STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315119	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arnold Walter Nursing & Rehabilitation Center	622 S Laurel Avenue Hazlet, NJ 07730

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315119	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arnold Walter Nursing & Rehabilitation Center	622 S Laurel Avenue Hazlet, NJ 07730

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews, record review, and review of other pertinent facility documents, it was determined that the facility failed to: ensure a physician's order to administer medication was followed for one of two residents reviewed, Resident # 2. Resident #2 did not received their Liothyronine medication (medication used to treat hypothyroidism) insufficient thyroid hormone. The 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. 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.According to the intake forwarding to the New Jersey Department of Health (NJDOH) on 2/13/25, the complainant reported that they left the faciity on 2/5/25 AMA (Against Medical Advice), because they did not receive their Liothyronine as ordered by the physician. 1. On 10/30/25 at 10:30 AM, the surveyor reviewed the closed medical record for Resident #2. The admission Face Sheet) admission summary) reflected that Resident #2 was admitted to the facility with diagnoses which included but were not limited to, Acute and chronic respiratory failure with hypoxia, unspecified congestive heart failure and hypothyroidism.The Physician Order Activity Detail Report (POADR) dated 1/27/25 timed 8:22 PM, reflected an order to administer Liothyronine 25 micrograms (mcg) 1 tablet orally four times a day for hypothyroidism. Schedule: Every Day at 10:00 AM, 3:00 PM, 5:00 AM, and 8:00 PM. A review of a Progress Note (PN) dated 1/28/25 timed 3:04 PM, written by the nurse, reflected that Resident #2 was awake, alert and oriented to time, place and person and was able to make their needs known. Another (PN) dated 1/29/25 timed 3:09 PM, written by the Social Worker revealed that Resident #2 was able to make their requests known Further review of the electronic PNs revealed a note written on 1/29/25 timed 6:34 PM, by the nurse which revealed the following: Spoke with wife regarding Liothyronine medication. Explained to wife there was no communication that family will be providing this medication. Medication issue cleared up; family will be providing medication for now on. Resident received medication. On 10/30/25 at 10:44 AM, the surveyor interviewed the Licensed Practical Nurse (LPN /UM) regarding the process to obtain medications for new admission. The UM stated: The Unit Manager (UM) will review and enter the order into the computer. The Pharmacy will verify the order and sent the medication to the facility. If the medication was not available, the physician would be contacted, and the physician would usually write an order for a substitute. The UM stated she started in July and could not comment on the above concerns regarding Resident #2.On 10/30/25 at 11:32 AM, the surveyor interviewed the Director of Nursing (DON) regarding the process of administering medications to residents. The DON stated that there would be a physician's order for medication administration and the order will be transcribed on the Medication Administration Record (MAR). The nurse would administer the medication and if the medication was not administered, the computer would prompt the nurse to add a comment. The surveyor then reviewed the medication administration record with the DON which showed that Resident #2 did not receive Liothyronine on 1/28/25 at 4:00 PM, 1/28/25 at 8:00 PM, 1/29/25 at 5:00 AM. Comment: Awaiting pharmacy delivery. There was no documentation that the physician was informed of the omission. On 2/1/25 and 2/2/25 Resident #2 did not receive Liothyronine as ordered at 8:00 PM, and there was no comment regarding the omission. The surveyor then asked the DON if Resident #2 should have received the Liothyronine as ordered, the DON stated that there should be a rationale added if the medication was not administered. The surveyor then asked the DON what her expectations regarding medications administration/ omission of medication was. The DON stated the physician, and the Unit manager were to be notified, the staff should have followed up with the pharmacy for a stat delivery or an alternative.A review of the facility provided policy titled, Policies, Procedures and Information last revised 12/27/24 included the following: POLICYIt is the policy of this facility to ensure that Medication Administration and Documentation occurs in a timely and