident #42 had diagnoses that included but were not limited to: NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. A Quarterly Minimum Data Set (QMDS) assessment, a tool used to facilitate management of care, dated NJ Ex Order 26.4b1, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #42 scored NJ Ex out of 15, which indicated the resident had NJ Ex Order 26.4b1. A review of physician progress notes for Resident #42 found there were no physician progress notes documented by the resident's primary physician. The surveyor requested from the US FOIA (b)(6) to provide further information. On 1/12/24 at 12:39 PM, the US FOIA (b)(6), in presence of US FOIA (b)(6) stated they reached out to the resident's primary physician who was currently out of the country. The US FOIA (b)(6) stated the physician notes were in the physician's office and could not be faxed to the facility. The US FOIA (b)(6) and the US FOIA (b)(6) acknowledged that the physician's documentation for the resident should be documented and stored in the resident's hybrid medical record. There was no additional documentation provided. A review of the facility's undated policy titled "Physician Progress Notes", under Policy Interpretation and Implementation it read: "1. Physician progress notes are maintained for each	F 842	progress notes are included in the medical record. Audits to be completed weekly x 4 weeks, monthly x 4 months with results reported to the Administrator and QAPI.	

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F 842	Continued From page 54 resident residing in this facility ...3. The resident's Attending Physician must write, sign, and date the physician progress notes upon each visit ..." A review of the facility's undated policy titled "Physician Visits", under Policy Interpretation and Implementation read: " ...5. The Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation ..." N.J.A.C. 8:39-35.2(d)	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		2/8/24

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F 880	Continued From page 55 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 56 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, it was determined that the facility failed to maintain proper infection control practices which was identified during dining observation and was evidenced by the following: On 1/9/24 at 12:28 PM, the surveyor observed a US FOIA (b)(6)) in the NJ Exec Ord Wing dining room and was holding a clear plastic bag. In addition the surveyor observed the US FOIA (b) walking towards a resident who was eating their lunch. The US FOIA (b) was observed touching the resident's meal tray and the resident's utensils while holding the clear bag. The surveyor interviewed the US FOIA (b) who stated that the clear bag contained a dirty "bib" (food protector) for one of the residents who was also in the dining room. The US FOIA (b) then placed the clear plastic bag on top of the bedside table in the hallway, sanitized her hands using an alcohol-based hand rub gel, took the soiled plastic bag and went to the dirty utility room to discard the bag. On 1/9/24 at 1:48 PM, the US FOIA (b)(6) and the US FOIA (b)(6) were made aware of the surveyor's observation. They both agreed that the US FOIA (b) failed to adhere to infection control practices by holding a soiled bag while aiding a resident during lunch. NJAC 8:39-19.4 (a) (1) (2) (n)	F 880	It is the policy of CareOne at the Highlands that Infection control and prevention are sustained for the safety and wellbeing of all residents. US FOIA (b) was immediately educated on infection control procedures, including the handling of soiled linen and hand hygiene. Soiled plastic bag containing dirty food protector was discarded in the dirty utility room. No residents were negative impacted related to this practice. All residents have potential to be affected. US FOIA (b) was immediately educated on infection control procedures including the handling of soiled linen. The clear plastic bag containing the dirty food protector was deposited in the dirty utility room. Education to all CNAs with regards to infection control procedures when handling soiled linen/dirty items and hand hygiene. Infection Preventionist or designee will re-educate all CNAs on infection prevention including the handling of soiled linen/dirty items and hand hygiene.	

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 _____	C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE 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 880	Continued From page 57	F 880	Infection Preventionist or designee will conduct audits to ensure compliance weekly x 4 weeks, monthly x 4 months with results reported to the Administrator and QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061202	A. BUILDING: _____ B. WING _____	C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE 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) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing	S 560	Nursing leadership met and continues to meet on an on-going basis to identify staffing challenges and areas of improvement and recruitment for certified nursing assistants necessary to maintain the required minimum direct care to ration as required. No residents were negatively impacted by this practice All residents have the potential to be affected To ensure the problem of staffing does not recur: Potential candidates are interviewed for Hospitality Aide positions. Facility will	2/8/24

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

Electronically Signed | 02/02/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061202	A. BUILDING: _____ B. WING _____	C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE 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) COMPLETE DATE
S 560	Continued From page 1 requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to	S 560	place them in the 5-weeks Certified Nurse Aide program provided every 6 weeks by CareOne. Nursing agency usage as needed to assist in filling open positions. The facility is offering incentives for new hires, such as sign on bonuses and referral bonuses. DON or designee and Administrator (or designee) will review staffing practices daily and document a weekly review of the daily staff x 4 weeks, then twice monthly x 3 months. Findings will be provided to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061202	A. BUILDING: _____ B. WING _____	C 01/12/2024

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

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S 560	Continued From page 2 affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 12/17/23 and ending 12/30/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 12 of 14 day shifts. The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -12/17/23 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/18/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/19/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/20/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/21/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/22/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/23/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -12/24/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/25/23 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/26/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/28/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/29/23 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061202	A. BUILDING: _____ B. WING _____	C 01/12/2024

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

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S 560	Continued From page 3 On 1/11/23 at 11:24 AM , the surveyor discussed the lack of required staff with the Registered Nurse VP Special Clinical Projects and Acting Licensed Nursing Home Administrator who did not provide any further information.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315132 Y1	A. Building B. Wing Y2	4/21/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT THE HIGHLANDS	1350 INMAN AVENUE EDISON, NJ 08820

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0583	Correction	ID Prefix F0640	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed	Reg. # 483.20(f)(1)-(4)	Completed
LSC	02/08/2024	LSC	02/08/2024	LSC	02/08/2024
ID Prefix F0641	Correction	ID Prefix F0658	Correction	ID Prefix F0695	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed
LSC	02/08/2024	LSC	02/08/2024	LSC	02/08/2024
ID Prefix F0711	Correction	ID Prefix F0712	Correction	ID Prefix F0755	Correction
Reg. # 483.30(b)(1)-(3)	Completed	Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	02/08/2024	LSC	02/08/2024	LSC	02/08/2024
ID Prefix F0756	Correction	ID Prefix F0812	Correction	ID Prefix F0836	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70(a)-(c)	Completed
LSC	02/08/2024	LSC	02/08/2024	LSC	02/08/2024
ID Prefix F0842	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	02/08/2024	LSC	02/08/2024	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061202		4/21/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT THE HIGHLANDS	1350 INMAN AVENUE EDISON, NJ 08820

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/08/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315132	A. BUILDING **01** B. WING _____	**01/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE 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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/20/2021 Care One at the Highlands was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Care One at the Highlands is a single story Type V Un-Protected building that was built in November 1, 1971. The facility is divided into 6 smoke zones. The facility has a temporary 350 KW Diesel Emergency Generator that supplies power to about 75% of the building.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 01/08/2024, it was determined that the facility failed to provide 1 of 9 designated exit discharge (illuminated exit signs above door) doors with-in the means of egress readily accessible and free of all obstructions or	K 211	Means of Egress All residents have the potential to be affected. On 1/8/2024, the Regional Maintenance Director immediately permanently affixed	1/18/24

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

Electronically Signed | 02/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315132	A. BUILDING **01** B. WING _____	**01/12/2024**

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

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K 211	Continued From page 1 impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 01/08/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the[redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with nine (9) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:20 AM on 01/08/2024 in the presence of the facility's [redacted] a tour of the building was conducted. At approximately 9:23 AM, the surveyor observed the main entrance outer set of (external) automatic exit discharge doors revealed thumb turn lock on the egress side of the external set of automatic doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. A review of an emergency evacuation diagram posted in the corridor identify the Main entrance double doors are the primary doors to reach an exit discharge in the event of an emergency. The [redacted] confirmed the findings at the times of observations.	K 211	a metal plate to the locked stile to prevent turning of the thumb turn lock on the egress side of the external set of automatic doors. Evidence of correction (Photo) sent to Department of Health via email. The Regional Maintenance Director also provided in-service to the staff to ensure the thumb turn lock is not installed again. The Maintenance Director will perform audits of the egress to the external set of automatic doors 2X weekly for 2 weeks, and then weekly for 2 weeks to ensure full compliance. The results of the audit will be presented to the Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the need for further performance improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT THE HIGHLANDS	**1350 INMAN AVENUE** **EDISON, NJ 08820**

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K 211	Continued From page 2 The[US FOIA (b)(6)] was informed of the deficiency during the survey exit on 01/09/2024 at approximately 12:15 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 211		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 01/08/2024 and 01/09/2024, in the presence of facility management it was determined that the facility failed to ensure that all means of egress were provided with continuous lighting with two lamps for 3 of 9 exit discharge doors in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. This deficient practice was evidenced by the following: On 01/08/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the[US FOIA (b)(6)] o provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified	K 281	Illumination of means of Egress All residents have the potential to be affected. On 1/09/2024, the Regional Maintenance Director contacted vendors to assess the emergency lighting outside of the south exit discharge door of the west wing as well as the designated exit discharge door by the emergence generator. Evidence of correction (Photo) sent to Department of Health via email. On 2/7/2024, the two lights by the south exit wing were wired to remain illuminated at all times and the light fixture at the discharge door by the generator was added.	2/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315132	A. BUILDING **01** B. WING _____	**01/12/2024**

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

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K 281	Continued From page 3 the facility is a single-story (1) building with nine (9) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:20 AM on 01/08/2024 and continued on 01/09/2024 in the presence of the facility's US FOIA (b)(6) the surveyor inspected 9 designated exit discharge doors for continuous emergency lighting and observed the following, On 01/08/2024: 1) At approximately 10:24 AM, the surveyor observed no emergency lighting outside of the South side exit discharge door of the West Wing Solarium. 2) At approximately 10:26 AM, the surveyor observed outside the North side exit discharge door of the West Wing Solarium. 3) At approximately 10:53 AM, The surveyor observed outside of the designated exit discharge door by the Emergence Generator only a single bulb light fixture. There was no supplemental light to ensure area is illuminated should the single bulb or single bulb light fixture failed. The US FOIA (b)(6) confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 01/09/2024 at approximately 12:15 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281	The Maintenance Director will perform audits of the emergency lighting outside to ensure they are lit at all times 2X weekly for 2 weeks, and then weekly for 2 weeks to ensure full compliance. The results of the audit will be presented to the Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the need for further performance improvement.	
K 321 SS=E	Hazardous Areas - Enclosure	K 321		4/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAREONE 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
K 321	Continued From page 4 CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 1/08/2024 and 1/09/2024, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting	K 321	Hazardous areas enclosure (there was a 1/2" x 8" long gap on the bottom of the corridor's double doors when allowed to self-close)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315132	A. BUILDING **01** B. WING _____	**01/12/2024**

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

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K 321	Continued From page 5 partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 01/08/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with a basement. Starting at approximately 9:20 AM on 01/08/2024 and continued on 1/09/2024 in the presence of the facility's US FOIA (b)(6) a tour of the building was conducted. During the two (2) day building tour the surveyor observed the following hazardous area that failed to have smoke resisting doors, On 1/08/2024: 1) At approximately 10:50 AM, during an inspection of the commercial laundry room when the corridor double doors were opened to a 90 degree open and allowed to self-close into the frame the surveyor observed and recorded a 1/2" by 8" long gap between the on the bottom meeting edge. With this corridor doors not smoke resistant, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.	K 321	Medical Records/MDS door did not self-close All residents have the potential to be affected. On 1/9/2024, the Regional Maintenance Director installed a self-closing fixture on the door in the MDS and Medical Records office. Evidence of correction (Photo) sent to Department of Health via email. The Regional Maintenance Director contacted a vendor NJ Ex Order 26.4b1 [redacted]) and a work order was issued to replace the custom orders commercial fire doors. Custom doors was delivered and installed on April 4, 2024. Self-closing fixture installed 1/9/24. The Maintenance Director or designee will perform daily rounds of the commercial doors with 1/2" x 8" gap, to monitor for passage of hazardous fumes into the exit access corridor. The Director will monitor daily until the custom doors are replaced. The results of the rounds/audit will be presented to the Quality Assurance Committee monthly. The Quality Assurance Committee will determine the need for further performance improvement.	

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	315132	A. BUILDING **01** B. WING _____	**01/12/2024**

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CAREONE AT THE HIGHLANDS	**1350 INMAN AVENUE** **EDISON, NJ 08820**

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K 321	Continued From page 6 On 1/09/2024: 2) At approximately 10:58 AM, during an inspection of the MDS/ Medical Records room the surveyor observed the corridor door had no means to self-close. The surveyor observed in the Medical Records are two (2) 7 shelves rack filled with combustible paper medical records and two filing cabinets with medical records. The MDS/ Medical Records room was larger than 50 square feet and had multiple combustible cardboard boxes and other combustible products. With this corridor door not closing into its frame, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted on the corridor wall identified these two rooms are the primary and/ or secondary exit access to reach an exit. The US FOIA (b)(6) confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 01/09/2024 at approximately 12:15 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1.	K 347		2/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 347	Continued From page 7 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation review of facility provided documentation on 01/08/2024 and 01/09/2024 in the presence of facility management, it was determined that the facility failed to provide smoke detector in rooms that are open to the exit access corridor, in accordance with National Fire Protection Association (NFPA) 72. Reference: 19.3.6.1 Corridor Separation. Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5 (see also 19.2.5.4), unless otherwise permitted by one of the following: (1) Smoke compartments protected throughout by an approved supervised automatic sprinkler system in accordance with 19.3.5.8 shall be permitted to have spaces that are unlimited in size and open to the corridor, provided that all of the following criteria are met: (a)*The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected	K 347	Corridor separation and smoke detection. There was no smoke detector by the copy room (located next to the Admissions Department) and the east wing day room used by Physical Therapy. All residents have the potential to be affected. On 1/26/2024, the Regional Maintenance Director replaced the double doors to the copy room. Evidence of correction (Photo) sent to Department of Health via email. Rehabilitation equipment removed from the East wing day room. This room will no longer be used for Rehab. Evidence of correction (Photo) sent to Department of Health via email. The Maintenance Director or designee will perform daily rounds by the copy room (located next to the Admissions Department) and the East wing Day room to ensure facility compliance with these areas. The results of the rounds/audit will be presented to the Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the need for further performance improvement.	

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K 347	Continued From page 8 throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. (2) In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8, waiting areas shall be permitted to be open to the corridor, provided that all of the following criteria are met: (a) The aggregate waiting area in each smoke compartment does not exceed 600 ft2 (55.7 m2). (b) Each area is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or each area is arranged and located to allow direct supervision by the facility staff from a nursing station or similar space. (c) The area does not obstruct access to required exits. (3)*This requirement shall not apply to spaces for nurses' stations. (4) Gift shops not exceeding 500 ft2 (46.4 m2) shall be permitted to be open to the corridor or lobby, provided that one of the following criteria is met: (a) The building is protected throughout by an	K 347		

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K 347	Continued From page 9 approved automatic sprinkler system in accordance with Section 9.7. (b) The gift shop is protected throughout by an approved automatic sprinkler system in accordance with Section 9.7, and storage is separately protected. (5) Limited care facilities in smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 shall be permitted to have group meeting or multipurpose therapeutic spaces open to the corridor, provided that all of the following criteria are met: (a) The space is not a hazardous area. (b) The space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the space is arranged and located to allow direct supervision by the facility staff from the nurses' station or similar location. (c) The space does not obstruct access to required exits. (6) Cooking facilities in accordance with 19.3.2.5.3 shall be permitted to be open to the corridor. (7) Spaces, other than patient sleeping rooms, treatment rooms, and hazardous areas, shall be permitted to be open to the corridor and unlimited in area,	K 347		

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K 347	Continued From page 10 provided that all of the following criteria are met: (a) The space and the corridors onto which it opens, where located in the same smoke compartment, are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4. (b)*Each space is protected by automatic sprinklers, or the furnishings and furniture, in combination with all other combustibles within the area, are of such minimum quantity and arrangement that a fully developed fire is unlikely to occur. (c) The space does not obstruct access to required exits. (8)*Waiting areas shall be permitted to be open to the corridor, provided that all of the following criteria are met: (a) Each area does not exceed 600 ft2 (55.7 m2). (b) The area is equipped with an electrically supervised automatic smoke detection system in accordance with 19.3.4. (c) The area does not obstruct any access to required exits. (9) Group meeting or multipurpose therapeutic spaces, other than hazardous areas, that are under continuous supervision by facility staff shall be permitted to be open to the corridor, provided that all of the following criteria are met: (a) Each area does not exceed 1500 ft2 (139 m2). (b) Not more than one such space is permitted	K 347		

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K 347	Continued From page 11 per smoke compartment. (c) The area is equipped with an electrically supervised automatic smoke detection system in accordance with 19.3.4. (d) The area does not obstruct access to required exits. NFPA 72 -17.5.3 Detector Coverage, Where required by other governing laws, codes, or standards, and unless other-wise modified by 17.5.3.1.1 through 17.5.3.1.5, total coverage of a building or portion thereof, shall include all rooms, halls, storage areas, basements, attics, lofts,, spaces above suspended ceilings and other sub-divisions and accessible spaces. Findings include: On 01/08/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with a basement. Starting at approximately 9:20 AM on 01/08/2024 and continued on 01/09/2024 in the presence of the facility's US FOIA (b)(6) a tour of the building was conducted. During the two (2) building tour the surveyor observed that the facility failed to provide proper fire alarm and detection (smoke detectors) in the following locations,	K 347		

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K 347	Continued From page 12 On 01/09/2024: 1) At approximately 10:36 AM, the surveyor observed that the copy room (located next to the Admissions Department) had evidence that the double corridor doors had been removed. There was no evidence of a smoke detectors inside the room that was open to the corridor. 2) At approximately 11:06 AM, the surveyor observed that the East Wing Day room was utilized as a Physical Therapy room. The surveyor observed inside the room, one therapy mat, one NJ Ex Order 26.4b1 bicycle, leg weights, sock aid/ assist tools and other Physical Therapy equipment. The was no evidence of of a smoke detector in the room which was open to the corridor. The US FOIA (b)(6) confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 01/09/2024 at approximately 12:15 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 347		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection	K 351		2/10/24

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K 351	Continued From page 13 measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 01/08/2024 and 01/09/2024, in the presence of facility management it was determined that: The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 01/08/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with sixty-eight (68) Resident sleeping rooms, offices	K 351	Sprinkler system - Installation in resident rooms #139 and resident # 127 rooms. All residents have the potential to be affected. On 1/10/2024, the Regional Maintenance Director contacted NJ Ex Order 26.4b1, a vendor, and a work order was issued to install and fix fire sprinkler appliances. Work completed 02/07/2024. Evidence of correction (Photo) sent to Department of Health via email. The Maintenance Director or designee will perform daily rounds of rooms #139 and #127 until fire sprinkler appliance is installed. The results of the rounds/audit will be presented to the Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the need for further	

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K 351	Continued From page 14 and common areas. Starting at approximately 9:20 AM on 01/08/2024 and continued on 01/09/2024, in the presence of the US FOIA (b)(6) a tour of the building was conducted. During the two (2) day building tour the of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 01/08/2024: 1) At approximately 110:09 AM, an inspection inside Resident room #139 was performed. The surveyor observed 1 of 2 fire sprinklers escuheon caps was hanging and not tight to the ceiling. This left an approximately one (1) inch gap around the sprinkler in the wallboard ceiling. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 2) At approximately 10:35 PM, an inspection inside Resident room #127 was performed. The surveyor observed no evidence of fire sprinkler coverage for the 9'-4" by 5'- 4" area where the Resident bed was located. The surveyor observed the one (1) fire sprinkler in the room's vestibule area would not reach around the corner in the room to cover the bed area. The US FOIA (b)(6) confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 01/09/2024 at approximately 12:15 PM. Fire Safety Hazard.	K 351	performance improvement.	

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K 351	Continued From page 15 NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 01/08/2024 and 01/09/2024 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly visual examination inspection for 3 of 24 portable fire extinguishers observed and inspected, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any	K 355	Portable fire extinguishers. All residents have the potential to be affected. On 1/9/2024, the Regional Maintenance Director audited all fire extinguishers in the facility. Undated and unlabeled fire extinguishers were identified and set aside. NJ Ex Order 26.4b1, a vendor, was contacted to remove the (3) ABC fire extinguishers that had no evidence of a monthly visual examination performed. This was completed on 02/02/2024. US FOIA (b)(6) was educated on monthly fire extinguishers check. The Maintenance Director or designee will perform monthly fire extinguisher checks monthly and ongoing. The results of the rounds/audit will be presented to the Quality Assurance	2/10/24

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CAREONE AT THE HIGHLANDS	**1350 INMAN AVENUE** **EDISON, NJ 08820**

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K 355	Continued From page 16 conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following, On 01/08/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the[redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with a basement. Starting at approximately 9:20 AM on 01/08/2024 and continued on 01/09/2024 in the presence of the facility's [redacted] a tour of the facility was conducted. During the two (2) day tour of the facility the surveyor observed and inspected twenty-four (24) portable fire extinguishers that were annually inspected September 2023 in various locations with the following, On 01/08/2024: 1) At approximately 9:35 AM, the surveyor	K 355	Committee quarterly. The Quality Assurance Committee will determine the need for further performance improvement.	

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	315132	A. BUILDING **01** B. WING _____	**01/12/2024**

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CAREONE AT THE HIGHLANDS	**1350 INMAN AVENUE** **EDISON, NJ 08820**

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K 355	Continued From page 17 observed inside the basement Electrical room two (2) ABC-type fire extinguisher being stored on the floor. At this time the surveyor asked the US FOIA are these two (2) fire extinguishers spare fire extinguishers. The US FOIA told the surveyor, yes they are. Further inspection identified one (1) extinguisher had no evidence of an annual inspection tag attached to the extinguisher. The surveyor observed on the second fire extinguisher tag was last annually inspected September 2024 with no evidence of a monthly visual examination being performed and documented on the tag for October, November and December 2023. 2) At approximately 10:55 AM, the surveyor observed one (1) ABC-Type fire extinguisher next to the Emergency Generator's transfer switch was last annually inspected November 2023 with no evidence of a monthly visual examination being performed and documented on the tag attached to the extinguisher for December 2024. The US FOIA (b)(6) confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 01/09/2024 at approximately 12:15 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		3/29/24

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K 363	Continued From page 18 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 01/08/2024 and 01/09/2024, in the presence of facility management it was determined that the facility	K 363	Corridor - Doors. Resident sleeping room #127, door	

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K 363	Continued From page 19 failed to ensure that 6 of 32 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following, On 01/08/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked the US FOIA how many Resident sleeping rooms are in the facility. The US FOIA did not know the number Resident sleeping rooms. A review of the facility provided lay-out identified the facility is a single-story (1) building with sixty-nine (69) Resident sleeping rooms, offices and common areas. Starting at approximately 9:20 AM on 01/08/2024 and continued on 01/09/2024 in the presence of the facility's US FOIA (b)(6) an inspection of the building was conducted. During the two (2) day tour of the facility the surveyor performed closure tests of the thirty-two (32) doors in the corridors with the following results, On 01/08/2024: 1) At approximately 10:40 AM, during a closure test of Resident sleeping room #127, when the door was closed into its frame the door self-opened. This left an approximately 2 inch opening	K 363	self-opened, leaving approximately 2 inch opening between door and door frame. Resident dining room with "kick stand" door hold open device. Resident room #209 1-1/4 inch gap at the bottom edge of the door. Resident room #207 1-1/4 inch gap at the bottom edge of the door. Resident room #205 1-3/8 inch gap at the bottom edge of the door. Recreation office 1-1/4 inch gap at the bottom edge of the door. All residents have the potential to be affected. The Regional Maintenance Director contacted a vendor, and a work order was issued to replace doors with fire rated doors. Evidence of correction (Work order #/921007929-00) sent to Department of Health via email. Kick-stand door hold open device immediately removed from the dining room door on 01/08/2024. Sweeps were installed to each of the doors: resident rooms #127, #209, #207, #205, and the recreation office. The task was completed on 03/29/2024 The Maintenance Director or designee will perform daily rounds to the corridors, resident rooms #127, #209, #207, #205, dining room, and recreation office until fire rated doors are installed. The Administrator or Maintenance	

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K 363	Continued From page 20 between the door and the door frame. This test was repeated two (2) additional times with the same results. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 11:25 AM, the surveyor observed the Resident Dining room had a set of double corridor doors. One door was propped in the open position with a "Kick-Stand" door hold open device. When both doors were in the closed position, the surveyor observed and measured a 1-1/4 inch gap along both doors bottom edges. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. On 01/09/2024: 3) At approximately 10:48 AM, the surveyor observed and measure Resident room #209 corridor door in the closed position a 1-1/4 inch gap along the bottom edge of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 4) At approximately 10:49 AM, the surveyor observed and measure Resident room #207 corridor door in the closed position a 1-1/4 inch gap along the bottom edge of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 5) At approximately 10:50 AM, the surveyor observed and measure Resident room #205 corridor door in the closed position a 1-3/8 inch	K 363	Director or designee will perform weekly rounds on all doors; corridors, resident rooms, offices, and all the fire rated doors in the building to ensure installed doors remains functional and all the other doors remains functional. The results of the rounds/audits will be presented to the Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the need for further performance improvement.	

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K 363	Continued From page 21 gap along the bottom edge of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 6) At approximately 10:55 AM, the surveyor observed and measure Recreation Office corridor door in the closed position a 1-1/4 inch gap along the bottom edge of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The US FOIA (b)(6) confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 01/09/2024 at approximately 12:15 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.	K 761		5/10/24

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K 761	Continued From page 22 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/08/2023 and 01/09/2023, in the presence of facility management, it was determined that the facility failed: 1) To ensure that fire rated doors fully function properly, 2) To ensure that the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. The findings include the following, On 01/08/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor asked the US FOI to provide all mandatory inspections from January 1, 2022 through January 7, 2024 for review later. A review of the facility provided lay-out identified the facility is a single-story (1) building with six (6) sets of corridor double doors. Starting at approximately 9:20 AM on 01/08/2024 and continued on 01/09/2024 in the presence of the facility's US FOIA (b)(6) a tour of the building was conducted. During the two (2) day building tour the surveyor observed and performed closure test of six (6)	K 761	NFPA 101 Maintenance, Inspection, & Testing - Doors Rooms #132, #215, #230 and #236 doors bottom latching mechanism did not engage. West Wing Nursing Station both doors bottom latching mechanism did not engage. All residents have the potential to be affected. The Regional Maintenance Director and designee completed an audit on all doors, and doors identified with broken latching mechanism hardware were ordered replacements. Evidence of correction (Work order #24051) sent to Department of Health via email. This is a special order fire rated latching mechanism/panic bar. Estimated manufacture and delivery is approximately 4-6 weeks. The panic bars will immediately be installed upon delivery. Estimated date of completion 5/10/2024. The Maintenance Director or designee will perform weekly rounds X 4 weeks, and then quarterly and ongoing to all doors with latching mechanism to ensure proper working condition. The results of the rounds/audit will be	

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K 761	Continued From page 23 sets of corridor double doors with the following results, On 01/08/2024: 1) At approximately 10:03 AM, during a closure test of the corridor double doors next to Resident room #132 the surveyor observed that the both doors bottom latching mechanism did not engage. At this time the surveyor made a request to the [redacted] "Are these fire rated doors or smoke doors in the facility." The [redacted] told the surveyor that all the corridor double doors are fire rated doors. 2) At approximately 10:06 AM, during a closure test of the corridor double fire rated doors next to Resident room #135 the surveyor observed that the both doors bottom latching mechanism did not engage. 3) At approximately 10:25 AM, during a closure test of the corridor double fire rated doors next to the West Wing Nursing Station the surveyor observed that the both doors bottom latching mechanism did not engage. At approximately 11:50 AM, during the documentation review, the facility did not provide an annual inspection log for the fire rated doors. On 01/09/2024: 4) At approximately 10:50 AM, during a closure test of the corridor double fire rated doors next to Resident room #215 the surveyor observed that the both doors bottom latching mechanism did not engage. 5) At approximately 11:01 AM, during a closure	K 761	presented to the Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the need for further performance improvement.	

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K 761	Continued From page 24 test of the corridor double fire rated doors next to Resident room #230 the surveyor observed that the both doors bottom latching mechanism did not engage. 6) At approximately 11:08 AM, during a closure test of the corridor double fire rated doors next to Resident room #236 the surveyor observed that the both doors bottom latching mechanism did not engage. The US FOIA (b)(6) confirmed the two (2) day findings at the times of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 01/09/2024 at approximately 12:15 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 .	K 761		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918		9/6/24

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K 918	Continued From page 25 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 01/08/2024 and 01/09/2024 in the presence of facility management, it was determined the facility failed to, 1) Install a permanent Emergency Generator.\, 2) Provide electrical wiring in accordance with National Electrical Code 70 (NEC-70). Reference: NFPA 110, 2010 Edition Section 4.4.3 4.4* Level. This standard recognizes two levels of equipment installation, performance, and maintenance. 4.4.1* Level 1 systems shall be installed where failure of the equipment to perform could result in loss of human life or serious injuries.	K 918	Electrical systems - Essential Electric system maintenance and testing. Facility Emergency Generator mounted on a mobile stand with temporary electrical cables. All residents have the potential to be affected. The Regional Maintenance Director and designee contacted a vendor and secured a work order to replace temporary mount with a permanent structure. Requesting time limited waiver as the anticipated work order completion is 09/06/2024. The anticipated time of	

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K 918	Continued From page 26 4.4.2* Level 2 systems shall be installed where failure of the EPSS to perform is less critical to human life and safety. 4.4.3 All equipment shall be permanently installed. 7.4 Mounting. 7.4.1 Rotating energy converters shall be installed on solid foundations to prohibit sagging of fuel, exhaust, or lubricating oil piping and damage to parts resulting in leakage at joints. 7.4.1.1 Such foundations or structural bases shall raise the engine at least 150 mm (6 in.) above the floor or grade level and be of sufficient elevation to facilitate lubricating-oil drainage and ease of maintenance. 7.4.2 Foundations shall be of the size (mass) and type recommended by the energy converter manufacturer. 7.4.3 Where required to prevent transmission of vibration during operation, the foundation shall be isolated from the surrounding floor or other foundations, or both, in accordance with the manufacturer's recommendations and accepted structural engineering practices. Findings include: On 01/08/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a	K 918	completion is due to approval process and permits. The Maintenance Director or designee will perform weekday visual check on the emergency generator to ensure mobile structure remains firm. The results of the rounding will be presented to the Administrator weekday and Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the need for further performance improvement.	

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K 918	Continued From page 27 request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also requested, "Does the facility have an Emergency Generator, How many Kilo Watt (KW) and what type of fuel does it use." The MD told the surveyor, yes we have a 350 KW Diesel Emergency Generator that supplies power to about 75% of the building. Starting at approximately 9:20 AM on 01/08/2024 in the presence of the facility's US FOIA (b)(6) a tour of the building was conducted. At approximately 10:53 AM, an inspection outside of the building, where the 350 KW Emergency Generator was located was performed. The surveyor observed that the Emergency Generator was mounted on a mobil stand with the temporary electrical cables running up a wood wall and then into the building. Further inspection inside the building, the surveyor observed that the electrical cables were not protected in metal conduit and was installed through the ceiling steel Z-Bar truss system. The surveyor asked the US FOIA (b)(6), how long has the temporary generator been here. The US FOIA (b) told the surveyor it's been here for about one year. At this time the surveyor made a request to the US FOIA (b)(6) to provide a copy of the local permit for the temporary generator. The US FOIA (b) told the surveyor had would have to find out about a permit for the generator. On 01/09/2024 (day two of survey) at	K 918		

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K 918	Continued From page 28 approximately 10:31 AM, The US FOIA (b) told the surveyor that he could not provide a copy of a permit for the Emergency Generator. The US FOIA (b)(6) confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 01/09/2024 at approximately 12:15 PM. National Fire Protection Association (NFPA) 99, NFPA 110. NJAC 8:39 -31.2 (c).	K 918		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K 920		1/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315132	A. BUILDING **01** B. WING _____	**01/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE 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
K 920	Continued From page 29 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation on 01/08/2024, in the presence of facility management, it was determined that the facility failed to prohibit the use of extension cords and power cords, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard and was identified in one (1) of six (6) areas observed and was evidenced by the following: On 01/08/2024: 1). At approximately 10:42 AM, during the building tour in the presence of the facility US FOIA (b)(6)). the surveyor observed inside the Nursing Office that the facility had a refrigerator that was plugged into a white multi-outlet power strip. The power strip was then plugged into a non-GFCI duplex wall outlet. The NJ Exec Order 26.4b1 confirmed the finding at the time of observation. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 01/09/2024 at approximately 12:15 PM. NJAC 8:39-31.2(e)	K 920	Electrical Equipment - Power Cords and Extension cords. Refrigerator in the nursing office was plugged into a multi-outlet power strip. All residents have the potential to be affected. On 1/8/2024, the Regional Maintenance Director immediately unplugged the refrigerator from a multi-outlet power strip and plugged it into a wall electrical outlet. Evidence of correction (Photo) sent to Department of Health via email. Staff were educated not to utilize multi-outlet strips for powering appliances. The Maintenance Director or designee will perform weekly office rounds X 4 weeks, and then monthly X 2 months and then quarterly to ensure staff compliance. The results of the rounds/audit will be presented to the Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the need for further performance improvement.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315132 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/17/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT THE HIGHLANDS	1350 INMAN AVENUE EDISON, NJ 08820

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0211	01/18/2024	LSC	K0281	02/10/2024	LSC	K0321	04/04/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0347	02/10/2024	LSC	K0351	02/10/2024	LSC	K0355	02/10/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0363	03/29/2024	LSC	K0761	04/04/2024	LSC	K0918	04/04/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0920	01/18/2024	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO