STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46049 Complaint NJ#166361 Complaint NJ#173486 Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) and the Ombudsman's office when a resident eloped from the facility in a timely manner and submit the facility's investigation within 5 days for 1 of 1 resident reviewed for elopement (Resident #123). This deficient practice was evidenced by the following: Refer to F689 On 2/25/25 at 8:43 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #123. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility that included diagnoses but were not limited to; unspecified dementia, low back pain, and chronic pain related to neoplasm (abnormal growth of tissue). A review of comprehensive Minimum Data Set (MDS), an assessment a tool, with an assessment reference date of 7/21/23, reflected a Brief Interview Mental Status (BIMS) score of 7 out of 15, which indicated the resident had severe cognitive impairment. Additionally, the resident was documented as needing supervision (oversight, encouragement or cueing) with activities of daily living (ADLs) which included walking and did not require an assistive device. A review of hospital medical records, dated 7/10/23, indicated the resident had a history of elopement and had required staff supervision while under their care. A nursing progress note (NPP) dated 7/29/23 at 9:53 PM written by Registered Nurse (RN) revealed the following: At 5:00 PM, the RN served the meal tray to the resident. (continued on next page)

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
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 6:00 PM, the RN searched for Resident #123, the resident was not found on the unit and the Licensed Practical Nurse/Supervisor (LPN/S) was notified. At approximately 7:00 PM, the police came to the unit and the RN provided information regarding the resident. The Resident Representative (RR) and the Physician were made aware of the resident's elopement. A NPP dated 7/29/23 at 10:01 PM written by the Assistant Director of Nursing (ADON) indicated the resident was returned to the facility, a body check was completed, there were no visible injuries, and a wanderguard was applied to the resident. There was no documentation in the facility's investigation that indicated notification of the elopement event to the NJDOH and the Ombudsman's office. A review of the submitted AAS-45 (Reportable Event Record/Report) submitted to the NJDOH was dated 8/4/23. The date of event was documented 7/29/23 at 5:30 PM. The AAS-45 further revealed the significant event was called in to the NJDOH on 7/31/23 at 11:05 AM and that the Ombudsman's office was notified 7/29/23. There was no exact time indicated for when the Ombudsman's office was notified by the facility. A review of a police report dated 7/29/23 for the incident, indicated that the police notified the Ombudsman's office regarding the resident's elopement. Ombudsman's office documentation indicated that the police informed them of the resident's elopement and not the facility. A review of the fax cover sheet sent with the facility's investigation to NJDOH revealed the summary and conclusion for the elopement incident was faxed on 8/8/23, 10 days after the event. On 2/27/25 at 11:48 AM, the surveyor interviewed the Director of Nursing (DON) and the DON about reporting facility reported events (FRE). The DON stated that any allegations of abuse, whether substantiated or not, were to be reported within two hours to the NJDOH and the ombudsman's office. The surveyor asked about other significant events, such as resident elopement. The DON did not provide a verbal response at this time and stated that she would review the facility's policy to provide an answer. On 2/27/25 at 12:16 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the DON, and the ADON of the concern with the delayed reporting of Resident #123's elopement. The facility was still looking at policy to provide response for the appropriate notification to the NJDOH and the Ombudsman's office. On 3/3/25 at 10:20 AM, the LNHA, the DON, and the ADON met with the survey team. The LNHA stated the facility followed state and federal regulations on notifying state agencies regarding reportable event. The surveyor asked for Resident #123's elopement when should it be reported to the NJDOH and the Ombudsman's office. The LNHA stated that the incident should have been reported within two hours. There was no additional information provided by the facility. A review of the facility's Accidents and Incidents-Investigating and Reporting Policy, with a last revised date 6/4/24, did not address notification of an incident to the NJDOH and the Ombudsman's office. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Wandering and Elopements Policy, with a last revised date of March 2019, did not address notification of an incident to the NJDOH and the Ombudsman's office. A review of the facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating Policy, with a last revised date of September 2022 revealed under Policy Statement: All reports of abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. NJAC 8:39-9.4(f)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 39885 Complaint NJ #176146 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to; a.) determine the cause, implement a new intervention, and start treatment to prevent further pressure injury/pressure ulcer (PI/PU) for a facility acquired PI/PU for 1 of 2 residents reviewed for PU, (Resident #102), b.) follow the recommendations of the wound care consultant physician for 1 of 2 residents reviewed for PU, (Resident #102), c.) follow a physician order for Braden Scale assessment for 2 of 2 residents reviewed for PU, (Resident #102 and #302), and d.) clarify multiple physician orders for 1 of 2 residents reviewed for PU, (Resident #302). This deficient practice was evidenced by the following: 1. On 2/24/25 at 10:19 AM, Surveyor #1 (S#1) observed Resident #102 seated in a wheelchair and the resident's legs were wrapped with ace bandages. S#1 interviewed Resident #102 who stated that they did not think they had any wounds or PI/PU. On 2/25/25 at 10:25 AM, S#1 interviewed Resident #102's Certified Nurse Assistant (CNA) who stated that Resident #102 had a PU on the heel. On 2/25/25 at 10:28 AM, S#1 interviewed Resident #102's Licensed Practical Nurse #1 (LPN#1) regarding the process for a new PI/PU. LPN#1 stated that when a resident had a new PI/PU that it would be reported to the wound team. She added that an incident report and investigation would be done. She added that a Braden Scale was in the computer. On 2/25/25 at 11:13 AM, S#1 requested from the Licensed Nursing Home Administrator (LNHA) any incident report and/or investigation for Resident #102 that was related to (r/t) the resident's skin. On 2/25/25 at 12:42 PM, S#1 reviewed the facility provided incident report and investigation for Resident #102 which was dated 1/16/25, and included the following: Incident Report: Incident description: The patient (also known as the resident) was seen today by Wound Consultant Physician (WCP), the wound team and the undersigned. The patient noted with a P2 collapsed blister to right lateral heel 6.5 x 6.0 x 0 P2, left lateral heel P2 collapsed blister 4.5 x 3 x 0. There was no conclusion listed on the incident report. WC Multi Wound Chart Details with 2 PU listed and 1 wound listed as blanchable redness to the right, dorsal second toe. Facility Acquired PU Investigation Form which under summary indicated patient has CKD4 (chronic kidney disease stage 4), liver transplant status, recently admitted to hospice Dx (diagnosis) pulmonary fibrosis. Although skin care and turning/positioning provided, wound developed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unavoidable PU Physician Documentation which indicated that despite preventive measures outlined above and in consideration of the underlying clinical conditions identified, this PU is an unavoidable outcome . Care Plan (CP) Report which did not contain the date(s) the actual skin breakdown CP was initiated or the interventions that were placed. A review of Resident #102's Admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to lung transplant status, congestive heart failure and anemia. A review of Resident #102's most recent comprehensive Minimum Data Set (cMDS), an assessment tool, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #102 was cognitively intact. Further review under Section M Skin Conditions indicated the resident had 2 Stage 2 PU which were not present upon admission/entry or reentry. A review of Resident #102's comprehensive CP included the following focus areas: At risk for alteration in skin integrity r/t impaired mobility with an initiated date of 1/10/2025, with the following interventions: Encourage and assist to reposition; use assistive devices as needed; Observe skin condition with ADL (activities of daily living) care daily; report abnormalities; Obtain labs as ordered and report results to physician. Actual skin breakdown r/t right lateral heel P2 with an initiated date of 1/13/2025, with the following intervention that was initiated the same date: Administer treatment (tx) per physician orders (PO). The following interventions were initiated on 1/27/25: Encourage and assist as needed to turn and reposition; use assistive devices as needed; Specialty low air loss mattress/wheelchair; Suspend/float heels as able; Use pillows and/or positioning devices as needed; WC as needed. The CP indicated that Resident #102 had developed a PU on 1/13/25. The incident report for the development of the PU was dated 1/16/25 when the WCP saw the resident. There were no added interventions in addition to wound treatment to prevent further PI/PU until 1/27/25. A review of Resident #102's progress notes (PN) did not include any description of skin breakdown prior to 1/16/25. A review of Resident #102's January 2025 electronic Treatment Administration Record (eTAR) included a PO for Braden Scale on admission x three weeks post admission in the evening every Mon (Monday) for three Weeks with a start date of 1/13/2025, which was not administered or signed by the nurse as being done for 1/13/25, 1/20/25 and 1/27/25. Further review of the eTAR included a PO for Braden Scale on admission x three weeks post admission one time only for one Day with a start date of 1/10/2025, which was signed by a nurse as administered on 1/10/25. A review of Resident #102's electronic medical record under the Forms tab (assessments and evaluations section) revealed that the only Braden Scale assessment that was done was on admission and it was included in the Resident Evaluation. The PO was not followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 10:28 AM, S#1 interviewed the Registered Nurse (RN) regarding the process for assessing skin and new PI/PU. The RN stated that upon admission, the skin was assessed and a Braden Scale assessment was done. She added that a second day skin check was also ordered but that one was in the PN. The RN stated that there was an order for a weekly skin observation and it would note no skin breakdown, a previously identified wound or a new wound. S#1 asked the RN what the process was if a new skin issue was seen between the weekly observation, and the RN stated that for every new opening a risk management/skin incident report would be done. She added that it would be reported to the wound team that came to the facility on Monday and Thursday. The RN further stated that there would be a PN that would document the location and size. She added that the CP would be updated by unit manager (UM). The RN stated that the wound team also saw residents when they first came to the facility. On 2/26/25 at 10:37 AM, S#1 interviewed the first floor UM regarding the process for a new skin issue. The first floor UM stated that when a staff saw a new opening that the staff would report it to the nurse or herself and that they would notify the wound team. She added that they would put an air mattress and skin prep before the wound team saw them. The first floor UM stated that the new skin issue would be documented in a PN and an incident report would be done. She added that the CP would be updated usually by the Infection Preventionist (IP) or that she herself could also do it. S#1 asked the first floor UM about Resident #102's incident report. The first floor UM stated that the wound team would visit all new admits and also if a referral was done. She added that maybe the wound team saw the PI/PU when they assessed the resident and in that case there would not have been a note before. S#1 then asked the first floor UM for more information regarding the CP that was initiated on 1/13/25 for an actual skin breakdown to the right lateral heel. The first floor UM stated she would get back to S#1. On 2/26/25 at 10:58 AM, S#1 interviewed the Assistant Director of Nursing (ADON) regarding the process of a new skin issue. The ADON stated that an assessment was done and would be documented in the PN and an incident report would also be done. She added the regular doctor would be notified and they would refer to wound healing. The ADON stated that usually there would be some documentation about the issue prior to the wound consultant. The ADON stated that when there was an actual opening a CP would be initiated. The ADON stated that Resident #102 was transferred from a sister facility. The ADON stated that Resident #102's PU was facility acquired. S#1 asked the ADON the reason there was no documentation regarding the PU when there was a CP initiated. The ADON stated she would have to look into it. On 2/26/25 at 12:37 PM, the ADON stated that CP was initiated by accident. She added that the resident was admitted to the facility and three days later when the CP was being reviewed the staff clicked on wound and then revised it on 1/16/25 when they saw the fluid filled blister. The ADON stated that according to the Nurse Practitioner note the resident was seen and noted no pressure wound on 1/13/25. A review of Resident #102's wound consultant notes (WCN) dated 1/16/25, included the following orders: Wound #2 Right, Lateral Heel Other Orders Wound Dressing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Apply: - Skin Prep. Foam Dressing Every Mon and Thursdays (Thur). Offload. Monitor for changes. Wound #3 Left, Lateral Heel Other Orders Wound Dressing Apply: - Skin Prep. Foam Dressing Every Mon and Thur. Offload. Monitor for changes. Wound #4 Right, Dorsal Second Toe Other Orders Wound Dressing Apply: - Skin Prep BID (twice a day) with Hygiene. Offload. Monitor for change A review of Resident #102's WCN dated 1/23/25, included the following orders: Wound #2 Right, Lateral Heel Other Orders Wound Dressing Apply: - Skin Prep. Foam Dressing Every Mon and Thur. Offload. Monitor for changes. Wound #3 Left, Lateral Heel Other Orders Wound Dressing Apply: - Skin Prep. Foam Dressing Every Mon and Thur. Offload. Monitor for changes. Wound #4 Right, Dorsal Second Toe Other Orders Wound Dressing Apply: - Skin Prep BID with Hygiene. Offload. Monitor for changes. A review of Resident #102's January 2025 eTAR included the following orders that were not the recommended orders that were written by the WCP: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skin prep to bilateral heels, and second toe (blanchable redness) every day shift for collapsed blister with an order date of 1/18/25, and a start date of 1/19/25. The order was not started until three days after the resident was seen by the WCP. The WCP order was for bilateral heels to have skin prep applied and a foam dressing on Mon and Thur and not be done daily. The WCP order was for the second toe to have skin prep applied two times a day and not only once a day. A review of Resident #102's WCN dated 1/27/25, included the following orders: Wound #2 Right, Lateral Heel Other Orders Wound Dressing Apply: - Skin Prep. BID Leave open to air. Offload. Monitor for changes. D/C Treatment - Foam Dressing Wound #3 Left, Lateral Heel Other Orders Wound Dressing Apply: - Skin Prep. BID Leave open to air. Offload. Monitor for changes. D/C Treatment - Foam Dressing Wound #4 Right, Dorsal Second Toe was resolved. A review of Resident #102's eTAR included the following order that was not the recommended order that was written by the WCP: Skin prep to bilateral heels (blanchable redness) every day shift for collapsed blister with a start date of 1/29/25. The WCP recommended that the skin prep was to be applied to bilateral heels two times a day. On 2/27/25 at 11:01 AM, S#1 interviewed the LPN regarding WCP. The LPN stated that the WCP after the assessment would pass the note to the UM and she put the notes in. She added that usually the tx was put in place the same day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 12:42 PM, S#1 notified the LNHA, Director of Nursing (DON) and ADON the concerns that Resident #102 did not have any documentation of a PI/PU when a CP for actual skin breakdown was initiated on 1/13/25 and the only description and measurement of the PI/PU was not until the incident report on 1/16/25 that the WCP did; there was no conclusion for the investigation related to the cause of the PI/PU and an added intervention to prevent further PI/PU until 1/27/25; the recommended initial tx and subsequent tx for Resident #102 from the WCP was not followed and an initial tx was not started until three days after the initial wound consult (WC) visit; and the order for Braden Scale was not followed. On 3/3/25 at 10:20 AM, the survey team met with the LNHA, DON, ADON and MDS Coordinator for their responses to the concerns that they were notified of from the previous day. At 10:41 AM, the ADON stated that there was no additional information for Resident #102. A review of the facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol Policy, with a revised date of March 2014, included the following: Assessment and Recognition 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history or pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; d. Current tx, including support surfaces: . Cause Identification 1. The physician will help identify factors contributing or predisposing resident to skin breakdown; . 2. The physician will help clarify relevant medical issues; . Tx/Management 1. The physician will authorize pertinent orders related to wound tx, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated for type of skin alteration 2. The physician will help identify medical interventions r/t wound management; . Monitoring (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or non-healing wounds. 2. The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions A review of the facility's Accidents and Incidents-Investigating and Reporting Policy, with a revised date of July 2017, included the following: Policy Statement All accidents or incidents involving residents, employees, visitors, vendor, etc. occurring on our premises shall be investigated and reported to the administrator. Policy Interpretation and Implementation 1. The nurse supervisor/charge nurse and/or the department director of supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/Accident form: a. The date and time the accident or incident took place; b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.); . k. Any corrective action taken; l. Follow-up information; m. Other pertinent data as necessary or required; and . 46049 2. On 2/26/25 at 9:48 AM, Surveyor #2 (S#2) reviewed the electronic medical record (EMR) of Resident #302. A review of the AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to; left and right knee contracture (a fixed tightening of muscle, tendons, ligaments, or skin preventing normal movement of the associated body part), left and right hip contracture, left and right ankle contracture, muscle wasting atrophy (loss of muscle mass and strength), osteoporosis (condition in which bones become weak and brittle), dysphagia (difficulty swallowing foods or liquids), malnutrition, failure to thrive, and Alzheimer's disease. A review of the cMDS, with an assessment reference date of 6/14/24, reflected a BIMS score of 99, which indicated the resident was unable to complete the interview. Under Section M (Skin Conditions), the resident was coded as a risk for pressure ulcer/injury and the resident had an unhealed unstageable PU. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of PO included the following: A PO dated 6/7/24, indicated Braden scale on admission times three weeks post admission every evening shift, every Friday for three weeks. Wound tx #1: A PO dated 6/7/24, indicated apply silver sulfadiazine cream (an antibiotic cream used to treat or prevent serious skin infections) 1% to sacral area topically every day and evening shift for wound care after cleansing with normal saline (NS) then cover with dry dressing. The order had a start date of 6/8/24, and was discontinued (d/c) on 6/17/24. Wound tx #2: A PO dated 6/17/24, indicated apply santyl ointment 250 Unit/gm (grams) (an ointment used to remove damaged tissue from chronic skin ulcers and severely burned areas) to sacrum topically every day shift for PU post cleanse with NS cover with dry dressing. The order had a start date of 6/18/24, and a d/c date of 7/1/24. Wound tx #3: A PO dated 6/24/24, indicated to apply compound ointment- (flagyl) metronidazole (an antibiotic) ointment 0.5% with (Bactroban) muciporin (cream used to treat skin infections) 1% (1:1) (100 gm) every day shift for PU post cleanse with Dakin's solution, cover with dry dressing. The order had a start date of 6/25/24, and was d/c on 7/23/24. Wound tx #4: A PO dated 7/1/24, indicated to apply Mupirocin Ointment (Bactroban) 2% to sacral area topically every day and evening shift for PU post hygiene, cleanse with Dakin's (mix with santyl). The order had a start date of 7/2/24, and was d/c on 7/8/24. Wound tx #5: A PO dated 7/1/24, indicated to apply santyl ointment 250 unit/gm to sacrum topically every day shift for PU post cleanse with Dakin's cover with dry dressing (Santyl mix with Bactroban [mupirocin]). The order had a start date of 7/2/24, and was d/c on 7/8/24. Wound tx #6: A PO dated 7/8/24, indicated to apply Mupirocin Ointment 2% to sacrum topically every day and evening shift for P4 [PU stage 4] post cleanse with Dakin's, pack lightly with calcium alginate cover with dry dressing. The order had a start date of 7/9/24, and was d/c on 7/12/24. Wound tx #7: A PO dated 7/8/24, indicated to apply to sacrum compound ointment -metronidazole ointment 0.5% with muciporin 1% (200 gm) every day shift for P4 post cleanse with Dakin's, pack lightly with calcium alginate cover with dry dressing. The order had a start date of 7/10/24, and a d/c date of 7/31/24. Wound tx #8: A PO dated 7/23/24, indicated to apply to sacrum compound ointment-metronidazole ointment 0.1% with gentamycin 1% (100 gm) every day shift for P4[PU stage 4] post cleanse with Dakin's. pack lightly with calcium alginate cover with dry dressing. The order had a start date of 7/29/24, and was d/c on 7/31/24. A review of WCN revealed the following: On 6/3/24, the WCP recommended wound orders for the resident's sacral PU to apply Silvadene two times a day and as needed (PRN) with hygiene. Miconazole (antifungal) cream to peri (around) wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24, the WCP recommended wound orders for the resident's sacral PU to cleanse with NS, apply santyl and 3 in 1 cream to peri-wound daily. On 6/18/24, the WCP recommended wound orders for the resident's sacral PU to cleanse with NS, apply santyl and 3 in 1 cream to peri-wound daily. On 6/24/24, the WCP recommended wound orders for the resident's sacral PU to d/c santyl and 3 in 1 cream; to cleanse with dakin's solution, apply flagyl, and Bactroban daily. On 6/27/24, the WCP recommended wound orders for the resident's sacral PU as, cleansing with Dakin's solution, apply flagyl, Bactroban, and cover with dry dressing daily and PRN. On 7/1/24, the WCP recommended wound orders for the resident's sacral PU to d/c flagyl; cleanse with dakin's, apply santyl, Bactroban, and apply dry dressing daily and PRN. On 7/4/24, the WCP recommended wound orders for the resident's sacral PU to cleanse with dakin's solution, apply santyl, Bactroban, and apply dry dressing daily and PRN. On 7/11/24, the WCP listed the resident's recommended wound orders as cleanse with Dakin's solution, pack with flagyl ointment, calcium alginate, Bactroban and cover with dry dressing daily and PRN. On 7/15/24, the WCP listed the resident's wound orders as cleanse with Dakin's solution, pack with flagyl ointment, calcium alginate, Bactroban and cover with dry dressing daily and PRN. On 7/18/24, the WCP listed the resident's wound orders as cleanse with Dakin's solution, pack with flagyl ointment, calcium alginate, Bactroban and cover with dry dressing daily and PRN. On 7/22/24, the WCP listed the resident's wound orders as cleanse with Dakin's solution, pack with calcium alginate, flagyl ointment, gentamycin cream and foam dressing daily. Additionally, 3 in 1 cream to peri (around) wound. On 7/22/24, the WCP listed the resident's wound orders to d/c calcium alginate; cleanse with Dakin's solution, pack with gauze, flagyl ointment, gentamycin cream and foam dressing daily. Additionally, 3 in 1 cream to peri (around) wound. On 7/25/24, the WCP listed the resident's wound orders as cleanse with Dakin's solution, pack with calcium alginate, flagyl ointment, gentamycin cream and foam dressing daily. Additionally, 3 in 1 cream to peri (around) wound. A review of the June 2024 eTAR revealed: The order entries for wound tx #2 and #3 were both signed as administered for the resident's sacral wound from 6/26/24 to 6/30/24. A review of the July 2024 eTAR and the electronic Medication Administration Record (eMAR) revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The order entries for wound tx #3, #4, and #5 were signed as administered for the resident's sacral wound from 7/2/24 to 7/8/24. The order entries for wound tx #3, and #6 were signed as administered for the resident's sacral wound from 7/9/24 to 7/12/24. The order entries for wound tx #3, and #7 were signed as administered for the resident's sacral wound from 7/10/24 to 7/23/24. The order entries for wound tx #7 and #8 were signed as administered for the resident's sacral wound from 7/29/24 to 7/31/24. On 2/26/25 at 12:24 PM, S#2 interviewed the IP. The IP stated that the resident had one sacral wound which was present upon admission to the facility. The resident was seen by the wound consultants who recommended wound tx for the resident. The IP stated that there was wound tracking documentation for each resident that kept weekly track of their wound status and tx recommendations. The IP stated she would provide the wound tracking for the resident. On 2/27/25 at 11:40 AM, S#2 interviewed the DON and the ADON about Resident #302's wound. The ADON and DON stated the resident had one sacral pressure ulcer and had also received tx for moisture associated skin damage. The DON provided the wound tracking form, a facility tool used to keep track of the resident's wound progress and wound tx. The wound tx corresponded to the WCP notes. S#2 reviewed with the DON and ADON the eMAR and eTAR of Resident #302 about the multiple wound tx that were signed as administered to the resident's sacral wound. S#2 asked if the multiple wound tx signed were ordered to be administered together. The DON and ADON stated that an ordered topical tx may have been unavailable at the time, and another order was placed until the topical tx was available. The DON stated that if there was a temporary order until an original tx was available, the nurses should clarify the orders with the physician, d/c the original tx order while the alternative tx was ordered. The DON and ADON acknowledged it would be expected if there were multiple tx orders which did not specify to use in combination, the nurses should have called the physician to clarify the orders. The DON and ADON stated they would review further to provide any additional response. On 2/27/25 at 12:16 PM, S#2 notified the LNHA, the DON, and the ADON of the above concerns. On 3/3/25 at 9:46 AM, S#2 interviewed LPN #2 who stated Braden scale assessments were completely weekly x 3 after the resident's admission per admission protocol. LPN#2 stated it would be found documented under the forms section of the EMR when completed. A review of the June 2024 eTAR indicated a Braden scale assessment was to be completed on 6/14/24, 6/21/24, and 6/28/24. The eTAR entries for 6/14/24 and 6/21/24 were signed as completed by the nurses. The 6/28/24 entry was left blank by the nurse. A review of the EMR for Braden scale assessments revealed there were no Braden scale assessments found completed for 6/14/24, 6/21/24 and 6/28/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/3/25 at 10:00 AM, S#2 interviewed the DON about Braden scale assessments upon admission. The DON stated it was done as part of the facility's admission protocol and when completed could be found documented with the skin assessment of the resident. S#2 notified the DON of the concern that no Braden scale evaluation was found for Resident #302 for the 3 weeks after admission as per the PO and the facility's protocol. The DON stated she would review to provide documentation of the Braden scale evaluations completion. On 3/3/25 at 10:20 AM, the DON, ADON, and LNHA met with the survey team. The DON and ADON stated they had no additional information to provide for the concerns r/t Resident #302. A review of the facility's Medication and Treatment Orders Policy, revealed under Policy Statement, Orders for medications and treatments will be consistent with principles of safe and effective order writing. Policy Section: A review of the facility's Pressure Injury Risk Assessment Policy, revealed under General Guidelines revealed: . 4. Use only a facility-approved risk assessment tool to obtain risk assessment data . 7. Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition. Orders for medications and treatments will be consistent with principles of safe and effective order writing . NJAC 8:39-27.1 (a)(e)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Complaint # NJ: #166361; #173486 Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to adequately assess a cognitively impaired resident, with a history of elopement as an elopement risk, and implement interventions to prevent the resident from exiting a secured unit, subsequently the facility, which resulted in the resident eloping on 7/29/23. This deficient practice was identified for 1 of 1 resident reviewed for elopement (Resident #123). On 7/29/23, Resident #123 who was cognitively impaired and ambulated independently with a history of elopement, eloped from the facility and was last seen by staff at 5:30 PM, in the television (TV) room. At 6:00 PM, the Registered Nurse (RN #1) could not locate the resident, and a code gray was called, and the facility began to search for the resident. The local police department and the police department from the adjacent town were called. The police from the adjacent town went to the resident's last known home address to conduct a wellness check and located the resident approximately four miles away from the facility. The resident was returned to the facility on [DATE] at approximately 9:40 PM, and was assessed with back pain. The facility's failure to provide adequate supervision to a cognitively impaired resident with a history of elopement who was able to exit the facility unsupervised posed a likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation which ran from 7/29/23 at 5:30 PM, when Resident #123 was last seen by staff, until 7/29/23 at 9:40 PM, when the police located Resident #123 and returned the resident to the facility. The IJ was Past Non-Compliance (PNC). The IJ was identified from 7/29/23 at 5:30 PM, to 7/29/23 at 9:40 PM, when the resident was found by the police and returned to the facility. The facility's administration was notified of the IJ on 2/26/25 at 3:30 PM. The facility submitted an acceptable Removal Plan (RP) on 2/27/25 at 9:42 AM. The facility was back in compliance when the facility addressed the situation by immediately searching and locating the resident; completed a full body assessment of the resident; a wanderguard alarm (personal alarm that triggers at exits to alert staff) was applied to the resident; the resident was re-assessed for an elopement risk; the facility reviewed the event with clinical leadership to identify areas for improvement and initiated immediate corrective actions and performance improvement; the resident's individualized comprehensive care plan (ICCP) was updated; and all staff were in-serviced on the facility's elopement protocol. The survey team verified the completion of the RP was 7/31/23, during an on-site survey on 3/6/25, and determined the IJ was PNC. This deficient practice was evidenced by the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a facility's Wandering and Elopements policy with a last revised date of March 2019, included Policy Statement: The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation: 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's [care plan] will include strategies and interventions to maintain the resident's safety . A review of the facility's Admission Assessment and Follow Up: Role of the Nurse policy with a last revised date of September 2012, included Purpose: .to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the [care plan], and completing required assessment instruments .Steps in the Procedure: 10. Conduct an admission assessment (history and physical), including .a. A summary of the individual's recent medical history, including hospitalization s, acute illnesses, and overall status prior to admission. b. Relevant medical, social, and family history. c. A list of active medical diagnoses and patient problems . On 2/25/25 at 8:43 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #123. A review of the Admission Record face sheet (an admission summary) reflected that the resident had diagnoses that included but were not limited to; unspecified dementia, low back pain, and chronic pain related to neoplasm (abnormal growth of tissue). A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 7/21/23, reflected a Brief Interview Mental Status (BIMS) score of 7 out of 15, which indicated the resident had severe cognitive impairment. Additionally, the resident was documented as needing supervision (oversight, encouragement or cueing) with activities of daily living (ADLs) which included walking and did not require an assistive device. A review of hospital medical records dated 7/10/23, indicated the resident had a history of elopement and had required staff supervision while under their care. A review of the resident's admission elopement risk assessment (ERA), a questionnaire completed by the nurse to determine if the resident needed additional safety measures dated 7/14/23, determined that based on the potential risk factors, Resident #123 was not at risk for elopement. The Licensed Practical Nurse (LPN #1), who completed the assessment, answered Yes to the resident being able to ambulate independently and had a history of elopement while at home or in another setting. LPN #1 answered No on the assessment for the resident being cognitively impaired or having a diagnosis such as dementia. (The resident was both cognitively impaired with a diagnosis of dementia on admission) A further review of the ERA revealed that the initial assessment was edited by a user to change the resident's risk for elopement from at risk to not at risk for elopement. The surveyor was unable to see the audit history of the assessment at that time. A review of the resident's ICCP included a focus area for cognitive loss due to dementia. The ICCP did not include a focus area initiated for the resident being at risk for elopement prior to the resident's actual elopement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Nursing Progress Note (NPN) dated 7/29/23 at 9:53 PM, written by RN #1 revealed the following: At 5:00 PM, RN #1 served the meal tray to the resident. At approximately 6:00 PM, RN #1 searched for Resident #123. The resident was not found on the unit and the LPN/Nurse Supervisor (LPN/NS #1) was notified. At approximately 7:00 PM, the police came to the unit and RN #1 provided information regarding the resident. The Resident's Representative (RR) and the Physician were made aware of the resident's elopement. A review of the NPN dated 7/29/23 at 10:01 PM, written by the Assistant Director of Nursing (ADON), indicated that the resident was returned to the facility; a body check was completed; there were no visible injuries; and a wanderguard was applied to the resident. The ADON documented that the resident verbalized walking out the front door and the resident just started walking and had planned to come back after their walk. A review of the NPN dated 7/29/23 at 10:16 PM, written by RN #1, revealed that the RN was notified by LPN/NS #1 that the resident was found by police at their last known home address. At approximately 9:30 PM, the resident returned to the facility. A body assessment was completed with no bruises or injuries noted, and the resident requested pain medication. The RN provided medication and a wanderguard was placed on the resident and functioning. A review of the facility's undated investigation revealed the following: Under the background section: The resident had a diagnosis of unspecified dementia, ambulated independently, and did not verbalize wanting to leave facility. The resident's BIMS was documented as 10 (moderately impaired cognition), which did not match with the comprehensive assessment completed by the facility prior to the elopement incident. Under the timeline for the event on 7/29/23, was the following: At 3:00 PM, the resident was seen by RN #1 during shift change in their room. At 5:00 PM, RN #1 delivered the resident's dinner tray and Resident #123 was sitting on their bed. At 5:30 PM, the resident was seen in the TV room by two nurses at the time. At 6:00 PM, LPN #2 went to check on Resident #123 in their room and noticed the resident was not there and had not touched their tray. At 6:30 PM, LPN/NS #1 was made aware and staff continued to search for the resident. At 6:45 PM, a code gray was initiated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 7:15 PM, the RR and the primary Physician were notified of the resident's elopement. At 7:38 PM, the local police department were called. At 7:45 PM, the local police came and interviewed staff. At 7:50 PM, LPN/NS #1 called the police department in the adjacent town where the resident last resided to request a wellness check at the home. At 8:45 PM, LPN/NS #1 was made aware by the local police department to prepare for a canine (K-9; police dog) search to be conducted at the facility. At 8:55 PM, the police department in the town where the resident last resided called LPN/NS #1 and informed her that Resident #123 was found at that location. At 9:00 PM, the facility informed the local police department that the resident was found during a wellness check by the adjacent town's police department. At 9:05 PM, the ADON requested from the local police department for the resident to be transported back to the facility. At 9:40 PM, Resident #123 was back in the facility. A body check was performed with no visible injuries. A wanderguard was applied to the resident. The staff interviewed the resident, who verbalized walking out the front door, and continued to walk until they reached their apartment. The resident stated to staff that they planned to come back to the facility after their walk. Under Intervention, the following were included: A wanderguard was applied to the resident's right ankle; an elopement assessment was done; a full body assessment was done upon the resident's return; and the resident complained of back pain and medication was administered. Under Conclusion of the Investigation, it documented a summary of the event. The conclusion did not include how the resident exited the facility. On 2/25/25 at 10:57 AM, the surveyor interviewed the LPN/Unit Manager (LPN/UM #1) about the resident's elopement. LPN/UM #1 stated that she did not work the day the resident eloped and she could not speak to the actual event. LPN/UM #1 recalled that at the time, the resident was not considered an elopement risk and that staff received in-service education after the elopement event. LPN/UM #1 stated at the time of the incident, the third floor only had a wanderguard alarm system for the elevator which locked the elevator if a resident with a wanderguard alarm went to it. LPN/UM #1 further explained the electromagnetic lock on the double doors of the unit were not there at the time of the elopement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/25/25 at 11:40 AM, the surveyor interviewed RN #1, who recalled not being able to find the resident; searched for the resident; and notified LPN/NS #1. RN #1 stated LPN/NS #1 informed the Director of Nursing (DON) and the ADON; the police were called; and the resident was later found at their last known address. RN #1 further explained a body assessment was performed when the resident returned to the facility and the Physician was called. RN #1 could not recall if it was determined how the resident exited the facility. RN #1 recalled after the resident's elopement, education was provided by the Nurse Educator to staff. On 2/25/25 at 11:52 AM, the surveyor interviewed LPN/NS #1, who recalled RN #1 informed her that the resident could not be found; a code gray was initiated; the resident was not found in the facility; and the local police, DON, and Licensed Nursing Home Administrator (LNHA) were called. LPN/NS #1 further explained that the local police department searched for the resident. LPN/NS #1 stated she also called the police department in the town of the resident's last known address, and the resident was found during the wellness check at that address. The resident was returned to the facility; a head-to-toe assessment was completed; and a wanderguard was applied to the resident. LPN/NS #1 stated the RR and the Physician were made aware of the resident being located. LPN/NS #1 could not speak to Resident #123's risk for elopement as she was unfamiliar with the resident at the time of the incident. LPN/NS #1 stated that camera footage was reviewed at the time of the incident by the facility, but she could not recall if it was determined how the resident exited the facility. The surveyor asked LPN/NS #1 about completion of the ERA for residents, and LPN/NS #1 stated the ERA were completed upon admission and at least quarterly. LPN/NS #1 stated based on the entries answered on the assessment, a result of whether the resident was at risk for elopement or not was automatically triggered. LPN/NS #1 stated that if the resident was triggered to be at risk for elopement, then an ICCP was initiated. On 2/25/25 at 12:20 PM, the surveyor interviewed the Director of Maintenance (DM), who confirmed that if camera footage needed to be reviewed, he was asked to help pull the footage for review. The DM recalled when the resident had an elopement incident, but he could not recall how the resident exited the facility. The DM stated at the time of the incident, there were not as many cameras in the facility as they had now. The DM could not say how long camera footage was stored for at the facility. On 2/25/25 at 12:28 PM, the surveyor interviewed the ADON about Resident #123's elopement and ERA. The ADON stated at the time of the incident, she was notified by staff that the resident could not be located. The ADON stated she arrived at the facility around the same time the resident had been returned to the facility. The ADON stated at the time of the incident, there were only cameras in the stairs at the first floor and the front lobby. The ADON recalled reviewing camera footage with other staff, and that it could not be determined how the resident exited the facility since the resident was not seen on the cameras. The ADON stated that after the incident, an ERA was completed; a wanderguard was applied to the resident; and the electromagnetic lock and keypad door was added to the unit. The ADON stated prior to incident, there was only a wanderguard alarm system for the elevator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At that same time, the surveyor asked the ADON about how elopement risk was determined for a resident. The ADON replied that upon admission, the resident's medical records from the sending facility and medical history were reviewed to identify the resident's risk factors and the facility's ERA was completed by the nurse. The ADON stated the nurse answered the questions on the ERA and it automatically triggered whether the resident was at risk for elopement. The ADON confirmed it was expected that the nurses followed up if a resident triggered as a risk for elopement and an ICCP was initiated with appropriate interventions and updated as needed. On 2/25/25 at 1:26 PM, the surveyor interviewed LPN #1 over the phone about the ERA completion. LPN #1 stated the ERA was completed as part of a resident's admission assessment and at least quarterly. LPN #1 stated that the nurse answered the questions on the ERA based on the resident's history which included a review of their medical records from the sending facility. LPN #1 further explained that the results of whether the resident was at risk for elopement was automatically triggered on the assessment. LPN #1 stated that an assessment could be edited by the person completing it and she was not sure if another person could edit the assessment. The surveyor asked LPN #1 about the elopement risk assessment for Resident #123 which was completed on 7/14/23, and LPN #1 replied that she could not recall the details about completing or editing the assessment. On 2/25/25 at 1:46 PM, the surveyor interviewed the DON and the ADON about the facility's protocol and Resident #123's elopement incident. The DON stated that residents were assessed for elopement risk factors such as verbalizing desire to leave, demonstrating exit seeking behavior, having a history of elopement, and if they were cognitively impaired. An ERA was completed by the nurse. If the resident was triggered as a risk for elopement, appropriate interventions such as, a photo of the resident was placed at the receptionist's desk; a wanderguard was applied to the resident; and initiation and update of an ICCP was implemented. The DON further stated that the hospital medical records and the resident's overall history were reviewed upon admission to the facility to identify if the resident was a risk for elopement. On that same date and time, the DON and ADON confirmed that the third-floor nursing unit at the time of elopement was considered a secure unit even though it was not a locked unit. The surveyor asked what a secured unit meant, and the DON and the ADON replied that the residents were supervised and could not leave the unit unattended. Furthermore, the ADON and the DON stated an investigation of an incident was conducted in coordination between nursing management and the LNHA. Individual statements were collected for the incident, and an interdisciplinary team (IDT) met to complete a root cause analysis as part of the conclusion and investigation findings. The DON and ADON stated that the facility could not determine the resident's exit point from the facility after reviewing cameras and interviewing staff. The DON and the ADON stated that they reviewed the camera footage for the front lobby, back exit door, and 1st floor stairway, which were the only cameras in the facility at that time, and the resident was not seen on any of the cameras at the time of the incident. The DON and the ADON could not speak to how long camera footage was stored at the facility and would find out if the camera footage was still available to review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At that same time, the surveyor asked the ADON and the DON if an ERA could be edited. The DON stated that only the nurse completing the assessment could edit the assessment. The surveyor with the DON and the ADON reviewed the ERA for Resident #123 completed on 7/14/23. The DON and the ADON acknowledged that the assessment did not document that the resident had a diagnosis of dementia, and it should have been based on the resident's medical history. The DON and ADON also acknowledged that the resident was documented as having a history of elopement and ambulated independently which were risk factors for elopement. The DON and the ADON could not speak to why it was noted that the assessment results had an edited response and would provide an audit history for the assessment. The DON and the ADON acknowledged that it was expected that the nurses completed the assessments accurately and if an elopement risk was triggered for the nurse to initiate an ICCP and the appropriate interventions for the resident. The surveyor reviewed with the DON and the ADON the hospital medical records for Resident #123. The ADON and the DON confirmed that the resident was considered an elopement risk at the time of admission since the resident had a history of elopement and a diagnosis of dementia. On 2/25/25 at 2:50 PM, the DON informed the surveyor that the camera footage was no longer available as it could not go back that far. The DON provided an audit history report for the ERA completed on 7/14/23. A review of the audit history report revealed that on 7/14/23 at 11:52 PM, the assessment results for the resident were at risk for elopement (implement plan of care for unsafe wandering/exit seeking behavior). On 7/14/23 at 11:58 PM, LPN #1 edited the entry to reflect that the resident was not at risk for elopement at this time. On 2/25/25 at 3:02 PM, the surveyor met with the LNHA, DON, ADON, and LPN/UM #1. The LNHA was not the administrator at the time of the incident and could not speak to the specifics of the event. The DON and ADON reiterated that prior to the incident, there was only a wanderguard alarm on the elevator and that residents were required to be accompanied by staff if they left the third floor. The facility expressed interventions were put into place after the event to ensure that it would not recur. The acceptable Removal Plan on 2/27/25 at 9:42 AM, indicated the action the facility took to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: the staff initiated the elopement protocol and contacted the police to search for the resident; Resident #123 was located, returned to the facility, and a full body assessment was completed; a wanderguard was applied to the resident; Resident #123's ICCP was updated to include a risk for elopement with interventions that included wanderguard placement and 30 minute monitoring; an ERA was completed; the facility reviewed the event with clinical leadership to identify areas for improvement and initiated immediate corrective actions and performance improvement; an electromagnetic lock was applied to the double doors on the third-floor unit; and staff were educated on the facility's elopement protocol including awareness of elopement risk factors, evaluation of elopement risk, interventions to prevent elopement, and elopement response. The facility self-corrected the deficient practice and it was determined that the IJ was Past Non-Compliance (PNC); that the facility corrected their non-compliance on 7/31/23. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 3/6/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 COMPLAINT #NJ175735 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to provide or obtain routine medications in order to meet the needs of each resident for 3 of 35 residents reviewed (Residents #5, #32, and #352). This deficient practice was evidenced by the following: 1. On 2/26/25 at 7:57 AM, the surveyor observed Licensed Practical Nurse #1 (LPN#1) prepared and administered medications (meds) of Resident #5 (from the 2nd floor unit). LPN#1 informed the surveyor that there was no available Florastor (used as a probiotic, or friendly bacteria, to prevent the growth of harmful bacteria in the stomach and intestines) 250 mg (milligrams) in the medicine (med) cart. LPN#1 stated that she would check later in the back up machine for Florastor. LPN#1 did two residents for med pass observation. The surveyor did not observed LPN#1 went to get the Florastor or notified the physician of unavailable med. The surveyor reviewed the medical records for Resident #5. A review of the Admission Record (AR, an admission summary) reflected that Resident #5 was admitted to the facility with the diagnoses which included but not limited to other sequelae of cerebral infarction (ischemic stroke) and ulcerative colitis (is a chronic condition characterized by an abnormal immune response where the immune system attacks the cells in the digestive tract. This leads to inflammation and ulcers in the lining of the large intestine and rectum), unspecified, without complications. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/8/25, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated severely impaired cognition. A review of the electronic Medication Administration Record (eMAR) revealed that the resident had a physician's order (PO) with a start date of 4/21/22 for Florastor capsule (cap) 250 mg give one cap by mouth two times a day for GI (gastrointestinal) stabilizer. The above order for Florastor was transcribed to the February 2025 eMAR, to be administered at 9:00 AM and 5:00 PM. A review of the Order Audit Report revealed that the Florastor 250 mg cap was reordered by LPN#2 on 1/21/25 and the med was exhausted on 1/22/25. On 2/26/25 at 10:51 AM, the surveyor observed LPN#1 on the 1st floor. The surveyor asked if she was able to administer the Florastor to Resident#5, and she responded that she was about to go and get it from the backup machine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the back up room, a contracted Staff from the backup company informed LPN#1 that it would be 15-20 minutes more before the LPN could use the machine. The surveyor asked LPN#1 if she notified the physician about the med, and she responded that she would call the physician later if she was unable to administer or get the med. LPN#1 further stated that she would call and follow up with pharmacy. A review of the medical records revealed that there was no documented evidence that Resident #5's physician was notified that the Florastor was unavailable. On 3/3/25 at 10:19 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Assistant DON (ADON), and the surveyor notified them of the concern with med pass observation and unavailable med of Resident #5. A review of the provided packing list of the ADON on 3/4/25 at 10:12 AM, for shipping dates of 12/13/24 and 12/18/24, revealed that the facility did not have a backup med for Florastor. 2. On 2/24/25 at 11:06 AM, the surveyor observed Resident #32 seated in a wheelchair in front of the elevator with other residents. The resident afterward was propelled by Recreation Aide, who informed the surveyor that the resident will be going down for lunch. The surveyor reviewed the medical records for Resident #32. A review of the AR reflected that Resident #32 was admitted to the facility with the diagnoses which included but not limited to; Parkinson's disease (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement) without dyskinesia, without mention of fluctuations, other specified persistent mood disorders, generalized anxiety disorder, bipolar disorder (a mental health condition characterized by significant mood swings) unspecified, and major depressive disorder, single episode, unspecified. A review of the most recent comprehensive MDS, with an ARD of 12/23/24, indicated that the resident had a BIMS score of 8 out of 15, which indicated moderate cognitive impairment. The MDS further reflected the resident received psychoactive meds. A review of the eMAR revealed that the resident was on the following psychotropic meds: A PO dated 3/21/24, and was discontinued (d/c) on 2/18/25, for Risperidone 1 mg give 3 tablets (tabs) by mouth two times a day for bipolar disorder, 3 tabs=3 mg. A PO dated 2/18/25, Risperidone 1 mg give 1 tablet (tab) by mouth at HS (bedtime) for bipolar disorder to be given with 4 mg to equal a total of 5 mg. Further review of the above orders for Risperidone revealed that it was transcribed to the February 2025 eMAR, and from 2/18/25 through 2/22/25, the eMAR was not signed by nurses as administered, and was left blank. The Risperidone order was signed not until 2/23/25. The Risperidone was not administered for total of five days. A review of the medical records revealed that there was no documented evidence as to why the Risperidone was not administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Order Audit Report revealed: Risperidone 1 mg tab was on hand (available) and dispensed on 2/23/25. Risperidone 4 mg tab was on hand and dispensed on 2/23/25. On 2/27/25 at 12:16 PM, the survey team met with the LNHA, DON, and ADON. The surveyor notified of the concern regarding Risperidone not signed from 2/18-2/22/25. On 3/3/25 at 10:19 AM, the survey team met with the LNHA, DON, ADON, and the ADON stated we did staff education about missing meds and the physician of Resident #32 was notified about the Risperdal. On 3/4/25 at 12:17 PM, the survey team met with the LNHA, DON, and ADON for exit conference, and there was no additional information provided by the LNHA. 48781 3. A review of Resident #352's electronic health records (EHR) revealed: A review of the AR reflected that the resident was admitted to the facility with a diagnosis that included but not limited to Alzheimer's disease unspecified (a brain disorder that gradually destroys memory and thinking skills) and glaucoma (a condition where the eye ' s optic nerve, which provides information to the brain, is damaged with or without raised intraocular pressure). A review of the MDS, with an ARD of 7/10/24, reflected a BIMS score of 2 out of 15 indicating severely impaired cognition. A review of the eMAR revealed that the resident was on the following eyedrop meds: A PO for Alphagan P Solution 0.1 % (Brimonidine Tartrate) Instill 1 drop in both eyes every 12 hours for glaucoma, ordered 7/7/24, d/c on 7/8/24. A PO for Alphagan P Solution 0.1 % (Brimonidine Tartrate) Instill 1 drop in both eyes three times a day for glaucoma, start date 7/ 8/2024, d/c on 7/11/24. Further review of the eMAR revealed that Resident #352 did not receive Alphagan P Solution eye drops from 7/7/24 to 7/10/24 (total of 4 days). The eMAR was coded as 9 indicating other/see nurses notes. The nursing progress note (PN) revealed that the Medical Doctor (MD) was notified that med was unavailable on 7/7/24, and no MD notification from 7/8/24 to 7/10/24. A review of Registered Nurse #1's (RN#1) PN on 7/7/24, revealed a note text stating, Awaiting delivery from pharmacy MD aware. A review of the RN#2's PN on 7/9/24, revealed a note text stating, Pending pharmacy delivery. RN#2's PN on 7/10/24, revealed, Awaiting med from pharmacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at New Milford	800 River Road New Milford, NJ 07646

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 10:25 AM, the 3rd floor Licensed Practical Nurse/Unit Manager (LPN/UM) stated, If a med is not available, we call the doctor and get an alternate, or we hold it, we also have a for back up [name of machine] meds. On 2/26/25 at 10:45 AM, the LPN/UM stated, If the Alphagan med was not given, that means the med was not here. That is something that is not going to be in the backup machine. I do not recall about the eye drops why it was not given. There was no indication that the doctor or pharmacy was called. On 2/26/25 at 11:08 AM, the surveyor interviewed RN #2, who confirmed that she indicated on the e[DATE] on 7/9/24 and 7/10/24, pending pharmacy delivery for the Alphagan P Solution eye drop. The surveyor asked what the process was when a med was not available and RN #2 stated, We notify the doctor and call the pharmacy if the med is not there. I do not know why I did not do that or document it. The LPN/UM and RN#2 confirmed that the process was not followed. On 2/27/25 at 12:26 PM, the surveyor notified the concern regarding Alphagan eye drops not being administered with the LNHA, DON, and ADON. A review of the facility's Administering Medication-Medication Unavailable Flow Chart Policy and Procedure revealed, Check med stock box; call pharmacy for Stat (immediate) delivery; notify supervisor and Medical Director; implement orders from physician; add a detailed entry to the medical record. On 3/3/25 at 10:40 AM, the survey team met with the LNHA, DON, ADON, and the ADON stated, We were able to narrow down on who the staff were that were involved, and we educated them regarding what to do when med is not available. NJAC 8:39-29.2(d); 29.6