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 08/12/2024

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 000	INITIAL COMMENTS Complaint # NJ00174172 Census: 108 Sample Size: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		9/23/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/24/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 609	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint # NJ 00174172 Based on interview, medical records (MR) review, and review of pertinent facility documents on 8/8/24 and 8/12/24, it was determined that the facility failed to report an NJ Ex Order 26.4(b)(1) to the New Jersey Department of Health (NJDOH) and follow their facility policy on "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" for 2 of 5 sampled residents (Resident #2 and Resident #4) reviewed for investigation and reporting. This deficient practice was evidenced by the following: 1. According to the "Admission Record (AR)," Resident #2 was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) The Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1), revealed Resident #2 had a Brief Interview for Mental Status (BIMS) of NJ /15 which indicated the resident's NJ Exec Order 26.4 was NJ Ex Order 26.4(b)(1). Review of the Care Plan (CP), initiated on NJ Ex Order 26.4(b)(1) and revised on NJ Ex Order 26.4(b)(, indicated that Resident #2 had NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) The CP noted that the Resident had	F 609	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 2 is no longer in the facility. 2. How the facility will identify other residents having the potential to be affected by same deficient practice . All resident have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The facility DON and ADON conducted an audit of the last three months (June, July and August) of incident reports in the facility and identified no additional unreported occurrences. On 8/13/2024, The Administrator met with the leadership/ department head team and discussed the importance of investigating and reporting injuries of unknown original to the authorities such as New Jersey Department of Health and LTC Ombudsman.	

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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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F 609	Continued From page 2	F 609		

NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1). The CP further indicated the following, "On NJ Ex Order 26.4(b)(1): Resident NJ Ex Order 26.4(b)(1) noted with NJ Ex Order 26.4(b) .. NJ Ex Order 26.4 ..." Initiated on NJ Ex Order 26.4(b)(1) and revised and canceled on NJ Ex Order 26.4(b)(1) (which is dated after the discharge of the Resident from the facility).

On NJ Ex Order 26.4 at 10:00 a.m., the Incident Report (IR) completed by a Licensed Practical Nurse (LPN #1) revealed that the assigned CNA (unidentified) observed NJ Ex Order 26.4(b)(during morning care to the Resident's NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1). The IR did not indicate that the Resident was able to explain how it happened and that the Resident was NJ Ex Order 26.4(b)(

LPN #1 documented on the progress note (PN) dated NJ Ex Order 26.4(b)(1) at 4:07 p.m., which confirmed the aforementioned incident.

On 3/10/24 at 12:41 p.m., the IR completed by RN #1 indicated that Resident #2 was observed to have NJ Ex Order 26.4(b)(1) on her/his NJ Ex Order 26.4(b)(1). The IR indicated that the Resident #2 was NJ Ex Order 26.4b1 description.

On 3/22/24 at 6:10 a.m., the IR completed by LPN #2 indicated that the assigned unidentified CNA reported that during care, Resident #2 was observed to have a NJ Ex Order 26.4(on her/his NJ Ex Order 26.4(b The IR indicated that the Resident NJ Ex Order 26.4b1 description and she/he was NJ Ex Order 26.4(b)(

The PN dated 3/22/2024 at 4:27 p.m., documented by LPN #4, revealed that the CNA #1 reported that the resident had NJ Ex Order 26.4(b)(1) on her/his NJ Ex Order 26.4(b)(1) The PN indicated that the

The ADON also provided education to all nursing staff on the importance of adhering to the to the facility's policy on accident and incident completion, notification of injuries to the Administrator and reporting to authorities.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change.

The Director of Nursing or designee will review and audit the accident and incident reports daily for one month, then 2X a week for two months and then quartely.

The Director of Nursing will present the results of the audit to the Quality Assurance Committee for review and 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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F 609	Continued From page 3 Resident had NJ Ex Order 26.4(b)(1) and NJ Ex Ord could cause the NJ Ex Order 26.4(b)(. The facility was unable to provide a document to verify that the aforementioned NJ Ex Order 26.4(b)(1) was reported to the NJDOH which was not according to the facility policy. During an interview with CNA#1 on 8/8/2024 at 1:30 p.m., she stated that one morning before providing care (unable to recall date and time), she observed Resident #2's NJ Ex O (unable to recall the exact location) was NJ Ex Order 26.4(b)(1) and she reported to the nurse who was not aware of what happened. because the Resident did not have NJ Ex O prior to that day. 2. According to the AR, Resident #4 was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26., and NJ Ex Order 26.4(b)(1) The Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) of NJ/15 which indicated the resident's cognition was NJ Ex Order 26.4(b)(1). In addition, NJ Ex O Activities of Daily Living (ADL) revealed that NJ Ex O was NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1). Review of the IR titled "NJ Ex Order 26.4(b)(1)," dated NJ Ex Order 26.4 at 7:21 a.m., completed by LPN #3, indicated that the unidentified CNA reported that Resident #4 had an NJ Ex Order 26.4 to the NJ Ex Order 26.4(b)(1). Resident #4 was NJ Ex Order 26.4b1 description and it was not witnessed.	F 609		

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F 609	Continued From page 4 Review of the facility policy "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating," dated 2001, under "Policy Statement...All reports of resident abuse (including injuries of unknown origin)...are reported to local, state and federal agencies (as required by current regulations)...Policy Interpretation and Implementation... Reporting Allegations to the Administrator and Authorities...1. If resident...injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman...d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials...3. 'immediately' is defined as: a. within two hours of an allegation involving abuse..." NJAC 8:39-94.1 (f) NJAC 8:39-27.1 (a)	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		9/23/24

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F 657	Continued From page 5 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: C# NJ00174172 Based on interviews, and record review, as well as review of pertinent facility documents on 8/8/2024 and 8/12/2024, it was determined that the facility failed to ensure that the residents' care plan (CP) was revised for 2 of 5 (Resident #2 and Resident #4) reviewed for CP revision. This deficiency is evidenced by the following: 1. According to the "ADMISSION RECORD" (AR), Resident #2 was admitted with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). The Minimum Date Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1), indicated that the Resident	F 657	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 4 diagnosis, orders and care plan were reviewed and updated to reflect NJ Exec Order 26.4b1. 2. How the facility will identify other residents having the potential to be affected by the same deficient pratice. All residents have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.	

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

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F 657

Continued From page 6

had a Brief Interview for Mental Status (BIMS) of NJ /15 which indicated the Resident's NJ Exec Order 26.4 was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) during NJ Ex Order 26.4(b)(1)).

The CP initiated on NJ Ex Order 26.4(b)(1) and revised on NJ Ex Order 26.4(b)(1) indicated that Resident #2 had NJ Ex Order , on NJ Ex Order 26.4(at about 1:00 p.m. the Resident NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4 , on NJ Ex Order 26.4(b)(1) Resident's had NJ Ex Order 26.4(b to her/his NJ Ex Order 26.4(b)(1), and on NJ Ex Order 26.4(b)(1) . The CP initiated on NJ Ex Order 26.4(b)(1) and revised on NJ Ex Order 26.4(b)(1) revealed that Resident #2 was at risk for NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) in room and on the unit, NJ Ex Order 26.4(b)(1) use of NJ Ex Order 26.4(b)(1) medication.

The Surveyors review of the Resident's incident reports (IR) revealed the following:

- On 1/14/24 at 1:19 p.m., the IR completed by Registered Nurse (RN #1), revealed that during care, Resident #2 was observed by the assigned unidentified Certified Nursing Assistant (UCNA#1) that Resident #2 had a NJ Ex Order 26.4(b on her/his NJ Ex Order The UCNA reported to the assigned Registered Nurse (RN #1).

- On 1/15/2024 at 10:00 a.m., the IR completed by Licensed Practical Nurse (LPN #1), indicated that she was alerted by UCNA #2 that Resident #2 had NJ Ex Order 26.4(b)(1) and NJ Ex Ord

- On 3/10/2024 at 12:41 p.m., the IR completed by RN #1, Resident #2's NJ Ex Order 26.4(b)(1) was observed to have NJ Ex Order 26.4(b)

F 657

The DON conducted an audit on the comprehensive care plan of residents with new wounds and residents with significant change in skin conditon.

On 8/13/2024, the DON and AON provided education in the nursing staff on the facility's comprehensive, person-centered care plan policy.

Nursing staff were also educated on the importance of updating resident's plan of care after any accident or incident report was completed.

The IDCT (interdisciplinary care team) will meet, review and revise as needed resident's care plans once a week to ensure care plans reflect interventions aligned to resident's needs.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change.

The Director of Nursing or designee will conduct an audit of 5 resident's comprehensive care plans with change in condition once a week for one month, then bi-weekly for two months and then quartely.

The Director of Nursing will present the results of the audit to the Quality

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F 657	Continued From page 7 - On 3/22/2024 at 6:10 a.m., the IR completed by LPN #2, indicated that she was notified by UCNA #3 that the Resident's NJ Ex Order 26.4 had NJ Ex Order 26.4(b). Resident #2's CP did not reflect that a new invention was added for the aforementioned IR to prevent reoccur of the aforementioned incidents. During the telephone interview with the Surveyors on 08/12/2024 at 11:58 a.m., RN #1 stated that when IR is completed, the CP had to be updated at the time of the incident. The RN further explained that the CP had to be revised to prevent the aforementioned incidents. The US FOIA stated that the CP was not revised on the aforementioned IRs on NJ Ex Order 26.4 and NJ Ex Order 26.4. He explained that "he forgot" and "it was an oversight." 2. According to the AR, Resident #4 was admitted with diagnoses which included but not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The MDS, dated 6/2/2024, revealed Resident #4 had a BIMS of NJ/15 which indicated the Resident's NJ Exec Order 26.4b was NJ Ex Order 26.4(b)(1) and he/she NJ Ex Order 26.4(b)(1). The CP initiated on NJ Ex Order 26.4(b)(1) and revised on NJ Ex Order 26.4(b indicated that Resident #4 had "NJ Ex Order 26. related to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(." The Surveyors review the Resident's IR revealed the following: - On NJ Ex Order 26.4(b)(1) at 7:21 a.m., the IR completed by LPN #3, revealed the UCNA #4 reported that the Resident an NJ Ex Order 26.4(to the Resident's NJ Ex Ord	F 657	Assurance Committee for review and 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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F 657	Continued From page 8	F 657		

NJ Ex Or of the NJ Ex Order 26.4(b)(1).

The CP and corresponding interventions were not revised after this incident.

During the interview with the Surveyors on 8/12/2024 at 3:31 p.m., the U.S. FOIA (b) (6) stated that the CP had to be updated right away when there was NJ Exec Order 26.4b1.

During an interview with the Surveyors on 08/08/2024 at 4:30 p.m., the U.S. FOIA (b) (6)) stated that the CP should be updated by the UMs at the time of the incident. However, she was not able to explain why the CP was not updated.

The policy titled "Care Plans, Comprehensive Person-Centered," dated 4/25/2022, under "Policy Interpretation and Implementation...13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition...b. When the desire d outcome is not met..."

NJAC 8:39-11.2(2)

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315132	A. Building B. Wing	9/30/2024

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 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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 09/23/2024	ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 09/23/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO