STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Old Bridge	111 Route 516 Old Bridge, NJ 08857

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and review of facility documents, it was determined that the facility failed to properly store, label, and date foods to prevent the development of food-borne illness. This deficient practice was identified in the main kitchen and one of two pantries (A-wing), and was evidenced by the following: 1. On 1/29/26 at 9:13 AM, the surveyor toured the kitchen with the Regional Food Service Director (RFSD) and observed the following:Near the dry storage room, two cardboard boxes of bananas were stacked one on top of the other. The top box was partially open with several dark discolored bananas in a clear plastic bag inside. In the presence of the surveyor, the RFSD lifted a plastic bag out of the box. The bag contained several dark brown/black bananas and dark brown liquid. The RFSD stated the bananas were rotten. She could not speak to when the bananas in the top box were last used or inspected by the kitchen staff. She further stated her expectation was that staff would not serve bananas that were wet, or brown or black in color. She removed the box containing the brown/black bananas from the kitchen area. In the front refrigerator on the top shelf, there were twenty-five clear plastic cups with clear lids. The RFSD stated the cups each contained chocolate pudding. Five of the lids were labeled with a use-by date. Twenty of the lids did not have labels. The RFSD stated, they [the staff] may just label one, and that label pertains to the whole group of them. The RFSD acknowledged if/when the five labeled pudding cups were moved, or removed, there would be no indication for the use-by date for the remaining twenty pudding cups. She further acknowledged her expectation was that every item in the group should have been labeled individually. In the front refrigerator on the second shelf down, a silver pan contained eight sandwiches in two stacks of four each. The two top sandwiches were each labeled with use-by dates of 1/26/26. The other six sandwiches in the pan were not labeled. The RFSD acknowledged each sandwich in the pan should have been labeled individually, and that the eight sandwiches were past their use-by date. The RFSD removed the pan with eight sandwiches and disposed of them in the garbage can. In the front refrigerator on the bottom shelf, twenty clear plastic cups with lids were on a sheet pan in a single layer. The cups had contents which were a light-yellow color. One cup had a label on the lid; the others did not. The RFSD stated the contents of each cup was ground pears. She stated the date on the label reflected the date the pears were prepared, not the use-by date. She further stated the label on the one cup meant that each of the other cups on the tray were also prepared on that date. The RFSD acknowledged that if the one labeled cup was removed, there would be no indication for the date(s) the other cups were prepared. She further acknowledged that her expectation was that every item in the group should have been labeled individually. 2. On 1/29/26 at 10:13 AM, in the pantry by the A-wing nurse's station, the surveyor observed the refrigerator which contained five sandwiches individually wrapped in clear plastic bags on the top shelf. The sandwiches did not appear to have labels. The surveyor interviewed the Licensed Practical Nurse (LPN) at the A-wing nurse's station who stated the kitchen provided the sandwiches as snacks for the residents. She could not speak to when the five sandwiches were put in the pantry refrigerator. On further inspection by the LPN in the presence of the surveyor, five of the five sandwiches were not labeled. The LPN acknowledged she could not identify when the sandwiches were prepared or (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should have been used by. She removed the sandwiches and disposed of them. On 1/30/26 at 10:13 AM, the surveyor interviewed the facility's Food Service Director (FSD) who acknowledged the observations made by the surveyor in the presence of the RFSD during the kitchen tour. The FSD acknowledged bananas that were brown/black in color should not be served and should have been disposed of. The FSD stated their process for storing refrigerated food was to label all items not just the one on top. The FSD stated their process was to go through the refrigerators in the kitchen and pantries each night and dispose of anything not used that day. She acknowledged the eight sandwiches in the front refrigerator should have been disposed of prior to their expiration date. The surveyor reviewed the facility provided policy titled Receiving Food and Storage, undated, which reflected the following: -Foods should be received and stored in a manner that complies with safe food handling practices. -All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).-Food items and snacks kept on the nursing units must be maintained as indicated below:All food items to be kept below 41 degrees F (Fahrenheit) must be placed in the refrigerator located at the nurse's station and labeled with a use by date. NJAC 8:39-17.2(g)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) maintain the necessary care and services for residents who were receiving oxygen (O2) treatment according to professional standards of practice and b.) ensure a physician's order was obtained for a resident receiving O2. The deficient practice was identified for three of three residents (Resident #9, #14 and #51) reviewed for Respiratory Care. This deficient practice was evidenced by the following: Reference: New Jersey Statues, 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 or 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 a 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.1.On 1/29/2026 at 9:45 AM, Resident #9 was observed lying in bed with the head of the bed minimally elevated. Resident #9 had a tracheostomy (a surgical opening in the neck to access the airway) tube with a collar and blue tubing connected to an oxygen concentrator. The concentrator was connected to an undated bottle of water used for humidification. The collar and the tubing were also not dated. On 1/30/2026 at 12:32 PM, the surveyor observed Resident #9 in bed, with the head of the bed elevated at approximately 45 degrees. Resident #9 had blue tubing from the oxygen concentrator to the tracheostomy (trach) collar dated 1/26. The water bottle connected to the concentrator was also dated 1/26. The surveyor reviewed the Electronic medical Record (EMR) for Resident #9. The admission Record (AR), an admission summary, revealed diagnoses which included but not limited to; chronic respiratory failure with hypoxia, adult failure to thrive, and pneumonia. A review of the Minimum Data Set (MDS), a resident assessment tool, revealed a Brief Interview of Mental Status (BIMS) that was not performed, and cognitive skills severely impaired related to daily decision making. A review of the Order Summary Report (OSR) for January 2026 revealed the following Physician Orders (POs) dated 1/21/2026: Tracheostomy (trach) check pulse oximetry every shift; Change nebulizer tubing every Monday; Change trach collar every Monday; Change Oxygen tubing, continuous aerosol tubing, aerosol bottle, drain bag, multi-access adapter if utilized and every Monday; Head of Bed maintained at 30 degrees if not contraindicated; Oxygen via trach collar @6L/35%; Clean oxygen concentrator filters every day shift Monday. A review of the Individualized Comprehensive Care Plan (ICCP) revealed a focus area for Tracheostomy dated 6/12/2025. The interventions did not reflect how often the oxygen supplies should be changed or dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/2026 at 9:33 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who explained the procedure for dating tubing related to oxygen supplies, including the oxygen tubing, nebulizer tubing, tracheostomy tubing, and water for the concentrator was to replace and date them on the Saturday 11pm-7am shift. The trach supplies were changed on Monday 7am-3pm shift. The LPN/UM reviewed the physician's orders for Resident #9, in the presence of the surveyor, and stated Resident #9 had orders for trach nebulizer tubing to be changed on Monday, disposable equipment every Monday, change water and Oxygen inhalation collar every Monday, and replace tubing for suction every Monday. Every shift, tubing is stored in a bag and dated. The nurse who is performing treatments for that day is responsible for dating these items and then signs it off on the Treatment Administration Record (TAR). At that time, the surveyor described the findings of the above-mentioned observations in Resident #9's room to the LPN/UM who stated That is not ok. The supplies should have the date that it was actually changed, or staff should put new ones (supplies) up and put the date for that day. The LPN/UM further stated it was important to date the tubing and water canisters for infection control, and to make sure they were changed routinely so we can monitor if the water and humidification were working properly. On 2/5/2026 at 12:46 PM, the surveyor made the Director of Nursing (DON), the Regional Director of Nursing (RDON), and the Licensed Nursing Home Administrator (LNHA) aware of the above-mentioned findings. 