

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2025
NAME OF PROVIDER OR SUPPLIER  Tallwoods Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  18 Butler Boulevard Bayville, NJ 08721	

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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Complaint # 2638538Based 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 to ensure adequate procedures for maintaining accurate records, tracking, and timely investigation of discrepancies related to controlled substances leading to actual and potential drug loss or diversion. This deficient practice was identified for a.) 1 resident (Resident #78) reviewed for pharmaceutical services and for b.) 5 unsampled residents (Residents #45, #115, #134, #142, and #168) identified during medication storage inspection of 2 of 4 medications carts (Maple High, Pine Low, and Pine Swing) and was evidenced by the following:1.) On 11/19/2025 at 11:30 AM, the surveyor observed Resident #78 in bed awake. The resident stated that they were not in pain. When resident was asked if they have missed any dose of their pain medication in the facility, the resident stated they have not missed any pain medication and had no complaints. On 11/20/2025 at 9:39 AM, the surveyor reviewed the medical record for Resident #78.A review of the admission Record (admission summary) indicated that Resident #78 was admitted to the facility with diagnoses which included but was not limited to cellulitis (bacterial infection of deeper tissues causing pain in the area affected) of the right lower limb and changes in skin texture.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 9/12/2025, indicated that Resident #78 scored a 15/15 on the Basic Interview for Mental Status (BIMS) which indicated that the resident had intact cognition. The MDS also reflected that the resident did not exhibit any untoward behaviors.A review of the Order Summary Report active as of 11/20/2025 included a physician's order for Percocet oral tablet 7.5-325 mg (oxycodone w/ acetaminophen) give 1 tablet by mouth four times a day for chronic pain started on 7/14/2025.A review of the September 2025 Medication Administration Record (MAR) reflected that the physician order for Percocet was administered to Resident #78 with no missed dose.A review of the form AA-45 (Facility Reportable Event) dated 10/7/2025, indicated that on an unspecified date, a suspected narcotic diversion of 1 blister pack (bingo card) containing 60 tablets of Percocet from a Registered Nurse (RN #1) was identified and reported by the facility to the Consultant Pharmacist, New Jersey Department of Health (DOH), New Jersey Board of Nursing (BON), the Drug Enforcement Agency (DEA), and the local law enforcement.A review of the facility investigation revealed that on 9/18/2025, two 60-count cards of Percocet was received by the facility from the pharmacy for Resident #78. On 10/5/2025, the first 60-count Percocet card was depleted. On 10/6/2025, the facility request for a refill of Percocet for the resident was declined by the pharmacy due to recent refill. Facility investigation identified discrepancies, including alterations and use of white-out eraser on the September 2025 narcotic inventory sheet NIS) of the Maple low unit, where Resident #78's medications were stored, dated 9/20/2025 on 11-7 and 7-3 shifts and on 11-7 shift of 9/21/2025. The facility concluded that the diversion was isolated to one agency nurse, RN #1 who worked on 9/20/2025 3-11 and 11-7 shifts until 4:00 AM of 9/21/2025.A review of September 2025 narcotic inventory sheet (NIS) for the Maple low unit by the surveyor revealed no signatures from the incoming and outgoing nurses on the 11-7 shift of 9/21/2025. According to the NIS, Must be counted and signed each shift. Supervisors to initial for all new additional narcotics. The box where the supervisor was supposed to sign when the 2 bingo cards of Percocet were delivered on 9/18/2025 at 11-7 shift was blank. A review of the NIS from 9/1/2025 to 9/30/2025, did not reveal any supervisor signature for all narcotics added to the inventory count. The surveyor noted white-out erasures and alterations on the number of cards for 11-7 and 7-3 shifts of 9/20/2025, and on 11-7 shift of 9/21/2025. On 9/20/2025, 26 narcotic cards were counted for 7-3 shift and out of the 26 cards, 2 cards were removed. Further review of the NIS revealed that the Individual Patient's Controlled Drug Record (IPCDR) sheets were not being counted to match the number of narcotic medication cards, boxes, bottles, and/ or bags and for comparison with every new narcotic medication received by the facility from the pharmacy. On 11/21/2025 at 11:32 AM, the surveyor interviewed the Pharmacy Consultant (PC) by telephone who stated that shift-to-shift report includes narcotic counting between 2 nurses must match and must be signed by 2 nurses.On 11/24/2025 at 10:22 AM, during an interview with the surveyor, Registered Nurse (RN #2) confirmed that they counted the narcotics in Maple low cart with RN #1 on 9/21/2025 at 4:00 AM. RN#2 was asked why the shift-to-shift NIS form was blank on 11-7 shift of 9/21/2025. RN #2 stated because there was no space on the form to sign at 4:00 AM.On 11/25/2025 at 9:43 AM, during an interview with the surveyor, the Director of Nursing (DON) was asked how the lost Percocet bingo card was not noted until 10/6/2025 when RN #1 last worked at the facility on 9/20/2025. The DON stated that RN</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Complaint # 2638538Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to properly store a controlled substance securely inside the medication room. The deficient practice was identified for 1 of 3 medication rooms inspected during the medication storage and labeling task was evidenced by the following: On 11/21/2025 at 11:48 AM, during an inspection of the Pine unit medication room with Unit Manager/ Licensed Practical Nurse (UM/ LPN) #1, the surveyor observed the metal narcotic box unlocked. Inside the narcotic box was a packaging labeled Lorazepam Intensol oral concentrate 2 milligram (mg) per milliliter (ml). Inside the packaging was a bottle filled with fluid labeled Lorazepam Intensol 2 mg/ml and a medicine dropper. UM/LPN #1 stated to the surveyor that the narcotic box should be locked at all times. On 11/24/2025 at 9:30 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that narcotic boxes should be kept locked. A review of facility- provided undated policy titled Controlled Medication Storage Policy reflected the following under Procedures: 1.) All controlled substances must be stored in a double-locked system. N.J.A.C. 8:39 - 29.4 (h)</p>