

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Arnold Walter Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to follow professional standards of practice and physician orders to ensure resident's receiving enteral feeding received appropriate care and services to prevent complications of enteral feeding. This deficient practice was identified for 3 of 3 residents (Residents #2, #8 and #75), reviewed for tube feeding. This deficient practice was evidenced by the following: 1. On 6/9/26 at 10:17AM, the surveyor observed Resident #2 lying in bed with a tube feeding (a medical device that delivers nutrition, fluids, and medications directly into the digestive system when a person cannot eat or swallow safely) in place and the pump turned off. The tube feed bottle was labeled Glucerna 1.5 and was dated for 6/7/26 at 9 AM. There was a breakfast tray on the bedside table against the wall that appeared untouched. On 6/9/26 at 11:57 AM, the surveyor observed a new bottle of Glucerna 1.5 dated 6/9/26 at 10:30 AM running at 50mL/hr (milliliters per hour). Resident #2 was in bed with their eyes closed. On 6/10/26 at 1:14 PM, the surveyor observed Glucerna 1.5 tube feed running at 50mL/hr with 220mL intake recorded on the pump. The tube feed bottle was dated 6/10/26 at 6 AM. The surveyor reviewed the electronic medical record (EMR) for Resident #2. A review of the admission Record (AR-an admission summary) reflected diagnoses that included but were not limited to; Type 2 diabetes mellitus (a chronic condition characterized by insulin resistance and high blood sugar levels) without complications, dysphagia (difficulty swallowing), oropharyngeal phase, and adult failure to thrive (a multifactorial syndrome in older adults characterized by unintentional weight loss, decreased appetite, functional decline, and social withdrawal). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 5/28/26, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderately impaired cognition. The MDS also revealed section I malnutrition, and section K swallowing disorder, feeding tube, and mechanically altered diet (designed to be easy to chew and swallow, often used for individuals with dysphagia). A review of the individualized comprehensive care plan (ICCP) included a focus area dated 2/25/26 of the resident requires tube feeding/PEG tube (a feeding tube inserted directly into the stomach to (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
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide nutrition when oral intake is insufficient or unsafe) in place. A focus area of at risk for malnutrition related to mechanically altered diet, history of poor oral intake .with intervention Monitor tube feed tolerance. A review of the Order Summary Report (OSR) revealed physician's orders (PO) for: A PO dated 5/19/26, Enteral Feed Order one time a day for nutrition Glucerna 1.5 @ 50ml/hour x24 hours (total volume 1200ml) via Gtube at 6 PM. A PO dated 6/4/26, 72-hour calorie count-document % consumed on tray ticket in yellow envelope (including snacks) three times a day for 3 days. A PO dated 6/8/26, Document food % consumed on the tray ticket in yellow envelope with meals for poor intake. A review of the Medication Admin Audit Report for June 1-10, 2026, revealed the enteral feed order Glucerna 1.5 @ 50ml/hr x 24 hours was signed by a nurse on 6/7/26 at 5:05 PM, indicating the tube feed was hung at this time. On 6/8/26 the order was signed by a nurse at 5:05 PM. On 6/9/26 at 12:12 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1), Resident #2's assigned nurse, who stated, I stopped the tube feed this morning, it was giving me issues. I started a new one. LPN#1 also stated Resident #2 will refuse at least one meal tray per day and staff would hold the tray for later. He stated the resident does have pleasure feeds (a type of feeding that focuses on comfort and quality of life rather than on providing full nutritional support) and snacks. On 6/11/26 at 9:44 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager #1 (LPN/UM#1), who stated the Glucerna 1.5 tube feed was hung every day at 6 PM. The amount of tube feed intake was reviewed in the presence of the surveyor with 50ml/hr x 24 hours being a total volume of 1200ml in 24 hours and the Glucerna 1.5 bottle being a 1000mL bottle. LPN/UM#1 stated, It should be continuous. I definitely think it is hung at 6 PM. LPN/UM#1 confirmed with the surveyor there was an order to document the amount of food consumed on each meal tray, but no order to document the amount of tube feed consumed in a shift. On 6/12/26 at 10:28 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed the amount of tube feed in a Glucerna 1.5 bottle was 1000mL. The DON further stated the nurse would hang a new bottle to run the other 200mL when the 1000mL bottle was empty, and this should be signed and documented when it was hung. A review of the facility provided Tube Feedings policy, last reviewed 1/20/26, revealed Policy: Tube feeding will be given as per physician's order via gastrostomy tube utilizing the enteral pump. Unless otherwise specified by the physician, it is the policy of this facility to begin all feedings at approximately 4pm on the evening shift and run as ordered until dose completed. Equipment: .Bags are changed every 24 hours on the evening shift. 2. On 6/10/26 at 8:22 AM, the surveyor observed Resident #8 eating breakfast in their bed. The (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain infection control practices implemented to prevent the spread of infection in accordance with accepted national standards, Centers for Disease Control (CDC) guidelines by ensuring a.) proper sanitizing of point of care equipment, (blood pressure machine) between residents during the medication administration observation for one (1) of two (2) nurses observed while administering medications, b.) performing appropriate hand washing technique during the medication administration observation for one (1) of two (2) nurses observed while administering medications, c.) appropriate handling of medications during the medication administration observation for one (1) of two (2) nurses observed while administering medications to one (1) resident, d.) posting appropriate signage for contact isolation precautions (used to help stop the spread of germs from one person to another by alerting staff to utilize PPE when entering the resident's room) observed for 1 of 1 resident (Resident #170) and e.) appropriate donning (putting on) and doffing (taking off) of personal protective equipment (PPE) for a resident on enhanced barrier precautions (EBP) observed for 1 of 1 resident (unsampled Resident #140).The deficient practices were evidenced by the following:According to the CDC Guideline for Hand Hygiene in Health-Care Settings, dated October 25, 2002, indicates when washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet. 1. On 6/10/26 at 8:18 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN #1) obtain a blood pressure (BP) using the blood pressure machine and cuff provided by the facility for unsampled Resident #64. On 6/10/26 at 8:38 AM, continuing the medication administration observation, the surveyor observed LPN #1 obtain a BP using the same blood pressure machine and cuff for unsampled Resident #132. The surveyor had not observed LPN #1 clean or disinfect the cuff before obtaining a BP or after obtaining a BP in between the two (2) residents. On 6/10/26 at 9:43 AM, the surveyor interviewed LPN #1 who acknowledged she had not disinfected the BP cuff in between the two residents during the medication administration observation. LPN #1 stated the correct method to clean the BP machine was to use the purple wipes before putting the BP cuff on a resident. On 6/10/26 at 1:18 PM, interviewed the Consultant Pharmacist (CP) via telephone who stated she does individual medication observations with the nurses and educates the nurse at the time for correct procedures which included infection control practices. CP added the nurses should disinfect the BP cuff before and after each resident. On 6/11/26 at 9:12 AM, the surveyor interviewed the Unit Manager/LPN (UM/LPN #1) who stated the nurses should wipe the BP cuff with the purple top wipes before and after each use. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy dated with a last review date of 12/10/26 for Sanitizing and Disinfecting of Reusable Equipment revealed the purpose was to prevent transmission of infectious agents through proper cleaning and disinfection of resident care equipment and devices used in resident care. The policy indicated all reusable resident care equipment such as blood pressure cuffs shall be cleaned and disinfected according to manufacturer instructions and infection prevention standards before use on another resident. In addition, the nursing staff was responsible for cleaning and disinfecting resident care equipment after each use. 2. On 6/10/26 at 8:49 AM, during the medication administration observation, the surveyor observed LPN #1 empty a urinal in the bathroom of unsampled Resident #132. Then, LPN #1 proceeded to wash her hands. LPN #1 turned on the faucet and lathered her hands with soap for three (3) seconds and placed her hands under the stream of water and scrubbed for 20 seconds. Upon returning to the medication cart, LPN #1 stated the Infection Preventionist (IP) had instructed her on the hand washing technique and timed them. LPN #1 added hand washing had to be 20 seconds and the hands should be scrubbed in the stream of water for 20 seconds. On 6/10/26 at 1:18 PM, interviewed the CP via telephone who stated she does individual medication observations with the nurses and educates the nurse at the time for correct procedures which included infection control practices. CP added she makes sure the nurses wash their hands when appropriate and felt the nurses took longer than 20 seconds to wash their hands but does not time them or watch whether the hands are being scrubbed in or out of the water. On 6/11/26 at 9:12 AM, the surveyor interviewed the UM/LPN #1 who stated the proper procedure for hand washing was lathering with soap and scrubbing the hands for 20 seconds outside the stream of water, then rinse with water. On 6/12/26 at 10:34 AM, the surveyor interviewed the IP/LPN in the presence of another surveyor. The IP/LPN explained the proper procedure for hand washing was to wet hands first then lather for at least 20 seconds outside of the stream of water and then rinse as per CDC recommendations. The IP/LPN added she performed Hand Hygiene Competency Validation reports for the nurses and inservices with handouts. A review of a Hand Hygiene Competency Validation for LPN #1 provided and completed by the IP/LPN dated 11/24/25 and 4/30/26 indicated the nurse was competent for hand hygiene with soap and water. A review of an inservice dated 4/14/26 to 4/16/26 given by the IP/LPN on Handwashing; Donning (putting on) & Doffing (taking off) of PPE (personal protective equipment): Cough Etiquette included lecture, handouts and demonstration was attended by LPN #1. A review of the CDC handout titled Your hands carry germs you can't see. Provided during the inservice included instructions on how to wash hands with steps to wet hands with clean water, soap them up, scrub them front and back, between fingers and under nails for 20 seconds then rinse with clean water. The surveyor observed the same handout posted throughout the facility. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy dated as last reviewed 4/8/26 for Hand Washing/Waterless Hand washing provided by the Licensed Nursing Home Administrator revealed handwashing, performed effectively by all personnel is essential for the prevention and control of infection. In addition, the procedure for the standard technique was to wet hands with water and apply enough soap to cover the hands and apply friction to all wetted surfaces, including between the fingers, for a period of 20 seconds and then rinse hands under running water from wrist to fingers. 3. On 6/10/26 at 9:31 AM, during the medication administration observation, the Registered Nurse #1 (RN #1) had prepared seven (7) medications in a medicine cup to be administered to unsampled Resident #128. RN #1 stated one of the medications was incorrect and was going to verify all the medications, remove the incorrect medication and replace it with the correct medication. The surveyor observed RN #1 take out two (2) tablets that she verified from the medicine cup containing the seven (7) tablets using her finger to push them into an empty medicine cup. RN #1 then stopped and put gloves on. RN #1 stated she put on gloves so she would not touch the medication with her hands. RN #1 proceeded to verify the medications and added the tablets to the medicine cup that contained the two (2) tablets she had pushed in using her ungloved finger. RN #1 discarded the incorrect medication and replaced it with the correct medication in the same medication cup. On 6/10/26 at 9:37 AM, the surveyor observed RN #1 administer the seven (7) tablets in the same medication cup to Resident #128. On 6/10/26 at 9:38 AM, the surveyor interviewed RN #1 who acknowledged she had touched two (2) of the medications with her finger before putting on the gloves. RN #1 acknowledged the tablets she had touched were all in the same medicine cup with the tablets she used the gloves on. On 6/10/26 at 1:18 PM, interviewed the Consultant Pharmacist (CP) via telephone who stated she does individual medication observations with the nurses and educates the nurse at the time for correct procedures which included infection control practices. The CP added the nurses were not to touch the medications with their hands. A review of the facility policy dated as reviewed 1/26 for Medication Administration provided by the Director of Nursing (DON) revealed infection control protocols must be maintained at all times. 4. On 6/10/26 at 8:19 AM, the surveyor observed signage posted at Resident #170's door for EBP (Enhanced Barrier Precautions is an approach of targeted gown and glove use during high contact resident care activities) and an orange-colored dot next to the resident's name on the name plate. The surveyor observed a bin containing PPE at the doorway. The surveyor observed Resident #170 resting in bed with their eyes closed. On 6/11/26 at 12:40 PM, the surveyor observed an orange-colored dot next to the resident's name on the name plate. The surveyor observed the EBP signage posted on the door and the PPE bin was available at the door. The surveyor observed the resident resting with their eyes closed. The surveyor reviewed the electric medical record (EMR) for Resident #170. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the admission Record (AR; an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; presence of left artificial hip joint, and Hepatic encephalopathy (a serious condition that occurs when the liver is unable to filter toxins from the blood, including ammonia from the intestines). A review of individualized comprehensive care plan (ICCP) initiated on 5/21/26 included a focus area for Enhanced Barrier Precautions, was at risk for transfer of MDRO (multi drug resistant organisms) due to: history [hx] ESBL (Extended Spectrum Beta Lactamase; superbug / antibiotic resistant bacteria) left hip. Interventions included you will be under EBP for the duration of your stay with us. A review of Order Summary Report (OSR) included the following physician orders (PO): A PO #1 dated 5/5/26 for - Single Room Isolation / Contact Precautions (As per CDC guidelines, Everyone must put on gloves and gown before room entry) for ESBL left hip sx wound- resident in the room alone and remains in room with all services taken to the patient such as meals, therapy and activities, every shift ESBL in left sx wound A PO #2 dated 5/28/26 for - Enhanced Barrier Precautions (PICC (Peripherally inserted central catheter; a long, thin, flexible tube inserted into a vein in the upper arm), hx ESBL left hip), every shift A review of June 2026 Medication Administration Record (MAR) reflected PO #1 transcribed in the MARs. The MARs indicated a check mark with nurse's initials for each shift (Day, Evening and Night), which meant the nurses were signing off as completed / confirming the resident was on Single Room Isolation/Contact precautions. A review of June 2026 Treatment Administration Record (TAR) reflected PO #2 transcribed in the TARs. The TARs indicated a check mark with nurse's initials for each shift (Day, Evening and Night), which meant the nurses were signing off as completed / confirming the resident was on EBP. On 6/11/26 at 1:17 PM, during an interview with the surveyor, LPN #2 stated the resident had ESBL at their left hip surgical site. LPN #2 stated if a resident has ESBL, we usually keep them in a single room and further stated Resident #170 was on contact isolation precautions. She stated the resident had Contact Precaution signage at their room. The surveyor accompanied the LPN #2 to Resident #170's room and observed EBP signage posted on the door. In the presence of the surveyor, LPN #2 reviewed the POs and stated the resident had a PO for Single room isolation/ Contact Precaution and then confirmed the resident did not have the correct signage at their door. LPN #2 stated, for EBP, when the aides go into residents' room to provide care to the resident then they had to use gloves and gown up. LPN #2 further stated for Contact isolation precautions, no matter what we are doing with the resident such as if I am administering meds, feeding the resident, and even if we are not doing anything with the resident, we all have to use gloves and gown up before entering the resident's room. She stated it was important to have the correct signage at the resident's door due to the kind of infection the resident had and alerting other staff to put gloves and gown up before entering the resident's room. LPN #2 stated if she did not gown up before entering in the contact isolation room then she would be putting herself and other residents in danger. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Arnold Walter Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 622 S Laurel Avenue Hazlet, NJ 07730	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/26 at 2:17 PM, the surveyor interviewed UM/LPN #2, who stated the resident was on IV antibiotics for ESBL at the Left hip surgical site. The surveyor made UM/LPN #2 aware of the above-mentioned findings. She stated, I believe [Gender Redacted] is now on EBP and was taken off of the isolation. In the presence of the surveyor, UM/LPN #2 reviewed the POs and confirmed the resident had POs for contact isolation. UM/LPN #2 was made aware that the nurses were signing off for Contact precautions on the MARs and EBP on the TARs. UM/LPN #2 stated if the resident was supposed to be on contact precautions and had EBP signage on the door, we are putting staff and the roommate at risk for spread of infection. On 6/12/26 at 10:34 AM, during an interview with the surveyor, the Infection Preventionist (IP) nurse stated she was responsible for facilitating the discontinuation of Transmission Based Precautions (TBP; which includes contact isolation) and once the TBP was discontinued, she would go out and take the signage off from the resident's door. The IP nurse stated she would speak with the residents and the staff to make them aware that the residents were off the isolation. The IP nurse stated she placed the EBP signage on Resident #170's door and further stated I forgot to discontinue the isolation order. The surveyor made the IP nurse aware of the above-mentioned findings. The IP nurse stated, I cannot answer why the nurses were signing off both orders for EBP and contact isolation. On 6/12/26 at 12:12 PM, during an interview with the surveyor, the Director of Nursing (DON) stated once the isolation precautions were discontinued, the PO should be discontinued from the EMR. The surveyor made the DON aware of the above findings for Resident #170. The DON stated the nurses should be checking what the correct order was and not signing off for something that was not active. 5. On 6/12/26 at 9:16 AM, during incontinence rounds with UM/LPN #2 and the Certified Nurse Aide (CNA) on the C Wing, the surveyor observed an Enhanced Barrier Precautions sign outside of unsampled Resident #140's door. The EBP sign included but were not limited to; Everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Care Activities. Providing Hygiene Changing briefs or assisting with toileting At that time, the surveyor observed a PPE bin containing gowns, gloves and surgical mask in the hallway at the door entrance. UM/LPN #2 and the CNA entered the room and then UM/LPN #2 asked the resident for permission to conduct an incontinence check. The resident granted permission, and the surveyor went into the room. UM/LPN #2 and the CNA performed hand hygiene and put gloves on. UM/LPN #2 then pulled the curtain and turned the resident to their left side. The surveyor observed the resident with a thin flexible tube connected to a drainage bag, which was placed on the right side of the bed. The surveyor observed UM/LPN #2 and the CNA did not wear the disposable gown. Upon exiting the resident's room, the surveyor inquired about the tube. UM/LPN #2 stated that it was a tube which was placed in the gallbladder and the drainage bag gets emptied every shift. The surveyor interviewed UM/LPN #2, who stated EBP was for residents with wounds, catheters, tracheostomies, IV antibiotics and for hemodialysis. UM/LPN #2 stated the resident had EBP signage on their door and PPE was not required if the staff were passing out meds (medications) or meals. UM/LPN #2 then stated PPE was required only if you were providing hands on patient care and confirmed that she should have put the gown on. UM/LPN #2 stated, donning PPE was important to protect me from getting what they (the resident) have and protecting them (the resident) as well. On 6/12/26 at 10:34 AM, the surveyor made the IP nurse aware of the above-mentioned findings for (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unsampled Resident #140. The IP nurse stated that when residents were on EBP, they were at risk for acquiring or transmitting MDRO, during high contact patient care. The IP nurse explained that the staff should follow precautions such as hand hygiene (HH), donning gown and gloves during care to prevent cross-contamination. The IP nurse stated they should have put on PPE this morning during incontinence rounds. The surveyor reviewed the EMR for unsampled Resident #140. A review of the AR revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; Ogilvie syndrome (a sudden, temporary paralysis of the large intestine), disease of digestive system (any health condition that prevents your body from properly breaking down food, absorbing nutrients, or removing waste) and gastrostomy (a surgical procedure to make a hole into the stomach through the abdomen to insert a feeding tube into the stomach) status. A review of the OSR revealed the PO for unsampled Resident #140 with a start date 1/2/26, for Enhanced Barrier Precautions every shift. On 6/12/26 at 1:15 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, the Regional Nurse and the Administrator in Training (AIT). The surveyor made the administration aware of the above-mentioned concerns for Resident #170 and unsampled Resident #140. A review of the facility's policy Enhanced Barrier Precautions last reviewed 4/14/26 included Policy: It is the policy of this facility to follow CDC guidelines by utilizing Enhanced Barrier precautions in the care of patients with multiple drug resistant organisms (MDRO) to reduce the spread of infection with MDRO even if the resident is asymptomatic. Enhanced Barrier Precautions &ndash; The use of gown and gloves for high-contact resident care activities is indicated, with wounds and/or indwelling medical devices .Enhanced Barrier Precautions require: Use of gown and gloves during high-contact resident care activities &ndash; Changing briefs, incontinence pads, toileting assistance. A review of the facility's policy Infection Control / Transmission Based Precautions last reviewed 1/2026 included under section Transmission based tracer: Signs indicating a resident is on transmission-based precautions are clear and visible. NJAC 8:39-19.4 (a) (1) (2); (b)(n)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Complaint #: NJ2676162, NJ2786980Based on observation and interview, it was determined that the facility failed to maintain the facility in a clean and sanitary environment. This deficient practice was identified for 1 of 4 units, (D Wing) and was evidenced by the following: On 6/09/2026 at 10:19 AM, during initial tour of D wing, the surveyor observed dark brown areas on the floors throughout the hallways. On 6/10/2026 at 8:58 AM, the surveyor observed the D wing hallways to have multiple dark brown areas on the floors. On 6/11/2026 at 10:01 AM, the surveyor observed the D wing hallways with wet floor signs in front of the nurse's station. The floor around the wet floor sign was observed with multiple dark brown areas. On 6/11/2026 at 10:15 AM, the surveyor interviewed a porter who stated that the floors were mopped daily as were the hallways. He further indicated that he had worked the prior two days and that the hallways on D wing were mopped daily. He further explained that D wing needed to be stripped and waxed, that this stuff (indicating to the floor) wouldn't come up with mopping. He was unsure how often the floors were stripped and waxed. When specifically asked about the area in front of D wing nurse's station, he stated the dirt was ground in and wouldn't come up. He indicated to the surveyor the area by the television and stated that area was stripped and waxed recently but the main hallway was not. The surveyor observed the area by the television observed to be without stains and was shinier. On 6/11/2026 at 10:27 AM, the surveyor interviewed the Administrator in Training (AIT) who indicated that the housekeeping director had resigned about two to three months ago. He explained that stripping and waxing the floors were a big job and they started with C wing, which was worse than D wing. He further stated that the floors were probably stripped and waxed once a year. He also stated that D wing was next and that it definitely needed it. When asked about the area in front of D wing nurse's station he agreed that it needed to be done but repeated that they started on C wing. On 6/11/2026 at 10:40 AM, the Licensed Nursing Home Administrator (LNHA) provided the resignation date for the housekeeping director, which was 1/8/26. On 6/12/2026 at 9:17 AM, the surveyor observed the porter buffing the hallways on the D wing. The surveyor observed the hallways to appear as they had on the prior days of the survey, with dark brownish areas evident. On 6/12/2026 at 9:42 AM, the surveyor interviewed the porter who was observed buffing the floor on D wing. He stated he was bringing the shine up. He also stated the floor had been previously mopped. When the surveyor asked about the marks and brown areas that were still present on the floor, he stated those were deep and would have to be stripped and scrubbed to take them up, then more wax applied. On 6/12/26 at 1:15 PM, the survey team met with the facility leadership and notified them of above concerns. The LNHA stated the schedule for stripping and waxing was twice yearly and that it was due in May; however, it was too humid due to the rain to do the floors at that time. On 6/15/26 at 8:55 AM, the surveyor reviewed the facility provided schedule for strip and wax of hallways which indicated:1st week November C wing hallways signed and dated for 11/12/25.4th week November A wing hallways signed and dated 11/15/25. 2nd week November C & D wing dayrooms with no date or signature.3rd week of November D wing hallways with no date or signature. On 6/15/2026 at 9:24 AM, the surveyor observed the hallway in front of D wing nurse's station had been stripped and waxed over the weekend. The floor in front of the nurse's station was noted to be shiny without any dark brown areas. No further information was provided by the facility. The surveyor reviewed the facility provided policy, Housekeeping Services, reviewed January 2026, which included: Purpose:To ensure a clean, sanitary, safe, and comfortable environment for residents, staff, visitors, and volunteers through the provision of comprehensive housekeeping services that (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comply with federal, state, and local regulations. Policy: The facility shall maintain an effective housekeeping program that promotes infection prevention and control, resident comfort, safety, and a homelike environment. Housekeeping services shall be provided on a routine and as-needed basis throughout the facility. Procedure: 1. General Responsibilities Housekeeping staff shall maintain all resident care areas, common areas, administrative offices, and ancillary departments in a clean and sanitary condition. Cleaning schedules shall be maintained and documented. 3. Common Areas Common areas shall be cleaned according to established schedules and include: Lobbies and reception areas. Dining rooms. Activity rooms. Corridors and elevators. Nursing stations. Public restrooms. 6. Floor Care Floors shall be maintained in a clean and safe condition. Wet floor signs shall be utilized during cleaning services. Stripping, waxing, buffing, and carpet cleaning shall be performed according to established schedules. 9. Quality Assurance Routine environmental rounds shall be conducted by housekeeping supervisors. Deficiencies identified during inspections shall be corrected promptly. Housekeeping services shall be monitored through the facility's Quality Assurance and Performance Improvement (QAPI) program. N.J.A.C. 8:39-31.4 (a) (b) (f)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to a.) complete reference checks for 10 out of 102 employees (Employee #7, #21, #22, #26, #33, #35, #50, #72, #91, #97) and b.) complete background checks for 14 out of 102 employees (Employee #2, #19, #23, #29, #30, #35, #41, #50, #62, #70, #72, #76, #84, #97). This deficient practice was identified for newly hired employees reviewed since the last Department of Health recertification survey of 1/24/25. This deficient practice was evidenced by the following: On 6/9/26 at approximately 10:31 AM, during the entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA), all newly hired employee files for active and inactive employees from 1/24/25 to the current date. 1.) A review of the employee personnel files revealed the following: For Employee #7, a Licensed Practical Nurse (LPN) with a date of hire (DOH) of 1/16/25, there was no evidence of a reference check prior to the start of employment; a reference check was dated 1/21/25. For Employee #21, a Recreation Aide with a DOH of 8/20/25, there was no evidence of a reference check prior to the start of employment; a reference check was dated 8/22/25. For Employee #22, an LPN with a DOH of 10/21/25, there was no evidence of a reference check prior to the start of employment; a reference check was dated 10/28/25. For Employee #26, an LPN with a DOH of 9/16/25, there was no evidence of a reference check prior to the start of employment; a reference check was dated 9/22/25. For Employee #33, a Registered Nurse (RN) Supervisor with a DOH of 3/13/25, there was no evidence of a reference check prior to the start of employment; a reference check was dated 3/24/25. For Employee #35, an LPN with a DOH of 1/10/26, there was no evidence of a reference check prior to the start of employment; a reference check was dated 1/27/26. For Employee #50, an LPN with a DOH of 4/29/25, there was no evidence of a reference check prior to the start of employment. For Employee #72, a Certified Nurse Aide (CNA) with a DOH of 3/13/25, there was no evidence of a reference check prior to the start of employment; a reference check was dated 3/24/25. For Employee #91, a Dietary Aide with a DOH of 11/3/25, there was no evidence of a reference check prior to the start of employment; a reference check was dated 11/10/25. For Employee #97, a Concierge with a DOH of 8/25/25, there was no evidence of a reference check prior to the start of employment; a reference check was dated 8/29/25. 2.) A review of the employee personnel files revealed the following: For Employee #2, a CNA with a DOH of 3/6/25, a background check was completed 10/30/23. For Employee #19, a CNA with a DOH of 3/13/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 3/14/25. For Employee #23, a Social Worker with a DOH of 1/21/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 2/10/25. For Employee #29, a Registered Nurse (RN) Supervisor with a DOH of 11/26/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 12/2/25. For Employee #30, a CNA with a DOH 11/17/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 11/18/25. For Employee #35, an LPN with a DOH 1/10/26, there was no evidence of a background check prior to the start of employment; a background check was completed on 1/27/26. For Employee #41, an LPN with a DOH 11/26/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 12/1/25. For Employee #50, an LPN with a DOH 4/29/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 10/30/25. For Employee #62, a CNA with a DOH 2/23/26, there was no evidence of a background check prior to the start of employment; a background check was completed (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 2/26/26. For Employee #70, a Director of Admissions with a DOH 2/17/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 2/18/25. For Employee #72, a CNA with a DOH 3/13/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 3/14/25. For Employee #76, an LPN/Unit Manager (LPN/UM) with a DOH 5/19/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 5/20/25. For Employee #84, a Physical Therapist with a DOH 8/4/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 8/14/25. For Employee #97, a Concierge with a DOH 8/25/25, there was no evidence of a background check prior to the start of employment; a background check was completed on 8/26/25. On 6/11/26 at 1:43 PM the surveyor interviewed the Director of Human Resources who stated she was responsible for background checks, onboarding process, and setting up a new hire orientation. She further stated that a new employee cannot start until a background check and reference checks were completed. She then stated that the importance of reference checks and background checks prior to hire was to be in compliance with the state regulations. On 6/12/26 at 1:16 PM, in the presence of the survey team, the LNHA, Director of Nursing (DON), and Regional Nurse were made aware of the above concerns regarding reference checks and background checks for newly hired employees. The Regional Nurse stated that Human Resources (HR) was responsible for completing background checks and reference checks prior to hire. She further stated that the background checks should be fully completed prior to starting. On 6/15/26 at 10:00 AM, the survey team met with the LNHA, DON, Regional Nurse, and Administrator in Training (AIT). The LNHA acknowledged the reference checks and background checks should be completed prior to hire. A review of the facility's Abuse, Mistreatment, Neglect, Misappropriation of Resident's Property policy, last review 2/20/26 revealed .the facility shall ensure the screening and training of employees, protection of residents, and for the prevention, identification, investigation, and reporting of abuse, mistreatment, neglect, and misappropriation of property. Section I: Screening. All potential employees and applicants shall be screened for past arrests including a history of abuse and other crimes before being afforded a position within the facility. will obtain a waiver of written consent on the employment application indicating that hire for employment is contingent upon the completion of a satisfactory reference screening. shall obtain information from previous employers and or current employers to validate applicant references. A review of the facility's New Hire Process policy, reviewed 1/2026 revealed .Policy. Employment is contingent upon successful completion or required background checks, license verification, and health screenings. all offers of employment are conditional upon successful completion of the following. background checks. health screen. start date is contingent upon pre-employment requirements. NJAC 8:39-9.3(b)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete the Comprehensive Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 2 of 10 residents (Resident #22 and Resident #153) reviewed for timing of assessments and was evidenced by the following: On 6/10/26, the surveyor reviewed the electronic medical records (EMR) of the residents in the Resident Assessment task which revealed: Resident #22 had an annual MDS with a date of 3/19/26 which was completed on 4/6/26 (due 4/2/26). Resident #153 had an annual MDS with a date of 5/14/26 which was completed on 5/29/26 (due 5/28/26). On 6/11/26 at 10:54 AM, the surveyor interviewed the Regional MDS Coordinator (RMDSC), who stated Resident #22's MDS should have been completed on 4/2/26 and Resident #153's MDS should have been completed on 5/28/26. He also stated that the facility MDS Coordinator resigned on 6/2/26. On 6/12/26 at 1:15 PM, the survey team met with facility leadership and notified them of the above concerns. On 6/15/26, no further information was provided by the facility. According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2025, page 2-17, the Annual assessment must be completed no later than the Assessment Reference Date + 14 calendar days. The surveyor reviewed the facility provided policy, MDS RAI Process reviewed 1/4/26, which included: Policy: It is the policy of [facility] to comply with the existing federal and state regulations governing the implementation of Resident Assessment Instrument (RAI) Process as basis for provision of quality of care to its residents. Purpose: To outline the procedure of identifying and addressing the resident's strengths and needs through the RAI process. NJAC 8:39-11.2 (e)		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete the Comprehensive Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 1 of 9 residents (Resident #121) reviewed for timing of assessments and was evidenced by the following: On 6/10/26, the surveyor reviewed the electronic medical records (EMR) of the residents in the Resident Assessment task which revealed: Resident #121 had a Quarterly MDS with a date of 2/5/26 was completed on 2/21/26 (due 2/19/26). On 6/11/26 at 10:54 AM, the surveyor interviewed the Regional MDS Coordinator (RMDSC), who stated Resident #121's MDS should have been completed by 2/19/26. He also stated that the facility MDS Coordinator resigned on 6/2/26. On 6/12/26 at 1:15 PM, the survey team met with facility leadership and notified them of the above concerns. On 6/15/26, no further information was provided by the facility. According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2025, page 2-17, the Annual assessment must be completed no later than the Assessment Reference Date + 14 calendar days. The surveyor reviewed the facility provided policy, MDS RAI Process reviewed 1/4/26, which included: Policy: It is the policy of [facility] to comply with the existing federal and state regulations governing the implementation of Resident Assessment Instrument (RAI) Process as basis for provision of quality of care to its residents. Purpose: To outline the procedure of identifying and addressing the resident's strengths and needs through the RAI process. NJAC 8:39-11.2 (e)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Arnold Walter Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 622 S Laurel Avenue Hazlet, NJ 07730	
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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of medical records, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to electronically transmit the Minimum Data Set (MDS, an assessment tool), within 14 days of completing the resident's assessment. This deficient practice was identified for 6 of 9 residents, (Sampled Resident # 8 and #22, Unsampled Resident #40, #60, #100, and #121) reviewed in the Resident Assessment Task for MDS record over 120 days old. This deficient practice was evidenced by the following: On [DATE] and [DATE], the surveyor reviewed the MDS history in the electronic medical records for the residents in the Resident Assessment task which revealed the following: Resident #8's Quarterly MDS dated [DATE] was completed on [DATE] and transmitted on [DATE] (due [DATE]). Unsampled Resident #21 died in the facility on [DATE] and the Discharge Tracking was completed and transmitted [DATE] (completion due on [DATE] and transmission due [DATE]). Resident #22's Quarterly MDS dated [DATE] was completed on [DATE] and transmitted on [DATE] (due [DATE]). Unsampled Resident #40's Quarterly MDS dated [DATE] was completed on [DATE] and transmitted on [DATE] (due [DATE]). Unsampled Resident #43's Discharge MDS dated [DATE] was completed on [DATE] and transmitted on [DATE] (due [DATE]). Unsampled Resident #60's Quarterly MDS dated [DATE] was completed on [DATE] and transmitted on [DATE] (due [DATE]). Unsampled Resident #100's Quarterly MDS dated [DATE] was completed on [DATE] and transmitted on [DATE] (due [DATE]). Unsampled Resident #121's Quarterly MDS dated [DATE] was completed on [DATE] and transmitted on [DATE] (due [DATE]). Unsampled Resident #126 was discharged on [DATE], no discharge assessment was found in the electronic medical record (completion due [DATE] and transmission due [DATE]). On [DATE] at 10:54 AM, the surveyor interviewed the Regional MDS Coordinator (RMDSC) via telephone. He stated that all MDS assessments completed on [DATE] should have been submitted by [DATE] at the latest. He stated he wasn't sure what happened with Resident #43. He stated that the death tracking for Resident #21 should be completed within 7 days of the death. He confirmed there was no discharge MDS for Resident #126. He further stated that [DATE] was the week the MDS Coordinator in the facility had resigned. On [DATE] at 1:15 PM, the survey team met with facility leadership and notified them of the above concerns. On [DATE], no further information was provided by the facility. According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated [DATE], page 2-18, the Quarterly assessment must be transmitted no later than MDS Completion Date + 14 calendar days, page 2-19, the discharge assessment must be completed no later than discharge date + 14 calendar days with the transmission date no later than MDS completion date +14 days, and page 2-20, the Death in Facility tracking record must be completed no later than the death date + 7 calendar days with the transmission date no later than MDS completion date +14 days. The surveyor reviewed the facility provided policy, MDS RAI Process reviewed [DATE], which included: Policy: It is the policy of [facility] to comply with the existing federal and state regulations governing the implementation of Resident Assessment Instrument (RAI) Process as basis for provision of quality of care to its residents. Purpose: To outline the procedure of identifying and addressing the resident's strengths and needs through the RAI process. NJAC 8:39-11.2 (e) 3		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on observations, interviews, record review and facility documents it was determined the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Level 1 a.) was completed and b.) was accurate for a newly admitted resident. This deficient practice was identified for one of three residents reviewed for PASRR (Resident #68) and was evidenced by the following: On 6/9/2026 at 11:40 AM, during the initial tour, the surveyor observed Resident #68 lying in bed, with their eyes closed. On 6/10/2026 at 10:54 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #68. A review of the admission Record (an admission summary) revealed the resident was admitted to the facility in April of 2026 with diagnoses which included but were not limited to; depression, unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities), anxiety disorder, unspecified, (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life) and Manic Episode, unspecified (involves extreme mood elevation, increased energy, and hyperactivity, often accompanied by disorganized behavior and impulsivity). A review of the admission Minimum Data Set (MDS), an assessment tool dated 4/17/2026, revealed the resident had a Brief Interview for Mental Status of 14 out of 15, indicating the resident was cognitively intact. Further review of the MDS, active diagnoses of anxiety disorder, depression, bipolar disorder (a chronic mental health condition characterized by extreme shifts in mood, energy, and activity levels). A review of the individual comprehensive care plan (ICCP) revealed a focus area of uses antidepressant and anti -anxiety medication r/t [related to] depression and anxiety, date Initiated: 04/11/2026. A review of the EMR revealed a PASRR dated 9/24/2025. Further review of the PASRR revealed under section two titled Mental Illness Screen was marked No for the resident having a diagnosis or evidence of a major mental illness or evidence of a major mental illness. Further review of the EMR did not reveal an updated PASRR for the most recent admission. On 6/12/2026 at 8:30 AM, the surveyor interviewed the Director of Social Services (DSS), who stated a PASRR was done on admission and was required for every resident. She stated the admissions department tried to request the PASRR from the hospital before admission but if the PASRR wasn't done, the social worker (SW) at the facility would do it. The DSS reviewed the EMR in the presence of the surveyor and stated the PASRR for Resident #68 was dated 9/24/2025. She stated the PASRR should have been reviewed for accuracy and updated if it was not accurate. The DSS reviewed the admission note from the SW dated 4/14/2026 and acknowledged the note did not include the PASRR was reviewed and accurate. On 6/12/2026 at 9:23 AM, the surveyor interviewed the Director of Nursing (DON), who stated a PASRR should be done with all new admissions that come from the hospital and if there were any changes, a new one should be done. She stated the purpose of the PASRR was for evaluation for a psych diagnosis and mental health. The DON stated the SW should make sure the PASRR was accurate and up to date. The DON stated, Absolutely psych diagnosis and mental health should be included, I believe it is on the 1st page. The DON stated if a resident had bipolar it should have been checked on the PASRR. On 6/12/2026 at 12:20 PM, the DSS provided the surveyor with an updated PASRR for Resident #68 dated 4/9/2026. She stated it was found in the admission's paperwork. Further review of the updated PASRR revealed under section two titled Mental Illness Screen was marked No for the resident having a diagnosis or evidence of a major mental illness or evidence of a major mental illness, which did not include the resident's diagnosis of bipolar. The provided updated PASRR had the same telephone number written on the top right corner on page 1, not in a space requested on the form, as the previous PASRR dated 9/24/2025. On 6/12/2026 at 12:30 PM, during a (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow-up interview with the DON, the surveyor presented the PASRR dated 9/24/25 and the one dated 4/9/26 to the DON for review. The DON compared the 2 PASRRs and acknowledged the similarities in the forms. She stated, I will have to speak to the DSS. On 6/12/2026 at 1:16 PM, in the presence of the survey team, the Licensed Nursing Home Administrator, the DON, the Regional Nurse, and Administrator in Training were made aware of all the above-mentioned concerns. No additional information was provided. A review of the facility's policy Pre-admission Screening and Resident Review (PASRR) Policy last reviewed 8/1/2025 revealed it is the policy of this facility to comply with all federal and New Jersey Pre-admission Screening and Resident Review (PASRR) requirements to ensure that individuals with Serious Mental Illness (SMI).are appropriately identified, evaluated, admitted , and provided necessary services. No resident shall be admitted or retained in the facility without compliance with applicable PASRR requirements.A. Pre-admission Screening: 1, The facility shall ensure that a PASRR Level 1 Screening is completed before admission to the facility.3. Admissions personnel shall: review referral documentation. Obtain and verify PASRR documentation from hospitals. Ensure the completed Level 1 screening accompanies the resident at admission. Place PASRR documentation in the active medical record. NJAC 8:39-5-1 (a); 27.1(a)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ00187199 (406115), 2676162Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to timely provide incontinence care to residents who required assistance with the activities of daily living (ADL). This deficient practice was identified for 2 of 9 residents (Resident #7 and 141) reviewed for Incontinence care. This deficient practice was evidenced as follows: This deficient practice was evidenced as follows: 1.) On 6/12/26 at 9:13 AM, during incontinence rounds with the Licensed Practical Nurse Unit Manager (LPN UM), Resident #7 was agreeable to be checked, and it was noted that the resident's incontinence brief was saturated with urine, the draw sheet was soaked with urine, and the bed pad was soaked with urine. The LPN UM confirmed Resident #7's incontinence brief was saturated with urine through to the draw sheet, and bed pad. The LPN UM stated the process for a resident who was incontinent was the resident should be changed at least every two hours, and the resident should not have been this soaked to maintain skin integrity. The LPN UM further stated the expectation was for the CNA to check the residents at the start of the shift. On 06/12/26 9:36 AM, during a follow up observation of Resident #7, the assigned CNA (CNA #1) confirmed that he did not check the resident at the start of the shift and confirmed the resident's night gown, draw sheet, and bed pad was soaked with urine. CNA #1 stated the resident should not have been this soaked, because it could cause bed sore, and that he should have changed the resident after feeding the other residents. The surveyor reviewed the electronic medical record (EMR) for Resident #7. A review of the admission Record (an admission summary) reflected diagnoses that included but were not limited to; Other Alzheimer's Disease, hyperlipidemia (high fats in the blood), and dementia (loss of memory). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/16/26, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severely impaired cognition. Further review of the MDS revealed the resident was dependent on staff for toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. A review of the individualized comprehensive care plan (ICCP) included a focus area for ADL self-care performance deficit related to (r/t) Alzheimer's, fatigue, impaired balance, musculoskeletal impairment, weakness initiated on 2/1/26, with interventions that included bathing/showering, personal hygiene/oral care requires maximum assistance of one person. 2.) On 6/12/26 at 9:46 AM, during incontinence rounds with the LPN/UM, Resident #141 was agreeable to be checked. The resident stated they were changed an hour ago. The resident's incontinence brief was very saturated with urine, the bed pad was wet, and the surveyor noted a very strong urine odor. The LPN/UM confirmed the resident's incontinence brief was saturated, confirmed the urine odor, and stated the resident should not have been left in this condition for wound prevention and skin integrity. On 06/12/26 10:15 AM, during a follow up observation of Resident #141 with the assigned Registered Nurse (RN), the resident was agreeable to be checked. The RN confirmed the resident's incontinence pad was soaked with urine and there was a very strong urine odor. The RN stated the resident should not have been left in this condition; the resident should have been changed earlier to protect the resident's skin and for dignity. The nurse also stated the resident often refused care. On 06/12/26 10:21 AM, during a follow up observation of Resident #141, the assigned CNA (CNA #1) stated when he did rounds, the resident stated they were changed an hour ago. CNA #1 stated he did not confirm if the resident was wet at the time, but stated the resident refused care. In the presence of the surveyor, the resident again stated that they were changed an hour ago. The resident was agreeable (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be checked and was not resistive or refused care. The CNA then checked and confirmed that the resident's incontinence brief was soaked with urine through to the bed pad. CNA #1 told the resident that he was going to wash and do morning (AM) care. Again, Resident #141 was agreeable for the CNA to do AM care. The surveyor observed no refusal or resistance to care at this time. The surveyor reviewed the EMR for Resident #141. A review of the admission Record reflected diagnoses that included but were not limited to; cerebral vascular disease (conditions that affect blood flow and the blood vessels in the brain) and Dementia. A review of the most recent quarterly MDS, dated [DATE], indicated the resident had a BIMS score of 5 out of 12, indicating severely impaired cognition. Further review of MDS revealed the resident was dependent on staff for toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. A review of the ICCP revealed the resident had an ADL self-care performance deficit r/t Dementia initiated on 2/4/26, with intervention that included toilet use with one assist. Further review of the ICCP revealed no focus area for refusals or resistive to care. On 06/12/26 at 12:34 PM, during an interview with the surveyor, the Director of Nursing (DON) stated the residents should not have been left wet through to the bed pad for skin protection, hygiene, and infection control. The DON stated the CNAs should have changed the residents when the residents were wet. The DON also confirmed there was no refusal of care in Resident #141's care plan in the current EMR system. On 6/12/26 at 1:15 PM, the surveyor presented the above-mentioned concerns to the Licensed Nursing Home Administrator, the DON, the Administrator in Training, and the Regional Nurse. On 6/15/26 at 9:00AM, the DON submitted an updated care plan reflecting Resident #141's non-compliance and resistance to care at times, after surveyor inquiry. A review of the facility provided Care Plans, Comprehensive Person-Centered policy dated 10/1/21, last reviewed 1/28/26, revealed Policy Interpretation and Implementation 8.b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. A review of the facility provided Documentation policy dated 11/10, last reviewed 1/26, revealed Policy Statement, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation revealed 2. The following information is to be documented in the resident ('s) medical record: c. Treatments or services performed. A review of the facility provided Incontinence Care policy, dated 11/10, last reviewed 1/26, revealed Purpose, to ensure residents received individualized care that promotes comfort, dignity, skin integrity, and the highest possible level of incontinence. 4. Incontinence Products - change when soiled; 5. Skin Care and Infection Prevention - Provide perineal care after episodes of incontinence. A review of the facility provided undated CNA Job Description revealed, Duties and Responsibilities, under Personal Nursing Care Functions - keep residents dry (i.e. [that is] change gown, clothing, linen, etc. [and so on], when it becomes wet or soiled). A review of the facility provided undated RN Job Description revealed, Duties and Responsibilities - Supervises and coordinates nursing personnel in providing direct resident care in adherence to State and Federal regulations. A review of the facility provided undated UM Job Description revealed, Supervises that all nursing services personnel are following their respective job description; Make daily rounds of the Nursing Services Department to ensure that all nursing service personnel are performing their work assignments in accordance with the acceptable nursing standards. N.J.A.C.:8:39-27.1(a)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, record review and pertinent facility documents, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on 6/10/26, the surveyor observed two (2) nurses administered medications to four (4) residents. There were 27 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.41%. The deficient practice was identified for two (2) of four (4) unsampled Residents, (unsampled Resident #147 and #128), that were administered medications by one (1) of two (2) nurses that were observed. The deficient practices were evidenced by the following: 1. On 6/10/26 at 8:59 AM, during the morning medication administration observation, the surveyor observed the Registered Nurse (RN#1) obtaining blood pressure results from unsampled Resident #147. RN #1 asked the resident if they wanted their medications crushed. The resident stated they wanted their medications smashed in applesauce because it was easier to swallow. On 6/10/26 at 9:06 AM, the surveyor observed RN #1 preparing to administer five (5) medications to unsampled Resident #147. RN #1 stated Ferrous Sulfate (an iron supplement) was in a bottle because it was an over-the-counter house stock (OTC-HS) medication, meaning the facility provided the medication. RN #1 stated she was allowed to crush the medications and crushed the five (5) medications which included one (1) tablet of Iron (Ferrous Sulfate) 325 milligrams (MG). On 6/10/26 at 9:07 AM, the surveyor observed RN#1 administer the five (5) crushed medications which included the Ferrous Sulfate tablet in applesauce to unsampled Resident who stated, That was a little bitter. On 6/10/26 at 9:08 AM, upon returning to the medication cart, the surveyor with RN#1 reviewed the electronic medication administration record (EMAR) for the Ferrous Sulfate. There was no physician's order to crush the Ferrous Sulfate and there was no cautionary warning indicating the Ferrous Sulfate should not be crushed on the EMAR. (ERROR #1) On 6/10/26 at 12:24 PM, the surveyor interviewed RN #1 who stated there was no handout regarding medications that cannot be crushed on the medication cart. RN #1 also stated the cautionary warnings such as Do not crush were indicated on the medication package labelling from the provider pharmacy. RN #1 acknowledged the Ferrous Sulfate was an OTC-HS and there was no label with cautionary warnings from the provider pharmacy. RN #1 stated she knew the Ferrous Sulfate tablets could be crushed and the unsampled Resident #147 wanted their medications crushed. RN #1 added she could look up if any medication could be crushed on her phone. At that time, RN #1 reviewed her phone and stated Ferrous Sulfate could irritate the stomach but was not a hard stop on crushing the medication. RN #1 then closed her phone and had not shown the surveyor what she had read. RN #1 added the resident had breakfast and had no stomach issues. The surveyor reviewed the medical record for unsampled Resident #147. A review of the admission Record revealed diagnoses that included, but not limited to, anemia (a lack of enough healthy red blood cells). A review of a quarterly comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 4/2/2026, reflected the resident had a brief interview for mental status (BIMS) score of 12 out of 15, indicating that the resident had a moderately impaired cognition. A review of the Order Summary Report revealed an active physician's order (PO) with a start date of 12/17/25 for Ferrous Sulfate 325 MG tabs Give 1 tablet orally one time a day related to Anemia, unspecified Avoid dairy products. On 6/10/26 at 1:18 PM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone who stated she does individual medication observations with the nurses and educates the nurse at the time for correct procedures. The CP added there was a list of medications that cannot be crushed that was provided to the facility. The (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CP also stated Ferrous Sulfate tablets cannot be crushed and should be changed to liquid form. The CP added she would instruct a nurse if she saw them crushing Ferrous Sulfate during a medication observation. A review of a Medication Pass Audit Tool provided by the Director of Nursing (DON) dated 1/12/26 completed by the CP for RN #1 indicated only products suitable for crushing were observed. On 6/11/26 at 8:51 AM, the DON provided the surveyor an inservice dated 4/14/26 for the topic Med Administration completed by the DON and the Assistant Director of Nursing and signed by RN #1 as attending. The inservice included a handout titled Drugs that SHOULD NOT be crushed developed by the CP. The handout revealed Ferrous Sulfate was not to be crushed. The inservice also included a handout titled Medications & Documentation which revealed instructions for crushing medications was to verify the medication may be crushed before preparation and to refer to the list of pharmacy medication. On 6/11/26 at 12:08 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated the OTC-HS medications usually had no cautionary warnings on the bottles, but the nurses could check. The UM/LPN added the CP lets the nurses know which medications cannot be crushed. The UM/LPN also stated if Ferrous Sulfate tablets needed to be crushed she would call the physician to change the physician's order to a liquid form. A review of a facility policy Medication Administration dated as reviewed 1/26, provided by the DON, reflected to obtain an order for crushing medications as appropriate or necessary as per manufacturer's directions. A review of the manufacturer specifications for Ferrous Sulfate revealed the tablets should be swallowed whole and do not crush, chew or break it. 2. On 6/10/26 at 9:37 AM, during the morning medication administration pass, the surveyor observed RN#1 administer seven (7) medications to unsampled Resident #128 which included a 25 MG tablet of Metoprolol Succinate (a medication used to lower blood pressure). There was no observation of a breakfast tray in the resident's room or collected trays in the hallway. On 6/10/26 at 9:38 AM, upon returning to the medication cart, the surveyor reviewed the medication label printed by the provider pharmacy for the Metoprolol Succinate 25 MG tablets which revealed a cautionary warning Take this drug preferably with or right after a meal. The surveyor, with the RN #1, reviewed the EMAR which indicated the Metoprolol Succinate had an administration time of 8 AM. RN #1 explained the EMAR indicated the medication was noted in a red color because it was late. RN #1 also explained she administered the most sensitive medications first such as insulin and that it was difficult to administer the 8 AM medications all at the same time. (ERROR #2) On 6/10/2026 at 9:53 AM, the surveyor interviewed a Certified Nursing Assistant (CNA #1) who stated Resident #128 had breakfast earlier and was unsure of the exact time. CNA #1 added that usually the trays are delivered by 7 AM and thought the resident would be finished by 8 AM. On 6/10/26 at 12:24 PM, the surveyor interviewed the RN #1 who stated Resident #128 was a very good eater for meals and always had a full stomach because they went to activities where there were many snacks. RN #1 could not speak to any difference between a medication ordered with a meal or with food. RN #1 also stated breakfast was delivered quite early between 7 to 7:30 AM. The surveyor reviewed the medical record for Resident #128. A review of the admission Record revealed diagnoses that included, but not limited to; heart failure and hypertension (high blood pressure). A review of a quarterly comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 4/23/2026, reflected the resident had a brief interview for mental status (BIMS) score of nine (9) out of 15, indicating that the resident had a moderately impaired cognition. A review of the Order Summary Report revealed an active PO with a start date of 2/17/26 for Metoprolol Suc (succinate) tab 25 MG ER (extended release), Give 1 tablet orally one time a day related to heart failure, unspecified, Hold for SBP (systolic blood pressure) less than 110. On 6/10/2026 at 1:18 PM, the (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor interviewed the CP via telephone who stated she does individual medication observations with the nurses and educates the nurse at the time for correct procedures. The CP added the cautionary warnings were on the labels of the medication cards by the provider pharmacy and observed the nurses when she did a medication observation to see if the nurses were following them. The CP explained Metoprolol Succinate should be administered with food and felt if the medication was administered 30 minutes after a meal that was allowed. The CP further stated if breakfast was at 8 AM then a 9AM administration time was totally fine. The CP was unable to speak to whether with food or with a meal had different times of administration. On 6/11/26 at 8:51 AM, the DON provided the surveyor an inservice dated 4/14/26 for the topic Med Administration completed by herself and the Assistant Director of Nursing and signed by RN #1 as attending. The inservice included Medications Administration which revealed instructions before administration were to verify a physician's order and apply the Rights of Medication Administration which included the right time. A review of a Medication Pass Audit Tool provided by the DON dated 1/12/26 completed by the CP for RN #1 indicated the medication label was compared to the EMAR to ensure the correct time and medications were given before, with, or after meals when ordered by the physician. On 6/11/2026 at 12:08 PM, the surveyor interviewed the UM/LPN who stated the nurses were able to filter the administration times of medications to know which medications were to be administered first and keep within the hour before and hour after an administration time. The UM/LPN stated RN #1 had not filtered the medications by time because she was not a regular nurse on the unit. The UM/LPN added the nurses were to follow cautionary warnings indicated on the labels and a medication indicating with a meal would have an administration time of 8 AM for the breakfast meal on the unit and should be administered as close to breakfast as possible. The UM/LN acknowledged 9:37 AM was not with a meal. A review of a facility policy Medication Administration dated as reviewed 1/26, provided by the DON, reflected medications were to be administered within a two-hour time frame (i.e. one hour before or after the medication order time. A review of the manufacturer specifications for Metoprolol Succinate revealed the medication should be taken with a meal or just after a meal. NJAC 8:39-11.2(b), 29.2(a)(d), 29.4(c)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Arnold Walter Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 622 S Laurel Avenue Hazlet, NJ 07730	
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure insulin was administered in accordance with physician ordered parameters to prevent significant medication (med) errors. This deficient practice was identified for 1 of 1 resident (Resident #19) reviewed for insulin administration. 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. 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. On 6/10/26 at 8:23 AM, the surveyor observed Resident #19 eating breakfast in their bed. The resident stated that they get insulin. The surveyor reviewed the electric medical record (EMR) for Resident #19. A review of admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; alcoholic cirrhosis (a condition where the liver is severely damaged) of liver without ascites (abnormal buildup of fluid within the abdomen usually causing swelling, abdominal pain and sometimes breathing difficulties), type 2 diabetes mellitus (DM; a common, long-term condition where the body cannot effectively use or produce enough insulin, causing sugar (glucose) to build up in the blood) without complications, and hepatic encephalopathy (loss of brain function occurs when the liver is unable to remove toxins from the blood). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 5/14/26, reflected that the resident had a Brief Interview for Mental Status score of 10 out of 15, which indicated that Resident #19 had moderately impaired cognition. Further review of the MDS indicated the resident had received insulin (a hormone that lowers the level of glucose (a type of sugar) in the blood) injections. A review of the resident's individualized comprehensive care plan (ICCP) revealed a focus area dated 6/9/25 for Diabetes Mellitus Type 2. Interventions included but were not limited to; diabetes medication as ordered by doctor. Monitor/document . Monitor blood sugar per MD (doctor of medicine) orders dated 6/9/25. A review of the Order Summary Sheet ([NAME]) included the following physician orders (POs): A PO, dated 4/8/26, for Humalog KwikPen (a prefilled, disposable insulin injection pen) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) - Inject 5 unit subcutaneously before meals related to HYPERGLYCEMIA (high blood sugar). Hold for Blood Sugar (BS) less than 200. A review of the May 2026 electronic Medication Administration Record (eMAR) revealed that the above PO for Humalog insulin was marked with a check which indicated the medication was administered for 5 doses when the resident's BS was recorded less than 200 for the following dates: 5/2/26 at 11:30 AM= BS 1895/6/26 at 7:30 AM= BS 1895/13/26 at 11:30 AM = BS 1815/19/26 at 11:30 AM = BS 1985/27/26 at (1630) 4:30 PM = BS 189A review of the June 2026 eMAR revealed that the above PO for Humalog insulin was marked with a check as administered for 3 doses when the resident's BS was recorded less than 200 for the following (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dates:6/4/26 at 7:30 AM= BS 1826/10/26 at 7:30 AM= BS 1236/10/26 at 11:30 AM = BS 138On 6/11/26 at 12:42 PM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) stated the check mark on the MARs meant the medication was administered. In the presence of the surveyor, the LPN reviewed Resident #19's POs and stated the resident received 5 units of Humalog before every meal and the insulin had hold parameters for if the BS was below 200 then the insulin would be held. The LPN stated Humalog insulin 5 units should not be given for a BS less than 200 as the resident was already getting insulin coverage as per the sliding scale and if the resident received 5 units for BS less than 200 then it could drop the BS. The surveyor reviewed the May 2026 eMAR and the LPN confirmed her initials and stated that it was her who administered insulin on 5/6/26 when the resident's BS was 189. The LPN acknowledged, It was a mistake and further stated she should have held the insulin. The LPN further stated that we should read the PO before med administration. On 6/11/26 at 1:58 PM, the surveyor interviewed the LPN/Unit Manager (UM), who stated Resident #19 was receiving 5 units of Humalog insulin before meals and the PO had parameters to Hold insulin if the BS was less than 200. In the presence of the surveyor, the LPN/UM reviewed the May 2026 eMAR and stated on 5/2/26 at 11:30 AM, it might have been her who administered the insulin when the resident's BS was 189. The LPN/UM stated the resident should not have received 5 unit of insulin because the BS was below the parameters and the insulin could drop the BS. The LPN/UM stated she should have paid more attention to the PO and should have called the physician when the resident's BS was less than 200. The surveyor made the LPN/UM aware of the above findings for May and June 2026. The LPN/UM acknowledged, I see the BS are low especially on 6/10/26, the BS were 123 and 138 and further stated the nurses need to follow the PO during med administration. On 6/12/26 at 12:12 PM, the surveyor made the Director of Nursing (DON) aware of the above concerns. The DON stated the insulin should not have been given for BS less than 200 as per the PO and the resident could have hypoglycemic (low BS) episodes which meant when the BS drops, the resident could feel weak, diaphoretic (excessive sweating due to a secondary condition), pass out and/or bottom out on us. On 6/12/26 at 1:15 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the DON, the Regional Nurse and the Administrator in Training (AIT). The surveyor made the administration aware of the above-mentioned concerns for Resident #19. A review of the facility's policy Insulin Administration date reviewed 1/26 did not address that the medications should be accurately administered as per physician orders. A review of the facility's Medication Administration policy date reviewed 1/26 did not address that the medications should be accurately administered as per physician orders. NJAC 8:39-11.2 (b); 29.2(d)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, record review, and pertinent facility documentation, it was determined that the facility failed to ensure a.) a medication (Lactulose solution) was properly labelled for one (1) of four (4) medication carts inspected and b.) an expired refrigerated medication (Omeprazole solution) was removed from active inventory for one (1) of two (2) medication refrigerators inspected. The deficient practices were evidenced by the following: 1. On 6/10/26 at 8:16 AM, during the medication administration observation, the Licensed Practical Nurse (LPN #1) was preparing medications for unsampled Resident #64. LPN #1 stated there was a physician's order for Lactulose solution (a medication used to relieve constipation) and removed the bottle from the medication cart. The surveyor with LPN #1 reviewed the bottle for a label. LPN #1 stated the label came off but she knew the bottle of Lactulose was for unsampled Resident #64 and showed the surveyor a corner of a label remaining that was unreadable. LPN #1 asked the surveyor if that was allowed. A review of the Order Summary Report for unsampled Resident #64 revealed a physician's Order for Lactulose Oral Solution 10 GM (grams)/15 ML (milliliters) Give 30 ML by mouth every 12 hours for constipation. On 6/10/26 at 1:18 PM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone who stated she performed unit inspections every month at the facility. The CP also stated all medications should be labelled and any medication from the provider pharmacy should have a label which included the resident's name. The CP added she points out to the nurses any time a label was missing. On 6/15/26 at 9:59 AM, the survey team met with the facility administrative team. The Director of Nursing (DON) stated the Lactulose solution was ordered from the provider pharmacy with a label for unsampled Resident #64. 2. On 6/12/26 at 8:33 AM, the surveyor in the presence of the Unit Manager/LPN (UM/LPN) reviewed the unit medication refrigerator for active inventory of medications. The surveyor observed a 140 ML Omeprazole solution bottle with approximately 38 ML remaining with a Use By date of 5/29/26 for unsampled Resident #67. The UM/LPN stated the Omeprazole solution for unsampled Resident #67 should have been removed because it was past the use by date. A review of the Order Summary Report for unsampled Resident #64 revealed a physician's order with a start date of 12/16/25 for Omeprazole 2 MG/ML soln (solution) (20) Give 10 ML via g-tube (gastrostomy tube) (a tube inserted into the stomach) one time a day related to Gastro-esophageal Reflux Disease without Esophagitis (a chronic digestive condition where stomach acids flows back to the esophagus without inflammation of the esophagus) 10 ML = 20 MG. On 6/10/26 at 1:18 PM, the surveyor interviewed the CP via telephone who stated she performed unit inspections every month at the facility. The CP added that any expired medications should be removed from active inventory. On 6/15/26 at 9:59 AM, the survey team met with the administrative team. The Regional Nurse stated she called the provider pharmacy and was told the Omeprazole solution had a do not use beyond date that was further than the use by date. The Regional Nurse acknowledged the use by date, indicated on the medication, was the date the nurses would have to rely on whether to remove any medication from active inventory. A review of the facility policy dated as last reviewed 12/15/26 for Medication Storage which revealed the purpose was to ensure the safe, secure, and compliant storage of medications in order to maintain drug integrity, prevent diversion, reduce medication errors, and comply with all applicable federal, state, and regulatory requirements for long-term facilities. In addition, the policy indicated medications shall be kept in their original labeled containers and expired medications shall be removed immediately per facility procedure. NJAC 8:39-29.4(a)(g)		