STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315195	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Berkeley Heights	35 Cottage Street Berkeley Heights, NJ 07922

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Complaint # NJ 159516 48422 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure their policy for Abuse Investigation and Icidents and Accidents was followed to ensure a thorough investigation was completed, and documented for: a.) an allegation of verbal abuse by staff to Resident #60, and b.) for a resident who was found on the floor, facing upright with a folded jacket under head, was saturated with urine, difficult to arouse and required emergent transport via 911 to the hospital (Resident #295). This deficient practice occurred for 1 of 1 resident investigated for verbal abuse (Resident #60), 1 of 3 residents investigated for unplanned hospitalization (Resident #295) and was evidenced by the following: a) On 7/14/24 at 6:28 PM, the surveyor observed Resident #60 in the hallway, the resident was alert and oriented and engaged the surveyor. On 07/16/24 11:02 AM, Reisdent #60 stated to the surveyor that there has been concerns that were shared with the Liscensed Nursing Home Admininstrator (LNHA) and there has not been resolution. The facility is very disorganized and the staff takes extended time to answer the call bell and it is hard to find them. The surveyor reviewed the medical record for Resident #60. A review of the Admission Record Face Sheet reflected the resident was admitted to the facility with diagnoses, which included but not limited to unsteadiness on feet, weakness, pure hypercholesterolemia (high cholesterol), acute kidney failure, bipolar disorder in full remission most recent episode mixed (mental health condition), hypertension (high blood pressure), and benign prostatic hyperplasia without lower urinary tract symptoms. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 2/20/24, reflected the resident had a brief interview for mental status score of a 15 out of 15, which indicated a fully intact cognition. On 7/16/24 at 2:30 PM, the surveyor reviewed a facility provided Grievance form for Resident #60 dated 11/22/22 at 6:30 PM. The Grievance form revealed: (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff Member receiving Concern: [name redacted], Human Resource Director (HRD) and [name redacted], Receptionist. Section 1: Describe the Nature of the Concern: upset not enough staff. Certified Nursing Aides (CNA) are so shorthanded. Resident puts light on, as needs help to the bathroom. No one comes. It's middle of night. CNA outside room making fun of resident. [Resident #60] needs to pee pee on [themselves] because they don't come. Unhappy with night shift. No one helps, day shift fine, night shift terrible. Section 2: Concern Referred to Department Head for Review and Intervention: Section 2 of the Grievance form, was not addressed; all sections were left blank. The sections that were left blank included: Department head, Date, Review and Action Taken. Section 3: Follow up with Resident/Family Member: Issue last night was that bed wasn't made and CNA denied this even though bed wasn't made. Name of Staff Completing Follow-up: Name redacted (Social Worker) dated 11/23/22 Section 4: Further Action Required and/or New Grievance Generate Concern and/or Grievance Resolved Section 4 of the Grievance form was not addressed; there was no check mark that indicated that the grievance needed further action or that the grievance was resolved. The Grievance Form was signed by the Director of Nursing (DON), dated 11/22/22. On 7/17/24 at 9:41 AM, the surveyor conducted a follow-up interview with Resident #60 about the Grievance that was filed on 11/22/22. The Resident stated that their memory was off sometimes and did recall however, that it was possible that the staff made fun of [them] and laughed. Resident #60 further stated that the staff often had attitudes, make faces, and ignore the residents. The Resident stated that they went, to the LNHA in the past about issues, and the LNHA does not do anything about it, This place is the most disorganized place in my life. On 7/17/24 at 12:40 PM, the surveyor interviewed the DON and the LNHA in the presence of the survey team. The LNHA and the DON were both made aware of the incomplete Grievance Form for Resident #60. The DON confirmed that it was an allegation of abuse. The surveyor requested all additional documentation regarding of the grievance that was filed by Resident #60 for verbal abuse. On 7/17/24 at 1:25 PM, in the presences of the survey team, the surveyor interviewed the DON who stated that she spoke with the resident and that is what I have, nothing more regarding the investigation. The DON then provided a copy of a Employee's Statement of Incident, with the DON Signing as the Employee. The DON then confirmed that she was the person who also signed the incomplete Grievance Form. The DON further stated that no investigation was completed and that she only spoke with the resident. The DON confirmed that she had nothing else to provide. The DON's Statement of Incident Form dated 11/25/22, revealed: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Type of Incident: __Fall __Skin Tear __Bruising __Facture Other Type of Incident: [Possible] Verbal Abuse IN YOUR WORDS DESCRIBE THE INCIDENT BELOW, INCLUDE WHHAT HAPPENED, WHO WAS INVOLVED, WHERE IT HAPPENED, WHY IT HAPPENED, WHEN REPORTING WHAT OTHER HAVE SAID USE QUOTES. SIGN AND DATE THE FORM. Employee's Statement: Resident #60 came to me laughing saying I pee pee on myself. There was not enough staff. I had a conversation with Resident #60. I asked them if they were alright. Did someone hurt your feelings? They said no, they were joking about it. Resident #60 said we need more staff, I explained we are trying to hire. I told Resident #60 if anyone hurts their feelings to come to me. They waived their hand and said, I don't care. Follow up: spoke with staff, all denied him complaining. I see Resident #60 daily and will continue following up. Signed by the DON The DON did not provide any additional statements regarding any other staff, residents, including a roommate that may have been present. Additionally, the DON failed to further address the resident's staffing concerns which were consistent with the concerns expressed to the surveyor 1.5 years later. On 7/17/24 at 1:43 PM, the surveyor interviewed the HRD who stated that she was standing there with the receptionist when Resident #60 came up to file a grievance. The HRD explained that they follow the chain of command, and she was told by the DON and LNHA that it was handled. On 7/18/24 at 6:58 PM, surveyor had a telephone interview with the receptionist who was present with the HRD, when Resident #60 wanted to file a grievance. The receptionist stated that the resident was very upset because the staff were laughing at them in the hallway. She stated, [Gender redacted] is someone that does not fabricate stories and if he comes with a complaint, I believe him. The receptionist stated she either put the grievance form in the LNHA's or Social Workers mailbox. b) On 07/15/24 at 9:15 AM, the surveyor reviewed the closed medical record for Resident #295 which revealed: An Admission Record that indicated the resident was admitted on [DATE] with diagnoses that including, but not limited to: Acute Respiratory Failure, Nontraumatic Intracranial hemorrhage, Unspecified, and Pulmonary Embolism. The Order Summary Report dated 11/09/22 revealed the Resident was a Full Code. An admission note, dated 11/09/22 at 14:29 and signed by a Licensed Practical Nurse (LPN) revealed Time of arrival 1:40 PM and medications confirmed and verified by the physician. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Physician Progress Note, Effective Date: 11/10/22 at 14:20 revealed that Patient AAO (Awake Alert and Oriented) X 3 but has periods of disorientation when asking history. A General Nurses Note, Effective Date 11/10/2022 at 20:57 [8:57 PM] and signed by Registered Nurse revealed: Note Text: Resident was received in bed at the beginning of shift this afternoon in bed watching TV in no acute distress, second day post admission adjusting well to service prior to this incident today. Nurse observed resident 10 minutes before being discovered. CNA [Certified Nurse Aide] was in resident's room to deliver dinner when the resident could not be found and the CNA called the resident's name while checking the bathroom until the CNA walked around the window side of the bed and discovered the resident on the floor in supine position with the folded jacket under the head and breathing but very difficult to arouse. Supervisor arrived to the scene and met an [AGE] year old female snoring heavily saturated with urine, the resident was first assessed on the floor placed on left side in a recovery position in case of emptying stomach content all vital signs were within normal limit including O2 at 98-99%. Resident was placed in bed while code status was confirmed as full code and 911 activated. The surveyor then reviewed the requested investigation provided by the Director of Nursing (DON) on 07/15/24 at 9:00 AM. The investigation revealed: Fall, Dated 11/20/2022 Nursing Description: Resident was observed on the floor next to the radiator in a supine position with head over a folded jacket snoring heavily, very difficult to arouse and non-responsive to call or touch. Resident Description: Unable to Obtain. Immediate Action Taken: Vital signs were all within normal limits . Resident was assisted to bed and place on non-rebreather mask as 911 was activated. Injuries Observed at Time of Incident, no injuries observed at time of incident. The Predisposing Physiological, Environmental and Situation Factors were all left blank. The Other info [information section] revealed Incident was unwitnessed. [Resident] was seen in bed by aide moments later went to serve dinner and located on the floor. Statements: No Witnesses Found. Progress Note 11/10/2022 at 20:57 [8:57 PM] attached to investigation. No witness statements, including statement from the CNA, no summary and conclusion regarding unwitnessed fall, including how the resident was found lying on their back with a jacket under their head like a pillow. On 07/15/24 at 1:45 PM, the surveyor interviewed the DON in the presence of the survey team, in presence of Licensed Nursing Home Administrator (LNHA) regarding the incomplete investigation and lack of statements. The DON stated that she told the regional that in the beginning of 2023 that she did not like the new process for investigations. The DON stated that for years they used the blue folder system and now they were told that the investigation had to be in the risk management system and it didn't feel complete, and now, if there was a witness, it would be type in. The DON stated I never had an issue with incident reports ever because for injuries of unknown origin we would investigate then. The DON stated she would look to see if she had anything else. On 07/15/24 at 2:20 PM, the DON informed the surveyor that what was provided for Resident #295 was all that she had and confirmed no other statements were taken and no other documentation regarding an investigation was completed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Incidents and Accidents Policy, dated 1/2024, revealed it is the policy of this facility for staff to report, investigate, and review and accidents or incidents that occur, on facility property and may involve or allegedly involve a resident. Definitions: Accident: refers to any unexpected or unintentional incident, which result or may result in injury or illness to a resident. Incident: is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor, or staff member. Policy explanation: The purpose of incident reporting can include Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. Alert risk management and/or administrator of occurrences that could result in claims or further reporting requirements. Meeting regulatory requirements for analysis and reporting of incidents and accidents. Compliance Guidelines: 3. Incidents or accidents involving employees or visitors will be documented per the facility policy. 4. Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed, and reported according to the facility's abuse prevention policy. A review of the facility's policy titled, Abuse Investigation and Reporting reviewed, and updated on October 2022, revealed the following: All reports or resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Abuse, Neglect and Exploitation Policy, dated 07/12/23 revealed: v. Investigation of Alleged Abuse, