STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Wall	2621 Highway 138 Wall, NJ 07719

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to treat a resident in a dignified manner that promotes their quality of life. This deficient practice was identified for 1 of 1 residents (Resident #106) reviewed for resident rights and was evidenced by the following:On 3/19/26 at 11:15 AM, during the initial tour, the surveyor noted Resident #106 lying in bed with a tracheostomy (a hole in the neck to help breathing), a feeding tube (tubing that attaches to a pump and delivers liquid nutrition to the stomach/intestines), and a biliary drain (tubing that drains liquid from the bile duct). The resident was unable to respond to surveyor questions.On 3/20/26 at 9:43 AM, the surveyor observed Resident #106 from their open door, in bed, uncovered, with their body exposed. The door to the resident's room was open and the curtain was not drawn. Upon entering the room, the surveyor observed that the resident was wearing an adult incontinence brief; a hospital gown was observed underneath the resident's body. The resident's feeding tube was attached to the pump and running; the biliary drain tubing was observed going under the resident's right arm under their twisted hospital gown. Sputum was noted on the resident's chest just below the tracheostomy site. The resident did not respond to surveyor questions. Non-slip socks were noted lying at the foot of the bed. At that time the Unit Manager (UM) and Licensed Practical Nurse (LPN) entered the room and stated that the resident was due for care. The surveyor left the room.On 3/23/26 at 9:41 AM, the surveyor observed the resident lying in bed covered with a sheet. The resident acknowledged the surveyor and attempted to provide answers to some yes/no questions at that time, the resident denied being in pain or having discomfort.On 3/24/26 at 9:02 AM, the surveyor observed Resident #106 from their open door, in bed, uncovered, with their body exposed. A drainage bag was observed hanging from the resident's bed sheet from the hallway; the surveyor entered the room. Resident #106 was observed with their tracheostomy collar (an oxygen delivery device) rotated to the resident's right side and a small amount of sputum at the site. The resident's left arm was out of their hospital gown, leaving only the right arm and shoulder area covered. An abdominal binder (a hook and loop fastener used to keep medical lines in place by wrapping around the torso/abdomen) was noted on the resident and what appeared to be a blue mechanical lift pad (used to lift/lower residents that are unable to get out of bed or roll over on their own) was noted under the resident. The resident appeared to be sleeping at that time.On 3/24/26 at 12:27 PM, the surveyor observed Resident #106 from the hallway resting in bed with their exposed legs toward the left side of the bed, close to the edge. The surveyor entered the resident's room and observed that the resident had a bed sheet bundled around their thighs and midsection; the resident's legs were bare, and the resident was wearing one sock on the right foot, with nothing on the left. Noted lying on top of the resident's chest was a blue pad, the resident had a hospital gown covering their chest underneath it.The surveyor reviewed the medical record for Resident #106.A review of the admission Record, an admission summary, revealed that the resident had diagnoses which included, but were not limited to, fracture of unspecified part of the neck of left femur (top of the thigh bone) with subsequent encounter for closed fracture with routine healing, encounter for surgical aftercare following surgery on the digestive system, encounter for surgical aftercare following surgery on the respiratory system, (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Wall	2621 Highway 138 Wall, NJ 07719

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acute cholecystitis (gallbladder inflammation), acute respiratory failure with hypoxia (low oxygen levels), severe sepsis with septic shock (bloodstream infection with extreme immune response), and unspecified dementia without behavioral, psychotic, or mood disturbance. A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, revealed that the MDS was still in progress as Resident #106 was newly admitted . A review of social services' assessments was completed instead. A Brief Interview/Assessment for Mental Status (BIMS) was completed on 3/18/26 and revealed that the resident was severely cognitively impaired. A review of social services Activity Evaluation V2 form revealed that the Resident was alert and oriented and required one-to-one needs. A review of the Social Service admission Evaluation V5 form revealed that the resident's verbal ability was poor, could understand and respond at times, with a communication note difficulty communicating due to trach, cognitive impairment, physical debility and a check mark under confused was noted. A review of the Individual Comprehensive Care Plan (ICCP) included a focus area, dated 3/17/26, that the resident had difficulty understanding/communicating related to Dementia with a goal of making needs known to staff. A focus area, dated 3/17/26, revised on 3/20/26, revealed a potential for complications related to cholecystostomy (bile duct) drain site, the goal was to be free from signs and symptoms of infection. An intervention dated 3/17/26 included: monitor placement of chole drain; an intervention dated 3/21/26 added: abdominal binder on at all times, remove for hygiene and skin checks every shift. An intervention from 3/23/26 included: pin the tube to clothing to anchor. The following focus areas, goals and interventions were added after surveyor inquiry. An intervention dated 3/22/26 included anticipating and meeting resident needs and communicating with yes/no questions when able. The ICCP also revealed a focus area, dated 3/22/26, that the resident's tracheostomy was at risk of becoming dislodged/removed related to cognitive impairment and history of self-decannulation; with a goal of the tracheostomy remaining in place. Interventions, dated 3/22/26, included frequent rounding (seeing the resident), providing a busy mat to hold and use, a second intervention for increased frequent rounding, and another for staff to continue with increased rounding, and if [resident] becomes agitated or restless, staff to stay with [resident] until calm. A focus area, dated 3/23/26, for inappropriate dressing/undressing such as removing clothing and sheets, often having skin exposed related to cognitive impairment and dementia; the goal was to maintain a neat and dignified appearance through daily routine. Interventions included a busy mat, elicit family input for best approaches, and to notify family and make arrangements to obtain adaptive clothing if needed. A focus area, dated 3/20/26, included: ADL (Activities of Daily Living) Self care deficit related to physical limitations. Goals for that focus included that the resident: will be clean, dressed and well groomed daily to promote dignity and psychosocial well-being; will not develop complications related to decreased mobility, and will receive assistance necessary to meet ADL needs. Interventions included: assist of 1 person with ADLs, assist to bathe/shower as needed, assist with daily hygiene, grooming, dressing, oral care and eating as needed.A review of the Order Summary Report (OSR), included the following physician orders (PO):A PO, dated 3/17/26, to cleanse biliary (bile duct) drainage tube site with normal saline and cover with CDD (clean dry dressing), every day shift.A PO, dated 3/16/26, to document right chole (bile duct) drain output, every shift.A PO, dated 3/21/26, after surveyor inquiry, for an abdominal binder on at all times, may remove for hygiene, every shift.On 3/24/26 at 12:44 PM the surveyor interviewed a Licensed Practical Nurse (LPN) regarding privacy and dignity for residents. When asked what the staff/facility did to provide privacy for residents, the LPN stated that staff would knock on the door before entering, close the door or curtain during care or sensitive procedures, and to only uncover the bare minimum while providing care. When asked how privacy and dignity are ensured for confused or incontinent residents the LPN responded that staff would do rounds and see the residents every two hours. The LPN stated that staff would look for any drinks that needed refilling, make sure the residents are covered, can reach their call bell and personal items, and to ensure their safety, she stated that nurses do not document the rounds. The surveyor then asked the LPN what (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Wall	2621 Highway 138 Wall, NJ 07719

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they would do if they saw a resident uncovered from the hallway; she responded that she would immediately go into the resident's room to cover them, for their dignity and privacy. When asked if someone in the hallway should be able to see a resident's drainage bag, the LPN responded that drainage bags should always be placed into privacy bags to ensure resident privacy and dignity is maintained. The surveyor then asked the LPN whose job it was to maintain a resident's privacy and dignity in a care setting, the LPN responded that it is all of the staff's responsibility.On 3/24/26 at 12:59 PM the surveyor interviewed the Director of Nursing (DON) regarding resident rights and dignity. The DON responded that it is every staff member's responsibility to ensure resident rights and safety at the facility. The DON also stated that the facility provides privacy for residents by closing doors or curtains depending on resident preference while performing sensitive care procedures such as incontinence care, and that it was her expectation that staff does rounding to check on residents frequently. When asked what staff looks for during rounds, the DON responded that staff would look at the resident's appearance, to see if they look clean and smell clean; that they were expected to do a diaper/brief check on incontinent residents, and to make sure the residents are safe in their room with their equipment. The DON stated that rounds and checks are documented in the electronic medical records under the tasks for nursing aides. When asked about seeing an uncovered resident from the hallways or a drainage bag, the DON stated that it was her expectation that staff would immediately go and assist an uncovered resident to get them covered and provide any care needed at that time. She then stated that any resident drainage bags should be always covered with privacy bags to ensure resident privacy and dignity.On 3/24/26 at 2:14 PM the above concerns and observations were presented to the Licensed Nursing Home Administrator (LNHA) in the presence of the DON and survey team and acknowledged.A review of the facility's policy Resident Rights, revised October 2025, revealed the following: Employees shall treat all residents with kindness, respect, and dignity.federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.a dignified experience.self-determination.privacy and confidentiality.wear or be dressed in clothing, accessories, or cosmetics or to engage in grooming practices that are permitted to any other resident.A review of the facility's Confidentiality of Information and Personal Privacy policy, revised February 2021, revealed the following: Our facility will protect and safeguard resident confidentiality and personal privacy.the facility will strive to protect the resident's privacy regarding his or her: accommodations, personal care, medical treatments.A review of the facility's Dignity policy, revised October 2025, revealed the following: Residents are treated with dignity and respect at all times.each resident is cared for in a manner that promotes and enhances individuality, a sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem.staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: helping the resident keep urinary catheter bags covered.staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example: addressing the underlying motives or root causes for behavior and not challenging or contradicting the resident's beliefs or statements.NJAC 8:39-4.1(a)(12)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Wall	2621 Highway 138 Wall, NJ 07719

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure medications (meds) were administered in the allotted timeframe for 1 of 1 resident (Resident #15) reviewed for medication administration times.This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 3/19/26 at 11:01 AM, during an initial tour, the surveyor observed Resident #15 awake and alert sitting in their wheelchair. Resident #15 informed the surveyor that they had returned from their doctor's appointment and were waiting for their medications. The resident further stated that it was not the first time they had to wait for their morning meds.The surveyor reviewed the electric medical record (EMR) for Resident #15.A review of the admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; Rheumatoid arthritis (a long-term condition that causes pain, swelling and stiffness in the joints), Atrial Fibrillation (A-fib; a common heart condition causing an irregular, often fast, heart rate) and essential (primary) hypertension (htn; high blood pressure that is not due to another medical condition).A review of the comprehensive Minimum Data Set, an assessment tool dated 12/20/25, revealed that the resident had a Brief Interview for Mental Status score of 15 out of 15, indicating cognitively intact cognition.A review of the individualized comprehensive care plan (ICCP) revealed a focus area created on 12/30/25, included pain related to fracture, pressure points/ulcers; right shoulder pain/arthritic. The ICCP Interventions included but were not limited to: administer analgesia (medicines that relieve pain) per physician orders. A further review of the ICCP included a focus area: anticoagulant therapy (blood thinners to prevent, treat, or stop the growth of blood clots) to treat A-fib: At risk for adverse effects, date initiated 3/22/26. The interventions included to administer medication per physician orders. A further review of the ICCP reflected another focus area date initiated 3/22/26: cardiac disease related to arrhythmia (an abnormal or irregular heartbeat where the heart beats too fast (tachycardia), too slow (bradycardia), or with an irregular rhythm), hypertension. The interventions included administer medication per physician orders.A review of Resident #15's Order Summary Record (OSR) included the following physician orders (POs): A PO dated 12/24/25 for enalapril maleate 20 mg - give one tablet by mouth one time a day for htn.A PO dated 12/24/25 for Eliquis 2.5 mg- give one tablet by mouth every 12 hours for A-fib. Monitor for bleeding, bruising and black tarry stools.A PO dated 12/25/25 for prednisone 5 milligram (mg) - give one tablet by mouth one time a day for rashes.A PO dated 12/25/25 for nifedipine extended release (ER) 24 Hour 30 mg - give one tablet by mouth two times a day for htn.A PO dated 3/9/26 for acetaminophen 500 mg - give two tablets orally every 12 hours for shoulder pain for 5 days, Stop date 3/14/26A PO dated 3/9/26 for lidocaine patch 4%- apply to right shoulder one time a day for pain management, apply for 12 hours in a 24-hour period and remove per schedule.A review of the March 2026 progress notes (PNs) revealed no documentation regarding Resident #15's medications not being administered as scheduled according to the PO's.A (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Wall	2621 Highway 138 Wall, NJ 07719

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility Medication Admin Audit Report, dated 3/1/26 through 3/20/26, revealed the following:On 3/1/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 9:49 AM.On 3/2/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 9:19 AM.On 3/3/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 9:13 AM.On 3/5/26:1.enalapril maleate 20 mg one tablet, scheduled for 9:00 AM was administered at 10:53 AM.On 3/7/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 11:02 AM2.enalapril maleate 20 mg one tablet, scheduled for 9:00 AM was administered at 11:02 AM.3.Eliquis 2.5 mg one tablet, scheduled for 9:00 AM was administered at 11:02 AM.4.nifedipine ER 30 mg one tablet, scheduled for 9:00 AM was administered at 11:02 AM.On 3/8/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 9:58 AM.2.enalapril maleate 20 mg one tablet, scheduled for 9:00 AM was administered at 10:03 AM.On 3/10/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 10:35 AM2.enalapril maleate 20 mg one tablet, scheduled for 9:00 AM was administered at 10:34 AM.3.Eliquis 2.5 mg one tablet, scheduled for 9:00 AM was administered at 10:35 AM.4.nifedipine ER 30 mg one tablet, scheduled for 9:00 AM was administered at 10:35 AM.5.acetaminophen 500 mg two tablets, scheduled for 9:00 AM were administered at 10:35 AM.6.lidocaine patch 4% to right shoulder, scheduled for 9:00 AM was applied at 10:39 AM.On 3/11/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 12:41 PM2.enalapril maleate 20 mg one tablet, scheduled for 9:00 AM was administered at 12:41 PM. 3.Eliquis 2.5 mg one tablet, scheduled for 9:00 AM was administered at 12:41 PM.4.nifedipine ER 30 mg one tablet, scheduled for 9:00 AM was administered at 12:41 PM.5.acetaminophen 500 mg two tablets, scheduled for 9:00 AM were administered at 12:42 PM.6.lidocaine patch 4% to right shoulder, scheduled for 9:00 AM was applied at 12:43 PM.On 3/12/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 10:14 AM2.enalapril maleate 20 mg one tablet, scheduled for 9:00 AM was administered at 10:14 AM.3.Eliquis 2.5 mg one tablet, scheduled for 9:00 AM was administered at 10:14 AM.4.nifedipine ER 30 mg one tablet, scheduled for 9:00 AM was administered at 10:14 AM.5.acetaminophen 500 mg two tablets, scheduled for 9:00 AM were administered at 10:14 AM.6.lidocaine patch 4% to right shoulder, scheduled for 9:00 AM was applied at 10:14 AM.On 3/13/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 9:09 AM.On 3/14/26:1.acetaminophen 500 mg two tablets, scheduled for 9:00 AM were administered at 10:07 AM.On 3/15/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 9:12 AM.On 3/16/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 9:43 AM.On 3/17/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 9:56 AM.2.enalapril maleate 20 mg one tablet, scheduled for 9:00 AM was administered at 10:10 AM.On 3/18/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 9:46 AM.On 3/19/26:1.prednisone 5 mg one tablet, scheduled for 8:00 AM was administered at 9:31 AM.On 3/20/26 at 12:51 PM, during an interview with the surveyor, the Registered Nurse (RN) stated that medications could be administered one hour before and one hour after the physician order scheduled administration time. The RN stated the electronic Med Administration Record (eMAR) gives you the time and that's how she knew what time the resident's meds were due at. The RN further stated she would administer meds as per physician orders. The RN further stated she would let the physician know if the meds were administered late. The surveyor inquired if the RN would document that she notified the physician about late med administration. The RN stated, not for that, they would document only if meds were not available and if the physician was made aware. The surveyor showed the Med Audit Report where the RN had signed for 3/12/26 9 AM, scheduled meds were administered at 10:14 AM, the RN stated, Yes, meds can be given late. In a perfect world, we cannot give all 12 patients their meds at 9 AM. I just do the best I can and try to get it done.On 3/23/26 at 12:04 PM, during an interview with the surveyor, the RN/Unit Manager (UM) stated the meds could be administered one hour before and one hour after the scheduled time. The RN/UM stated the nurses should follow the five rights during med administration which include: right patient, right time, right (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Wall	2621 Highway 138 Wall, NJ 07719

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dose, right drug and right route. The RN/UM stated the expectation from the nurses was to make the physician aware if the meds were being administered late, either get a separate order if the meds were delayed for over an hour or if it was okay with the physician then write a progress note stating, MD (doctor) was made aware and okay to administer meds. The surveyor reviewed the Med Audit Report with the RN/UM, and she acknowledged that meds were administered after the hour window. The RN/UM stated once again that the nurses should notify the doctor and document it.On 3/23/26 at 12:21 PM, the Licensed Practical Nurse (LPN/UM) informed the surveyor that she did not see any documentation for Resident #15 where the physician was notified for late med administration.On 3/24/26 at 10:17 AM, during an interview with the Director of Nursing (DON) she stated the expectation from the nurses was to give the meds timely. The DON further stated the nurses should sign off meds as soon as they administer them. The surveyor made the DON aware of the above-mentioned concerns for Resident #15 and the DON acknowledged, I think there is an issue with the late meds and I will speak with them (the nurses) and further stated the nurses should be notifying the physician if it was a true late med administration.On 3/24/26 at 1:58 PM, the survey team met with the DON, and the Licensed Nursing Home Administrator (LNHA). The surveyor made the facility administration aware of the above-mentioned concerns for Resident #15. A review of the facility's Administering Medications policy with revision date 4/19 and CO Edited 2/26/25 revealed Policy statement: Medications are administered in a safe and timely manner, and as prescribed. Under section Policy Interpretation and Implementation: 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication; c. honoring resident choices and preferences. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 10. The individual administering the medication checks the label THREE (3) times to verify the right resident.right time . of administration before giving the medication. 21.If a drug is withheld, refused, or given at a time other than the scheduled time, . using electronic documentation (e.g. eMAR), enter the appropriate documentation code.A review of the facility provided, Job Description - Staff Nurse included but was not limited to; Under Staff Nurse Essential Duties and Responsibilities: 10. Ensures timely and accurate medication.N.J.A.C. 8: 39-27.1