2.On 1/29/26 at 10:14 AM the surveyor observed Resident #14 in bed. The resident was unable to respond to surveyor inquiries. The resident was observed with a tracheostomy collar (an oxygen delivery method for individuals with a tracheotomy) providing oxygen. The tubing for the concentrator, humidification, and oxygen delivery to the resident's tracheostomy collar were not labeled or dated. On 1/30/26 at 9:49 AM, the surveyor observed Resident #14 in bed with a tracheostomy collar. The oxygen tubing was observed to be labeled and dated with 1/25/26. The surveyor reviewed the EMR for Resident #14. A review of the admission Record revealed that the resident had diagnoses which included but were not limited to; Hydrocephalus (pressure on the brain), encephalopathy (altered brain function), acute kidney failure, protein-calorie malnutrition, down syndrome, traumatic subdural hemorrhage (bleeding between the brain and the skull), and altered mental status. A review of the resident's most recent comprehensive MDS, dated [DATE], included in the Brief Interview for Mental Status (BIMS) that the resident was unable to complete the interview for BIMS, indicating the resident's cognition was severely impaired. Further review of the MDS, indicated that the resident received oxygen therapy, suctioning and tracheostomy care as a resident in the facility. A review of the resident's ICCP included a focus area dated 2/12/25, that the resident had a tracheostomy with a goal of no infection through the next review date. Interventions included: Give humidified oxygen as prescribed, maintain enhanced barrier precautions. A review of the Order Summary Report included the following physician orders (PO): A PO, dated 7/31/25, for: Trach: Ensure nebulizer tubing is dated and properly stored in the respiratory bag when not in use every shift for Protocol. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A PO, dated 7/31/25, for: Trach: Oxygen Inhalation (via collar) 6L/min @ 35% humidification every shift. A PO, dated 7/31/25, for: Trach: Oxygen Equipment - Change tubing every day shift every Thursday for Protocol. A PO, dated 7/31/25, for: Trach: Change nebulizer tubing every day shift every Thursday for Protocol. A PO, dated 7/31/25, for: Trach: Trach care every shift for Protocol AND as needed. On 2/5/26 at 9:24 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding Resident #14's respiratory care and needs. When asked about the labels present on the tubing and their importance, the LPN responded that the tubing was changed weekly and that along with tracheostomy care changing the tubing helped to prevent infections. On 2/5/26 at 10:39 AM, the surveyor interviewed the Director of Nursing (DON) regarding Resident #14's respiratory care and needs. When asked about the labels on the tubing and their importance, the DON replied that the tubes were labeled so staff knew when they needed to be changed. She stated that all respiratory tubing was changed weekly per protocol to prevent infections. On 2/5/26 at 12:43 PM, in the presence of the survey team, the surveyor made the Licensed Nursing Home Administrator (LNHA) and the DON aware of the concerns regarding Resident #14's tubing being unlabeled on 1/29/26. The Administrator and DON acknowledged that their expectation was that respiratory tubing would be labeled during weekly changes with the date of change. 3. On 1/29/26 at 10:20 AM, during an initial tour, the surveyor observed an O2 concentrator (medical device that helps people with breathing problems get more O2) with humidifier (a medical setup that adds moisture to the O2 you breathe from a machine or tank) dated 1/24 and a nasal cannula (NC; a light, flexible tube used to deliver extra O2 to a person who has trouble breathing) dated 1/25 was connected to the concentrator. The NC was looped around right side siderails and was hanging in the air. The NC was not in any protective covering and was exposed to the environment. The surveyor did not observe O2 in use signage at the resident's door. On 1/29/26 at 12:07 PM, the surveyor observed Resident #51 sitting in their w/c in the dining room. Resident #51 was observed to be on supplemental O2 via (by way of) NC which was connected to O2 tank behind the wheelchair. On 1/30/26 at 10:39 AM, the surveyor observed that the resident was not in their room. The surveyor observed the NC connected to the O2 concentrator, looped through the right side siderail and was hanging on the O2 concentrator. The NC was not in any protective covering. The surveyor did not observe O2 in use signage at the resident's door. The surveyor reviewed the EMR for Resident #51. A review of the admission Record face sheet reflected that Resident #51 was admitted to the facility with diagnoses which included but were not limited to; Acute respiratory failure with hypoxia (low levels of O2 in your body tissues) and Chronic obstructive pulmonary disease (COPD; a common lung disease causing restricted (blockage) airflow and breathing problems). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the most recent comprehensive MDS, dated [DATE], reflected that the resident had a BIMS score of 8 out of 15, indicating that the resident had moderate cognitive impairment. Further review of the MDS, indicated that Resident #51 was coded for O2 while a resident at the facility. A review of ICCP revealed a Focus for Resident #51 [Resident] had diagnosis (dx) of COPD related to smoking, date initiated 12/21/25. Interventions included but were not limited to: give oxygen therapy as ordered by the physician, date initiated 12/21/25. A review of the OSR for January 2026 revealed a POs as follows: Clean oxygen concentrator filters every Saturday night shift for Protocol, dated 11/19/25; Oxygen Equipment - Change tubing every week every night shift every Saturday for Protocol, dated 11/19/25; Oxygen Equipment - Change water canister every week every night shift every Saturday for Protocol, dated 11/19/25; Pulse Oximetry - check every shift for protocol, dated 11/19/25; Oxygen: Change nebulizer tubing/mouthpiece and Date every night shift every Saturday, dated 11/22/25. The OSR did not reflect any active orders to administer O2 continuously or as needed. A review of the OSR for November 2025 revealed a PO for OXY *Oxygen inhalation (via nasal cannula at 2 LPM (liters per minute) as needed for SPO2 (measurement of how much oxygen your blood is carrying as a percentage) below 92% for 14 days, dated 11/19/25. On 1/30/25 at 1:12 PM, the surveyor interviewed Resident #51's Registered Nurse (RN) who stated before O2 administration, he would check the orders first because it's (O2) a medication and an order is an order, if there were no orders then he would call the provider to get orders for O2. The RN stated he would not administer O2 without physician's orders because if resident was hyper oxygenated (giving too much O2) then they (resident) can end up with a pneumothorax (a medical condition where air leaks into the space between the lung and the chest wall). The RN stated if the resident was not using O2, he would store the equipment in the plastic bag and label the tubing and the bag with resident's name, date and time. The RN stated it was important to properly store the NC tubing to prevent contamination, and residents can get infections and pneumonia. At that time, the surveyor inquired about Resident #51's O2 status. The RN stated the resident was on continuous O2 at 2 LPM. The RN stated if the resident was on O2, there should be a O2 in use signage at the door to make visitors aware that the resident was using O2. In the presence of the surveyor, the RN checked Resident #51's O2 tank which was secured in the back of their w/c, he then pointed towards the O2 tank regulator (regulates the flow of oxygen from the tank to deliver the right amount of oxygen to the patient) and stated the resident was on 2L. The RN observed the O2 tank regulator needle pointed towards refill which indicated the O2 tank was empty and needed to be replaced. The RN stated usually if the O2 tank was empty and needed to be replaced then it would beep but there was no beeping sound heard at the time of the interview. On 1/30/26 at 1:25 PM, during an interview with the surveyor, the LPN/UM stated the NC should be placed in the bag when not in use for infection control. The LPN/UM stated residents who were on O2 should have No smoking, O2 in use signage at the door and confirmed Resident #51 did not have signage at their door when. In the presence of the RN, the LPN/UM noted the empty O2 tank that was connected to Resident #51's NC while resident had the NC applied to their nose. The LPN/UM stated all nurses were responsible for monitoring O2 supply to make sure the tank was not empty. The RN stated, I am taking accountability for not checking the O2 tank. The surveyor along with the LPN/UM went to Resident #51's room to check the concentrator filter. She stated the nurses did not change the filter because it was screwed in. The LPN/UM stated the maintenance staff were responsible for (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changing the filter on O2 concentrators. In the presence of the surveyor, the LPN/UM reviewed the MARs/PO order Clean O2 concentrator filters every Saturday night shift for protocol and confirmed it was not done by the nurses. The LPN/UM further stated, the nurses should not be signing it off if something that they were not doing. On 1/30/26 at 1:40 PM, in the presence of the surveyor and the LPN/UM, the Maintenance Staff (MS) unscrewed the concentrator and removed the filter and noted dark colored debris / build up. The MS stated the filters were usually changed as needed or when the staff would tell them to change them. The MS stated the process was that there was a timer in the concentrator that would either beep or a light would turn red, and then the staff would ask them to change the filter. The MS stated they would write a date on the filter when it was changed last time. In the presence of the surveyor and the LPN/UM, the MS removed the filter, and the surveyor observed the filter was not dated. While looking at the filter, the MS stated, I cannot tell when this was changed and confirmed there were no documentation or logbook for filter change. At that time, the LPN/UM reviewed Resident #51's PO and confirmed that the resident did not have O2 administration orders and should not have been on O2. On 2/5/26 at 12:46 PM, the surveyor made the DON, the Regional DON and the LNHA aware of the above-mentioned concerns. On 2/6/26 at 10:52 AM, the DON, Regional DON and the LNHA met with the survey team. The LNHA confirmed that Resident #51 did not have an order for O2 administration, and the equipment should not have been there in the room. The LNHA further stated the MS were responsible for changing or cleaning the filter and further stated the nurses should not be signing off orders if they have not done it. A review of the facility provided Oxygen Administration policy dated 10/25 under Policy Statement reveals: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. In Section Policy Explanation and Compliance Guidelines: Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control .Oxygen warning signs must be placed on the door of the resident's room where oxygen is in use .Other infection control measures include: Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.change nebulizer tubing and delivery devices every week or per facility policy and as needed. The policy did not reveal how to store oxygen tubing when not in use and how often the concentrator filter should be changed and/or cleaned. A review of the facility provided Oxygen Safety policy dated 10/25 under Interpretation and guidance reveals: 5.k. Replace the oxygen tank before the needle on the gauge drops below 200 psi (Pounds per Square Inch; is a common unit used to measure pressure). 6.f. No Smoking signs will be utilized to clearly identify oxygen is in use before connecting the oxygen supply, and will remain in place until oxygen administration has been discontinued. The policy did not reveal how to store oxygen tubing when not in use and how often the concentrator filter should be changed and/or cleaned. NJAC 8:39-11.2(b); 25.2(c)3; 27.1(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards by a.) ensuring routine medications were acquired in a timely manner and administered as per prescribed physician's orders for one (1) of seven (7) residents, (Resident #110), reviewed for medication management and b.) ensuring proper procedures to acquire routine medications be available for administration for one (1) of four (4) residents, (Resident #13), observed during medication administration. The deficient practices were 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. 1.On 2/4/26 at approximately 8:48 AM, during the medication administration observation, the surveyor was approached by Resident #110 who stated they would like to speak to the surveyor. Resident #110 was agreeable to a private discussion after the surveyor completed the medication administration observation.On 2/4/26 at 9:19 AM, the surveyor interviewed Resident #110 in their room. The resident stated that the observation the surveyor had seen earlier that morning was not usual because the nurse had all their medications. The resident requested the surveyor to review their medication administration because the nurses frequently do not have them. The resident stated they understood there was an insurance issue with one of their medications used for their liver, a while back in November, but thought that was resolved and recently was told it wasn't available. The resident added the nurses just tell them the medication was not in the medication cart and then they don't receive the medication that day. The resident added approximately two (2) weeks ago they were told they didn't have their Zoloft (a medication used for depression), and another day in January it was their blood pressure medication and some other days it was medications that they weren't as upset about.The surveyor reviewed the medical record for Resident #110A review of the resident's admission Record reflected that the resident had diagnoses, which included but not limited to; essential (primary) hypertension (high blood pressure), alcoholic liver disease and major depressive disorder. A review of the most recent quarterly comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 11/16/25, reflected the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating that the resident had an intact cognition. A review of the resident's electronic medication administration record (EMAR) for January 2026 revealed the following dates, times and medications with physician's orders (PO) that were not administered and coded with the number 9 which corresponded to Hold/see progress notes ; On 1/2/26 at 9 AM and on 1/5/26 at 5 PM, a PO dated 4/28/25 for Rifaximin (an antibiotic used to prevent liver damage) oral tablet 550 MG (milligrams), Give 1 tablet by mouth two times a day for Liver Cirrhosis. On 1/2/26 at 9 AM and 5 PM, PO dated 12/10/25 for Fluticasone Propionate (Flonase) Nasal suspension 50 MCG(micrograms)/ACT(actuation), 1 spray in both nostrils two times a day for congestion Shake and prime prior to first use. Instruct resident to bow nose prior to administration.On 1/12/26 at 9 AM, PO dated 12/29/25 for Artificial Tears (an eye (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lubricant)Ophthalmic Solution 0.2-0.2-1% (Glycerin-Hypromeliose-Propylene Glycol 400) Instill 1 drop in both eyes two times a day for Dry eyes. On 1/29/26 at 9 AM, PO dated 11/11/25 for Sertraline HCL (Zoloft)(a medication used for depression) oral tablet 50 MG Give one tablet by mouth one time a day for anxiety.On 1/31/26 at 8:30 AM, PO dated 3/28/26 for Carvedilol (Coreg) (a medication used to lower blood pressure) Oral Tablet 3.125 MG, Give 1 tablet by mouth two times a day for hypertension. Give with meals. Hold for SBP (systolic/lower number blood pressure) less than 100 or HR (heart rate) less than 60. On 1/31/26 at 12: 30 PM, PO dated 7/29/25 for Polyethylene Glycol 3350 Powder (Miralax) (a medication used to relieve constipation), Give 17 gram (GM) by mouth one time a day for constipation, Mix with 4 oz(ounces) of fluid prior to administration 17 GM = 1 cap.A review of the resident's electronic nursing progress notes (EPN) revealed the following corresponding documentation for the reason the above medications were not administered; On 1/2/26 at 10:51 AM, for the Rifaximin dose, Registered Nurse (RN #1) documented on order. In addition, for the Rifaximin on 1/5/26 at 7:36 PM, RN #2 documented awaiting delivery. On 1/2/26 at 10:55 AM, for the Flonase nasal spray RN #1 documented reorder. In addition, for the Flonase nasal spray, on 1/2/26 at 6:12 PM, Licensed Practical Nurse (LPN #1) documented not at hand.On 1/12/26 at 10:12 AM, for the Artificial Tears, RN #1 documented on order.On 1/29/26 at 9:49 AM, there was no documentation by LPN #2 explaining why Zoloft dose was not administered.On 1/31/26 at 8:54 AM, for the Coreg dose, LPN #3 documented Record showed that medication was reordered. Waiting for pharmacy to delivery medication. Blood pressure was taken, it normal range. On 1/31/26 at 1:53 PM, for the Miralax dose, LPN #3 documented Resident out of facility. There was no other documentation indicating on 1/31/26 the resident had left the facility and was not available for medication administration. There was no documentation on the above dates indicating the physician was notified regarding the above medications that were not administered and follow up orders. On 2/4/26 at 12:31 PM, the surveyor interviewed Unit Manager/LPN (UM/LPN) who explained if a nurse did not have a medication that was ordered by a physician for a resident they should check the back up supply and if the medication could not be obtained then the physician would have to be called for follow up on what should be done and then the nurse should document in the EPN. The UM/LPN stated she was familiar with Resident #110, and the resident was cognitively intact and ambulated on their own. The UM/LPN added the resident walked a lot and usually returned when they had medication due so the nurses should be able to administer the resident's medications. The UM/LPN stated that she was aware at one time there was an issue with the resident's Rifaximin but thought that was taken care of and she was unaware of any other medications that were not administered to the resident. On 2/4/26 at 1:00 PM, the surveyor interviewed the Director of Nursing (DON) who stated she would review Resident #110's January EMAR for medications not being administered. On 2/5/26 at 9:49 AM, the surveyor interviewed the DON, who explained that the nurses were to call the physician if a medication was not available and see if there was another medication in the back up supply or follow instructions from the physician and document in the EPN. The DON had provided documentation that the resident was on a leave of absence from the facility from 1/6/26 until 1/11/26. The DON explained that the nurses were able to reorder medications from the pharmacy electronically. The DON was unable to speak about why there was documentation that medications were not administered and documented as being not available or on order. The DON added that she thought the documentation meant the physician was notified. On 2/5/26 at 10:04 AM, the surveyor interviewed Resident #110 who stated that they do walk a lot but would return for medication administration. The resident stated they had not left the faciity on 1/31/26. The resident then stated that they remembered back in March 2025 there was a problem with their pain medication, Morphine, and was told by the nurses that they didn't have the Morphine on 3/24/25 and 3/25/25. The resident then stated that they knew how the nurses ordered medications from the pharmacy but could not understand why medications continued to not be available. The surveyor further reviewed the resident's medical record. A review of the March 2025 EMAR revealed a PO dated 9/30/24 for Morphine Sulfate ER (a long-acting pain medication) Oral (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tablet Extended Release 15 MG, Give one tablet by mouth every 12 hours for pain related to presence of wounds. Do not crush, swallow whole may cause respiratory depression, sedation, constipation, continue to monitor and assess pain management as frequently as necessary. Further review of the March EMAR revealed on 3/24/26 at 9 AM and 9 PM and 3/25/26 at 9 AM the Morphine ER was not administered and coded with the number 9 which corresponded to Hold/see progress notes. The corresponding EPN for the above dates and times revealed the following; On 3/24/25 at 12:01 PM, RN #3 documented the Morphine ER was Pending delivery.On 3/24/25 at 9:46 PM, RN #3 documented the Morphine ER was Pending delivery.On 3/25/26 at 9:47 AM, a nurse documented the Morphine ER was awaiting pharmacy, pharmacy called. There was no documentation on the above dates indicating the physician was notified regarding the above medication that was not administered and follow up orders. On 2/5/26 at 11:30 AM, the surveyor interviewed the DON who stated if a controlled drug was not available the nurses should check the back up supply of controlled drugs to see if the medication was there and if not available the nurses were to call the physician and ask the physician for a substitute or follow up and document in the EPN. The surveyor was provided a list of controlled drugs that were in the back up supply and Morphine ER 15 MG was handwritten on the list. The DON explained that Morphine ER was added to the list due to a need. The DON further stated that agency nurses were utilized and tried to make sure medications were ordered and the nurses must follow up when a medication was not available and were not allowed to just say they don't have it. The DON added she thought the nurse, whose name corresponded to the EPN on 3/25/26, was an agency nurse and was unsure if she worked at the facility. On 2/5/26 at 11:44 AM, the surveyor interviewed RN #3 who acknowledged her initials on the EMAR for Resident #110 on 3/24/25 at 9 AM and 9 PM indicated the Morphine was not administered. RN #3 stated that it was a while back and was unable to speak about what occurred. RN #3 added that she thought she called the physician and documented it in EPN. RN #3 explained when a medication was not available there was a backup supply to check and call the physician who would tell her what to do. RN #3 was unable to speak to why there was no documentation in the EPN that the physician was notified and if there was follow up. On 2/5/2026 at 12:47 PM, during a meeting with the survey team, the surveyor made the LNHA, the DON, and the Regional DON aware of the above findings. On 2/5/26 at 1:34 PM, the surveyor interviewed the DON who stated Morphine ER 15 MG was added to the controlled drug back up list in September 2025. A review of the facility policy Medication Administration provided by the DON with a revision and updated date of October 2025 revealed medications were to be administered .as ordered by the physician and in accordance with professional standards of practice.A review of the facility policy Medication Reordering provided by the DON with a reviewed date of 10/25 revealed It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. In addition, the policy revealed Compliance Guidelines which included, but not limited to, Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. And In the event if medication is not available, the physician will be notified. 2. On 2/4/26 at 8:58 AM, during the medication administration observation, the surveyor observed RN #4 administering the 9 AM medications to Resident #13. RN #4 stated there was a PO for Lactulose solution and Flonase nasal spray but was unable to find the medications in the cart.At that time, RN #4 stated she would have to check and see if she could obtain the medications and administer as the PO indicated.The surveyor reviewed the medical record for Resident #13.A review of the resident's admission Record reflected that the resident had diagnoses, which included but not limited to; essential (primary) hypertension (high blood pressure), dementia, and schizoaffective disorder. A review of the most recent quarterly comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 12/20/25, reflected the resident had a brief interview for mental status (BIMS) score of 11 out of 15, indicating that the resident had a moderately impaired cognition. A review of the residents' EMAR revealed the following:- PO dated (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/21/25 for Lactulose Oral Solution, Give 30 ML (milliliters) by mouth one time a day for constipation.-PO dated 10/28/25 for Flonase Allergy Relief Naal Suspension (Fluticasone Propionate (Nasal) 1 spray in both nostrils two times a day for allergies. On 2/4/26 at 10:10 AM, the surveyor interviewed RN #4 who stated that both Lactulose and Flonase were not over the counter house stock medications (medications that were stored at the facility as a backup supply). RN #4 added since the Lactulose and Flonase would not be able to be administered within the timeframe for the PO she had called the physician and received a PO to administer the Lactulose and Flonase when the medications were obtained. RN #4 explained when medications were not available the nurses had to notify the physician and receive a follow up PO and document in the EPN what was to be done. RN #4 stated that she thought she had ordered the Flonase nasal spray yesterday but was unsure about Lactulose and would check when the medications were ordered from the pharmacy. On 2/4/26 at 11:01 AM, the surveyor interviewed the DON who stated RN #4 was the usual nurse on the medication cart and had not ordered either Lactulose or Flonase. The DON confirmed that neither was stored as over-the-counter house stock. The DON added that she had called the pharmacy provider, and Lactulose was last dispensed on 12/26/25 and delivered 12/27/25 and Flonase was last dispensed 11/3/25 and delivered 11/4/25. The DON acknowledged the nurses were to reorder routine medications to ensure they were available for administration.On 2/5/26 at 11:21 AM, the surveyor interviewed Resident #13 who stated the nurses bring their medications when they were supposed to take them. The resident was unable to identify any medications or times. The resident stated they need their medications every day for pain and constipation.On 2/5/2026 at 12:47 PM, during a meeting with the survey team, the surveyor made the LNHA, the DON, and the Regional DON aware of the above findings.A review of the facility policy Medication Reordering provided by the DON with a reviewed date of 10/25 revealed Acquiring medication is the process by which the facility requests and obtains a medication. In addition, the policy revealed Compliance Guidelines which included, but not limited to, The facility will utilize a systemic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident. And Each time a nurse is administering medications and observes less doses left of one kind, that nurse will reorder the medication, time permitting. NJAC 8:39-11.2(b); 29.2(a)(d)

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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. Based on observation, interview and review of facility documents, it was determined that the facility failed to maintain a clean/homelike and sanitary environment for 1 of 2 nursing units (B Wing).This deficient practice was evidenced by the following:On 1/30/2026 at 9:47 AM, during an environmental tour on B wing, the surveyor interviewed unsampled Resident #30. During the interview, the surveyor observed a large white patched area with a hole in the wall below the patch on the left wall of the room, just beyond the bathroom door. Further review of the room revealed a white patched area around the soap dispenser near the sink, and a large white patch area on the right side wall, near the resident's bed. The surveyor asked Resident # 30 what happened to the walls. Resident #30 stated they did not know because it was like that since they were admitted in October. The surveyor asked Resident #30 what they thought of the walls, the resident stated, it is not pretty. On 1/30/2026 at 11:14 AM, the surveyor interviewed the Director of Maintenance (DM) in Resident #30's room. The resident was not in the room at the time. The DM acknowledged the white patches on the walls. He identified the white patches as spackle from when the walls had been repaired. He could not speak to why the walls had not been repainted. The DM stated it had been like that for about 2 months. He stated he was not aware of the hole in the wall, but he would fix it right away to keep dust and dirt out of the room. The DM stated it was his priority to make the facility pleasing to the residents. On 1/30/2026 at 11:18 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated the walls should have been painted as soon as the spackle was dry. He stated the purpose was for resident rights to a home-like environment. On 2/5/2026 at 12:47 PM, during a meeting with the survey team, the surveyor made the LNHA, the Director of Nursing, and the Regional Director of Nursing aware of the above findings. A review of the facility policy Maintenance Policy updated 1/2025 revealed Policy statement: All facility staff are responsible for identifying and promptly reporting maintenance or environmental issues that may impact infection control.The Maintenance Department will ensure all issues are addressed in a timely and documented manner. Policy purpose: To ensure a safe, clean, and well-maintained environment for residents, staff, and visitors by establishing clear procedures for promptly reporting and addressing maintenance concerns in accordance with state and federal regulation. NJAC 8:39-31.2 (e), 31.4(a)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #2684176 Based on interviews, record review and review of facility provided documents, it was determined that the facility failed to ensure that a resident was free from exploitation and misappropriation of resident income. This deficient practice was identified for one of one resident (Resident #115) reviewed for misappropriation of personal property and was evidenced by the following: On 1/29/26 at 10:19 AM, during an initial tour of the facility, the surveyor observed Resident #115 in their room. Resident #115 was not interviewable. The surveyor reviewed the Electronic Medical Record (EMR) for Resident #115. A review of the admission Record, an admission summary, reflected diagnoses which included but were not limited to; major depressive disorder, and altered mental status. Further review reflected: [Resident Representative name #1 redacted] POA (Power of Attorney)-Financial, Emergency Contact #1, Durable POA [address, phone number and email redacted][Resident Representative name #2 redacted] POA-Care, Emergency Contact #2 [phone number and email redacted]A review of the Quarterly Minimum Data Set (MDS), a resident assessment and care screening tool, dated 12/6/25, reflected a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated the resident had moderate cognitive impairment. On 2/4/26 at 10:36 AM, the surveyor interviewed the Director of Admissions (DA) who stated she was familiar with Resident #115 and Resident Representative #1, whom she described as being very involved. The DA stated the Business Office, which was offsite, handled all financial information for the residents. On 2/4/26 at 12:14 PM, the surveyor interviewed the Administrator who stated he had limited interactions with Resident representative #1 for Resident #115. The Administrator acknowledged he was aware that Resident representative #1 had concerns that were mainly financial, related to Resident #115's income that went directly to the facility. He further stated Resident representative #1 was the financial POA for Resident #115. On 2/5/26 at 10:29 AM, in the presence of the survey team, the surveyor interviewed the BO Medicaid biller via phone. The BO Medicaid biller stated in the case of Resident #115, the BO filed to be a representative payee (person or organization who receives Social Security benefits for anyone who can't manage or direct the management of his or her benefits. These individuals or organizations receive the Social Security check on behalf of the beneficiary .) with Social Security in November 2025 so we can help manage their income. The BO Medicaid biller further stated, when we file to be representative payee we don't need consent. She further stated Resident Representative #1 would not be able to contact Social Security regarding Resident #115's benefits because the facility has payee status now. The BO Medicaid biller was unable to provide the date the BO became representative payee for Resident #115. The surveyor reviewed the facility-provided admission Agreement dated 9/10/25 for Resident #115. Section 1. C.) Resident Finances reflected .The Resident has the right to manage his or her own financial affairs under the Resident's [NAME] of Rights.The surveyor reviewed the facility-provided Representative Payee Application (Form SSA-11-BK) for Resident #115, signed and dated 11/15/25 by the BO manager. The application reflected the following:Section 2 had instructions Explain why you think the claimant is not able to handle his/her own benefits. (In your answer, describe how he/she manages any money he/she receives now). The typed response reflected patient is unable to handle their finances.Section 3 had instructions Explain why you would be the best representative payee. The typed response reflected patient resides in our nursing facility.Section 8 had instructions List the names and relationship of any (other) relatives or close friends who have provided support and/or show active interest with the claimant. Describe the type and amount of support and/or how interest is displayed. The corresponding response area was blank.On 2/5/26 at 12:47 PM, during a meeting with the survey team, the surveyor made the Administrator, the Director of Nursing, and the Regional Director of Nursing aware of the above findings.On 2/6/26 at 9:53 AM, the surveyor interviewed the AD, in the presence of the Administrator. The AD stated all demographic information was sent to the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BO when a resident was admitted to the facility, including contact information and information about POA's. Neither the AD nor the Administrator could speak to why the BO would not have listed Resident Representative #1 and/or Resident Representative #2 on the representative payee application filed on behalf of Resident #115 on 11/15/25. The surveyor requested the following information:1. The date the BO was approved to be representative payee for Resident #115. 2. Documentation that indicated Resident representative #1 was notified the BO was representative payee for Resident #115.3. The facility policy or agreement that stated the facility would apply to be a representative payee on behalf of a resident. On 2/6/26 at 11:24 AM the survey team met for an Exit Conference with the Administrator, Director of Nursing, and Regional Director of Clinical Services. The Administrator acknowledged they were unable to provide any additional information. NJAC 8:39-4.1(a)7, 9.5(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of medical records and other facility documentation, it was determined that the facility failed to develop a comprehensive, person-centered Care Plan (CP) to address the needs for a.) a resident who was on an anticoagulant (blood thinners) for Paroxysmal Atrial Fibrillation (A-fib; a type of irregular, rapid heart rhythm that comes and goes on its own) (Resident #51) and b.) a resident with a suprapubic catheter (a medical device used to drain urine from the bladder) (Resident #3). This deficient practice was observed for Two (2) of 23 residents reviewed for CP.This deficient practice was evidenced by the following: 1.On 1/29/26 at 12:07 PM, the surveyor observed Resident #51 sitting in their wheelchair, in the dining room. The surveyor reviewed the electronic medical records (EMR) for Resident #51. A review of the admission Record face sheet (an admission summary) reflected that Resident #51 was admitted to the facility with diagnoses which included but were not limited to; Paroxysmal A-fib and essential hypertension (HTN; high blood pressure that develops over time without a direct, identifiable medical cause). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 11/25/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating that the resident had moderate cognitive impairment. Further review of the MDS indicated that Resident #51 received Anticoagulants (medicines that prevent harmful blood clots from forming or growing). A review of the physician order summary report for January 2026 revealed a Physician Order (PO) for Apixaban oral tablet 5 MG (milligrams) – give 1 tablet by mouth every 12 hours for A-fib, monitor for bleeding, bruising and black tarry stools, dated 11/19/25. A review of the January 2026 Medication Administration Record (MAR) revealed that Resident #51 was receiving Apixaban 5 mg by mouth twice a day. A review of individualized comprehensive care plan (ICCP) revealed a Focus for Resident #51 at risk for malnutrition related to (r/t) .HTN, A-fib,. Date initiated: 11/20/25, Resident at risk for falls related to h/o (history of; hx) falls prior to admission.Date initiated 11/21/25; [Name Redacted] has dx (diagnosis): Hypertension r/t hx smoking, Date initiated 12/21/25. Further review of the ICCP did not include a CP including interventions for Paroxysmal A-fib and/or for Anticoagulant use. On 2/4/26 at 1:10 PM, during an interview with the surveyor, the Registered Nurse (RN) stated the purpose of the CP was to be able to get an understanding of resident's needs and care and it was a means of communication between different departments. The RN stated the CP would be initiated on admission by the admitting nurse and then would be updated/changed as needed by the Unit Manager (UM). The RN further stated if the resident had a hx of A-fib and was receiving blood thinners, there should be a CP with intervention to monitor the resident for bleeding risks. The surveyor inquired if the RN reviewed the CP for Resident #51 and the RN stated if there was a significant change then she would review the CP but not daily. In the presence of the surveyor, the RN reviewed Resident #51's (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CP and confirmed there was no FOCUS area CP for A-fib or the blood thinners and further stated there should have been one. On 2/4/26 at 1:53 PM, during an interview with the surveyor, the Licensed Practical Nurse/UM (LPN/UM) stated the purpose of the CP was to follow the care needs of the residents, depending on their diagnoses and treatments. The LPN/UM stated if the resident was on blood thinners like Lovenox, coumadin, Eliquis . behavioral issues, depression, any psychiatry medications all would be included in the CP. The LPN/UM further stated, the interventions for blood thinners would include monitoring the resident for bruising, bleeding and black tarry stools. The LPN/UM stated the CP would be updated with any changes in resident's condition by the Director of Nursing (DON), Assistant DON and myself. In the presence of the surveyor, the LPN/UM reviewed Resident #51's CP and acknowledged there was no CP related to the resident's A-fib diagnosis or Anticoagulant medication use. The LPN/UM acknowledged that there should be one included in the resident's CP. The LPN/UM stated she would update the CP. On 2/5/26 at 12:46 PM, the surveyor made the DON, the Regional DON and the Licensed Nursing Home Administrator (LNHA) aware of the above concerns. 2. On 1/30/2026 at 12:41 PM, the surveyor observed an Enhanced Barrier Precautions (EBP) sign on the wall outside of Resident #3's room, and Personal Protective Equipment (PPE) hanging on the door. Resident #3 was sitting in a wheelchair, dressed, and eating lunch. A blanket was across Resident #3's lap that reached to the bottom of the wheelchair. The surveyor reviewed the electronic medical records (EMR) for Resident #3. A review of the admission Record Face sheet revealed the resident was admitted to the facility with diagnoses that include but are not limited to: Displaced fracture of the patella (a break in the kneecap that required surgical intervention), Hypo osmolality and hyponatremia (an imbalance of water and electrolytes), disorientation, dementia, benign neoplasm of the prostate (enlarged prostate), neuromuscular dysfunction of the bladder (nerve damage that affects bladder control), and Urinary Tract Infection (UTI). A review of physician's orders dated 11/25/25 included Suprapubic catheter (SPC) care, Measure and record output every shift. A review of the most recent MDS dated [DATE], revealed a BIMS of 7 out of 15, which indicated severe cognitive impairment. A further review revealed the resident had an indwelling catheter (including suprapubic catheter), urinary continence not rated. A review of the ICCP initiated 1/8/2026 revealed a focus area to include: Nutrition risk, Alert and able to make his own decisions concerning recreational programming, Left patella fracture related to fall, Pain, At risk for falls, Activities of Daily Living self-care performance deficit, and Chronic/progressive decline in intellectual functioning. No focus areas were identified for the SPC. On 2/5/2026 at 9:37 AM, the surveyor interviewed the LPN/UM regarding Resident #3. The LPN/UM stated care plans were created and updated by the team, including the LPN/UM, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the dietician, the social worker, the activities director, and a representative from the corporate office. Care plans were updated by the team if anything had changed with the patient. Care plan meetings were quarterly, and the LPN/UM or (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	corporate representative would help update the care plan. The LPN/UM acknowledged when a resident had a SPC, we should care plan for that. In the presence of the surveyor, the LPN/UM reviewed the care plan for Resident #3. The LPN/UM confirmed Resident #3 currently had a SPC and there were no focused care plan items for SPC. The LPN/UM further confirmed there should be a focused care plan item for the SPC and stated, I'll create one now. The LPN/UM also stated, the importance of having a care plan is to monitor infection control, placement of the SPC, for the team to know the resident has a SPC, monitoring drainage, privacy bags, follow up with the urologist, and changes. On 2/5/26 at 12:46 PM, the surveyor made the DON, the Regional DON and the Licensed Nursing Home Administrator (LNHA) aware of the above concerns. A review of the facility provided Comprehensive Care Plans Policy, with a copyright of 2022 revealed Policy Explanation and Compliance Guidelines .All Care Assessment Ares (CAAs) triggered by the MDS will be considered in developing the plan of care ., and .The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. N.J.A.C. 8:39-11.2 (d)(e)(1)(2)

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Autumn Lake Healthcare at Old Bridge	111 Route 516 Old Bridge, NJ 08857

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a low air loss (specialized) mattress was functioning properly and accurately setup according to manufacturer instructions and a physician's order for residents who were previously identified to have had an alteration in skin integrity.This deficient practice was identified for 2 of 4 residents (Resident #14 and Resident #48) reviewed for pressure ulcers and was evidenced by the following:A.) On 1/29/26 at 10:14 AM, the surveyor observed Resident #14 lying in bed, resting on an air mattress. The resident's air mattress pump was observed to be set to a weight of 200 pounds.On 1/30/26 at 9:49 AM, the surveyor observed Resident #14 lying in bed, the air mattress pump was noted to be set to a resident weight of 200 pounds.On 02/04/26 at 8:59 AM and 11:58 AM, the surveyor observed the air mattress pump set to a resident weight of 200 pounds.A review of the admission Record, an admission summary, revealed that the resident had diagnoses which included but were not limited to; Hydrocephalus (pressure on the brain), encephalopathy (altered brain function), acute kidney failure, protein-calorie malnutrition, down syndrome, traumatic subdural hemorrhage (bleeding between the brain and the skull), and altered mental status.A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 2/10/25, included in the Brief Interview for Mental Status (BIMS) that the resident was unable to complete the interview for BIMS, indicating the resident's cognition was severely impaired. Further review of the MDS indicated that the resident was at risk to develop a pressure ulcer/injury. Additional review of the MDS revealed that the Skin and Ulcer/Injury Treatments section included a pressure reducing device for the bed.A review of the resident's electronic medical record revealed the last recorded weight for the resident was 117.6 pounds.A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 2/6/25, that the resident was at risk for skin impairment related to their history of ulcers, immobility and incontinence. Interventions included: an alternating pressure mattress to prevent further skin breakdown, monitor for functioning and to follow facility policies/protocols for the prevention/treatment of skin breakdown.A review of the Order Summary Report included the following physician orders (PO):A PO, dated 12/8/25, for: Alternating air pressure mattress to prevent further skin breakdown; every shift, monitor for functioning. A PO, dated 7/30/25, for: Consults: Wound consult and treat as needed. A review of the Wound Care Progress Notes included the following:A progress note, dated 1/8/26, included: Assessment states wound is improving.alternating air mattress remains in place; continues on supplements to promote wound healing.A progress note, dated 1/15/26 included: Assessment states wound is resolved on 1/15/26, preventative measures include alternating mattress, [seat] cushion. B.) On 1/29/26 at 10:32 AM, the surveyor observed Resident #48 lying in bed, sleeping, on an air mattress. The resident's air mattress pump was observed to be set to a weight of 280 pounds.On 1/30/26 at 9:31 AM, the surveyor observed Resident #48 lying in bed, awake, on an air mattress. The resident's air mattress pump was observed to be set to a weight of 280 pounds. The resident stated that they were unsure when the mattress or pump was last checked for function or adjusted.On 2/4/26 at 8:52 AM, the surveyor observed Resident #48 lying in bed, awake, on an air mattress. The resident's air mattress pump was observed to be set to a weight of 280 pounds. On 2/5/26 at 9:03 AM, the surveyor observed Resident #48 lying in bed, awake, on an air mattress. The resident's air mattress pump was observed to be set to a weight of 280 pounds.A review of the admission Record revealed the resident had diagnoses which included but were not limited to; Fracture of the right femur (thigh bone), protein-calorie malnutrition, hydrocephalus, cerebellar stroke syndrome (impaired circulation in the brain), acute and chronic respiratory failure with hypoxia.A review of the resident's most recent comprehensive MDS, dated [DATE], included a BIMS score of 11 out of 15, indicating that the resident had moderately impaired cognition. Further review of the MDS, indicated that the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was at risk to develop a pressure ulcer/injury, and on that date had one stage 4 pressure ulcer (a full-thickness wound that can have exposed muscle, tendon, or bone) present. Additional review of the MDS, revealed that the Skin and Ulcer/Injury Treatments section included a pressure reducing device for the bed and pressure ulcer/injury care. Under nutrition the resident's weight was noted to be 99 pounds.A review of the resident's ICCP included a focus area dated 4/25/19, that the resident had a potential for alteration in skin integrity related to limited mobility, incontinence, and non-compliance with repositioning. Interventions included: Alternating air mattress for skin breakdown prevention; monitor for functioning. A review of the Order Summary Report included the following PO's:A PO, dated 1/16/25, for: Alternating air pressure mattress for skin breakdown prevention; monitor for functioning; every shift.A PO, dated 4/29/25, for: Consults: Wound consult and treat as needed.A review of the Wound Care Progress Notes with a noted dated 12/23/25, noted Wound Dr. saw resident today upon evaluation: no excoriation or wounds found and noted to use Alternating mattress, bilateral heel booties, [seat] cushion for preventative measures. No new wounds have been noted for the resident.On 2/5/26 at 9:24 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding Resident #14's and Resident #48's air mattress settings. The LPN stated air mattresses function was to offload pressure from actual wounds and to alleviate pressure points for at-risk residents. The LPN stated that residents were care planned for them, a wound care consultant wound recommend the air mattress and a doctor would sign an order for it. She then stated that they were initially set up by a vendor for the rented units, or by facility housekeeping for facility owned beds; she continued that they were checked every shift multiple times, and that everyone was responsible for checking proper function. When asked about the different settings on the air mattress pump, the LPN replied that the numbers went by increments, and the number should be set to the one closest to the resident's weight.On 2/5/26 at 10:30 AM, the surveyor interviewed the Director of Nursing (DON) regarding Resident #14 and #48's air mattress settings. The DON stated that a wound specialist or primary physician would typically place the order for a specialized mattress. She then stated that facility owned beds were set up by staff, and that her expectation was that nursing would check the mattresses after setting up for proper function. She stated that air mattresses were to be set according to the resident weight; that her expectation was that nursing would check for proper function every shift and stated that if the mattress was deflated it could cause injury or affect healing of wounds. At 10:37 AM, the surveyor asked the DON to check Resident #14 and Resident #48's last recorded weights. The DON stated that Resident #14's last recorded weight was 117.6 pounds and Resident #48's last recorded weight was 99 pounds.On 2/5/26 at 10:39 AM, the surveyor and the DON entered Resident #14's room and checked the air mattress setting. The DON confirmed that it was set to 200 pounds and adjusted the mattress to 120 pounds.On 2/5/26 at 10:41 AM, the surveyor and the DON entered Resident #48's room and checked the air mattress setting. The DON confirmed that it was set to 280 pounds and adjusted the mattress to 100 pounds.On 2/5/26 at 12:43 PM, in the presence of the survey team, the surveyor made the Administrator and the DON aware of the concerns regarding Resident #14's and Resident #48's air mattress. The Administrator and DON acknowledged that air mattresses should be set according to a resident's weight to prevent skin breakdown.A review of the facility's Support Surface Policy, reviewed 10/25 by the facility, included: Support surfaces will be utilized in accordance with manufacturer recommendations and physician orders.a schedule for inspection and replacement will be established accordingly.for powered devices, or those requiring air, the licensed nurse will check each shift and PRN (as needed) for proper functioning and/or inflation.A review of the manufacturers Operation Manual for the air mattress and pump provided to the surveyor by the facility states: Step 4.0 system package: Weight, simply press weight button to adjust patient, weight 100 pounds to 325 pounds according to patient weight.Step 7.0 Program Settings, .adjust the mattress' internal pressure according to the patient weight by using the weight button on the control panel.A review of another manufacturers Operation Manual for the air mattress and pump provided to the surveyor by the facility states: Step 6, Determine the patient's weight and set the control knob to that weight setting on the control unit.NJAC 8:39-27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to consistently write a Progress Note (PN) as per physician orders for residents on hemodialysis (HD-a treatment that replicates the kidney's function and cleans the waste from the blood for individuals with kidney disease or failure) pre and post HD treatment. This deficient practice was identified for 2 of 2 residents (Resident #1 and #6) reviewed for dialysis.This deficient practice was evidenced by the following:1.On 1/29/26 at 10:04 AM, during the initial tour, the surveyor observed Resident #6 resting in their bed. The resident informed the surveyor that they received HD.The surveyor reviewed the electronic medical records (EMR) for Resident #6.A review of Resident #6'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; dependence on renal dialysis (a state of chronic dependence on a machine and medical professionals to maintain life when the kidneys are no longer able to function properly), and anemia in chronic kidney disease (damaged kidneys cannot produce enough of the hormone erythropoietin (EPO- a hormone produced mainly by the kidneys), which tells the body to make red blood cells).A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 11/25/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #6 had intact cognition. Further review of the MDS indicated the resident received HD.A review of the individualized comprehensive care plan (ICCP) created on 7/25/25 included a focus care area of the resident was on Hemodialysis related to renal failure, Dialysis days: Monday and Friday. Time for pick up from dialysis: 2:00 pm and approximate return time was 2:30 pm.A review of Resident #6's Order Summary Sheet (OSR) revealed the following physician orders (POs): Dialysis return documentation: under progress note (PN). Select Dialysis every evening shift every Monday, Wednesday, and Friday for dialysis protocol, dated 8/19/25; Dialysis outgoing documentation: under PN every day shift every Monday, Wednesday and Friday for dialysis protocol.A review of Resident #6's December 2025 and January 2026 Medication Administration Record (MAR) reflected both POs were transcribed in the MARs for Monday, Wednesday and Friday. The MARs reflected a check mark with nurse's initial which meant the nurses were signing off as the PN were completed for each HD day.A review of Resident #6's PNs in the EMR indicated the following:There were missing Pre-HD (prior to leaving for HD) notes for the following dates: 12/1/25, 12/3/25, 12/8/25, 12/10/25, 12/12/25, 12/15/25, 12/17/25, 12/19/25, 12/22/25, 12/24/25, 12/26/25, 12/31/25, 1/2/26, 1/7/26, 1/14/26, 1/16/26, 1/19/26, 1/28/26 and 1/30/26.There were missing Post-HD (upon return from HD) notes for the following dates: 12/1/25, 12/3/25, 12/5/25, 12/10/25, 12/12/25, 12/17/25, 12/22/25, 12/24/25, 12/26/25, 12/31/25, 1/7/26, 1/9/26, 1/14/26, 1/16/26, 1/19/26, and 1/28/26. On 2/4/26 at 1:26 PM, the surveyor interviewed the resident's assigned Registered Nurse (RN) who stated the process for a HD resident was to check vital signs (VS; measurements of BP, Heart rate, Respirations .) prior to them leaving the facility and documenting those VS in the HD communication form (a simple, standardized document used to share critical patient information between a dialysis center and another facility). The RN further stated VS would be documented in the EMR also. The RN stated Resident #6 had HD twice a week on Monday and Friday and the resident's old scheduled days were Monday, Wednesday and Friday. The RN further stated they would document PNs in the EMR for post HD including resident's VS and list of medication that they received during HD.On 2/4/26 at 2:06 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated the process for the HD residents was to check resident's VS pre and post HD, check the site for bleeding post HD and assess the site for Bruit (an important sound and indicator of how well your dialysis access is functioning) and Thrill (buzzing sensation can be felt) and all the findings would be documented in the HD book. The LPN/UM further stated VS, and any concerns should be documented in General notes (PN) in the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EMR. In the presence of the surveyor, the LPN/UM reviewed Resident #6's HD POs and stated when the nurses sign on the MARs, then they should be documenting in the PNs for Pre and Post HD. The surveyor made the LPN/UM aware of the above-mentioned concerns regarding Resident #6's missing PN for the above listed dates. 2.On 1/29/26 at 10:30 AM, during the initial tour, the surveyor did not observe Resident #1 in their room. The surveyor reviewed the EMR for Resident #1.A review of Resident #1's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; dependence on renal dialysis and anemia in chronic kidney disease.A review of Resident #1's most recent quarterly MDS dated [DATE], reflected that the resident had a BIMS score of 13 out of 15, which indicated that Resident #1's had intact cognition. Further review of the MDS indicated the resident received HD.A review of Resident #1's individualized comprehensive care plan (ICCP) created on 7/25/25 included a focus care area that the resident was on Hemodialysis related to renal failure. Dialysis days: Monday, Wednesday and Friday. Chair time at 5:15 AM, pick up at 4:30 AM.A review of Resident #1's OSR revealed the following POs: Dialysis outgoing documentation: under PN every night shift every Tuesday, Thursday, and Sunday for Protocol, dated 9/12/25; Dialysis return documentation: under PN. Select Dialysis every day shift every Monday, Wednesday, and Friday, date 9/10/25.A review of Resident #1's December 2025 and January 2026 MAR reflected that both POs were transcribed on the MARs. The MARs reflected a check mark with nurse's initial which meant the nurses were signing off as the PN were completed for each HD day.A review of Resident #1's December 2025 through January 2026 night shift PNs in the EMR indicated no pre-HD PNs for the following dates: 12/7/25, 12/21/25, 1/1/26, 1/4/26, 1/6/26, 1/20/26, 1/26/26.A review of Resident #1's December 2025 through January 2026 day shift PNs in the EMR indicated no post HD PNs for the following dates: 12/3/25, 12/8/25, 12/23/25, 12/26/25, 12/29/25, 1/7/26, 1/9/26, 1/14/26, 1/16/26, 1/19/26, 1/23/26, and 1/30/26. On 2/5/26 at 10:30 AM, in the presence of the surveyor, the LPN/UM reviewed Resident #1's EMR for HD POs and stated the nurses should be documenting/writing PN because they were signing off POs in the MAR as completed. The LPN/UM stated they (nurses) should be writing a PN each time when the resident went out and returned from HD. The surveyor made the LPN/UM aware of the above-mentioned concern of the missing HD PN.On 2/5/26 at 12:46 PM, the surveyor made the Director of Nursing (DON), the Regional DON and the Licensed Nursing Home Administrator (LNHA) aware of the concerns for Resident #6 and Resident #1. A review of the facility's Hemodialysis policy dated 10/23 revealed under policy: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders,. of residents receiving hemodialysis.A review of the facility's Documentation in Medical Record policy dated 10/25 revealed under policy Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Under Policy explanation and compliance guidelines: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, no later than the shift in which the assessment/evaluation, observation, or care service occurred. 3.a. Documentation shall be factual, objective, and resident centered. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care c. Documentation shall be timely and in chronological order.NJAC 8:39- 27.1(a)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to post the daily Nursing Home Resident Care Staffing Report (NHRCSR) that was up to date. This deficient practice was identified on 1/29/2026 and was evidenced by the following:On 1/29/2026 at 8:55 AM, upon entrance to the facility, the surveyor observed the NHRCSR posted in the main lobby dated 1/22/2026 for all three shifts: 7 AM to 3 PM, 3 PM to 11 PM and 11 PM to 7 AM. On 1/30/2026 at 11:41 AM, the surveyor interviewed the Staffing Coordinator (SC), who stated she was responsible for completing the staffing report. She stated she posted the staffing report daily during the week and the weekend supervisor posted it on the weekends. The surveyor made her aware of the above observations. She acknowledged the report should have been changed every day.On 1/30/2026 at 11:55 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated the SC was responsible for posting staffing the staffing report during the week and the weekend supervisor posted it on the weekend. On 2/5/2026 at 12:47 PM, during a meeting with the survey team, the surveyor made the LNHA, the Director of Nursing, and the Regional Director of Nursing aware of the above findings. A review of the undated facility policy Nurse Staffing Posting Information revealed Policy: It is the policy of this facility to make sure staffing information readily available in a readable format to residents and visitors at any given time. Policy Explanation and Compliance Guidelines: 1. The Nurse Staffing sheet will be posted on a daily basis.4. A copy of the schedule will be available to all supervisors to ensure the information posted is up to date and current.NJAC 8:39-41.2 (a)(d)

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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. Based on observation, interview, and review of medical records, it was determined that the facility failed to follow a physician's orders (PO) for medications with a parameter and acceptable professional standards of practice for one (1) of seven (7) residents (Resident #1), reviewed for medication management. The deficient practice is 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 casefinding, 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 casefinding; 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 1/29/26 at 10:30 AM, during the initial tour of the unit, the surveyor observed Resident #1's room with a No smoking, O2 (Oxygen) in use signage on the door. The surveyor did not see the resident in the room.The surveyor reviewed the electronic medical records (EMR) for Resident #1.A review of the admission Record (admission summary) revealed that Resident #1 had diagnoses that included but were not limited to; end stage renal disease (the final, permanent stage of kidney failure where kidneys no longer function well enough to support life, usually operating at less than 15% capacity), Essential hypertension (high blood pressure that occurs in the absence of any contributing medical condition), and type 2 diabetes mellitus (a common, long-term condition where the body cannot effectively use or produce enough insulin, causing sugar (glucose) to build up in the blood).A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 11/9/25, revealed the resident had a Brief Interview Mental Status (BIMS) score of 13 out of 15, which indicated that the resident had intact cognition. Further review of the MDS indicated that Resident #1 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) included a focus area Diabetes Mellitus dated 5/17/23. Interventions included but were not limited to: diabetes medication as ordered by doctor initiated on 5/17/23. Another focus area with date initiated 8/7/25 included that the resident had diagnosis (Dx) Hypertension. Interventions included: Give anti-hypertensive medications (class of drugs that are used to treat high blood pressure(bp)) as ordered. Monitor for side effects .A review of the February 2026 Order Summary Report (OSR) reflected the following POs:1. NovoLOG FlexPen (pre-filled, disposable insulin injection device) Subcutaneous (located underneath the skin) Solution Pen-injector 100 UNIT/ML (Insulin Aspart (a fast acting insulin to treat diabetes)) - Inject 4 unit subcutaneously two times a day every Mon, Wed, Fri for DM Hold for Blood Sugar less than 120 AND Inject 4 unit subcutaneously three times a day every Tue, Thu, Sat, Sun for dm Hold for Blood Sugar less than 120 dated 9/10/25.2.Midodrine HCl Oral Tablet 5 MG (Milligrams) - Give 1 tablet by mouth one time a day every Mon, Wed, Fri for hypotension (low blood pressure) hold for spb (Systolic blood pressure / the top number in a blood pressure reading) greater then 140 dated 9/17/25.A review of the December 2025 electronic Medication Administration Record (eMAR) revealed that the Novolog insulin was marked with a check which indicated the medication was administered for 3 doses when the resident's blood sugar was recorded less than 120 for the following dates:12/5/25 at 12:15 PM= BS 11412/12/25 at 1715 (5:15 PM) = BS 10712/17/25 at 1715 (5:16 PM) = BS 110A review of the January 2025 eMAR revealed that the Novolog insulin was marked with a check as administered for 2 doses when the resident's blood (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sugar was recorded less than 120 for the following dates:1/20/26 at 8:15 AM= BS 1091/22/26 at 12:15 PM= BS 118A review of the December 2025 eMAR revealed on 12/22/25 resident's BP was recorded to be 137/77 and the midodrine was marked with code #4 which meant medication was not administered due to vital signs out of perm (parameters). The medication should have been given for a BP less than 140.A review of the January 2026 eMAR revealed on 1/21/26 resident's BP was recorded to be 146/72 and the midodrine was marked with a check as administered. The medication should have been held for a BP greater than 140.On 2/5/26 at 10:05 AM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated the check mark on the MARs meant that the medication was administered. She stated if the medication was held due to hold parameters, there would be a code number entered. The surveyor reviewed Resident #1's Novolog insulin PO with the LPN/UM who stated if the BS was less than (<) 120 then they would not administer and would write a progress note (PN) in the eMAR or they would generate a separate PN in the [Name Redacted] EMR. The LPN/UM stated insulin should not be given if the BS was < 120 as it was a PO and further stated it could cause a drop in the resident's BS and the resident could get confused, diaphoretic (sweating heavily due to BS too low) and loose conscious if the BS dropped too low. The surveyor made the LPN/UM of the above-mentioned Novolog administration concerns. The LPN/UM stated the nurses should have held the insulin if the BS was < 120 as per the PO. In the presence of the surveyor, the LPN/UM reviewed December 2025 and January 2026 MARs and stated they were medication errors and further stated she would notify the physician, fill out a pharmacy incident report, notify the Director of Nursing (DON) and the medical director (MD).At that time, the surveyor interviewed the LPN/UM about the Midodrine, and the LPN/UM stated Resident #1 was on dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys cannot) and medication should be administered so the resident's blood pressure does not drop too low. The LPN/UM further stated if the resident's BP dropped too low then they could lose consciousness, get confused and it could cause multiple other complications. In the presence of the surveyor, the LPN/UM reviewed the December and January 2026 MARs and confirmed the medication was not administered on 12/22/25 for BP 137/77 and it should have been given. The LPN/UM confirmed that the dose was administered on 1/21/26 when the BP was 146/72 and it should have been held. The LPN/UM further stated midodrine elevates BP and can cause a heart attack, stroke with high blood pressure and many other complications. The LPN/UM stated the expectation from the nurses was to follow the PO correctly and they should not be administering mediations if they were out of parameters as they (parameters) are there for a reason.On 2/5/26 at 12:46 PM, the surveyor made the DON, the Regional DON and the Licensed Nursing Home Administrator (LNHA) aware of the above concerns.A review of the facility's Insulin Administration policy dated 10/25 reflected, 1. All insulins will be administered in accordance with physician's orders. 4. Administer insulin per physician order .7. Review the insulin order.A review of the facility's Medication Administration policy dated 10/25 reflected, Under Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, . Under Policy Explanation and Compliance Guidelines: 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medications for those vital signs outside the physician's prescribed parameters. NJAC 8:39-11.2 (b); 29.2(d)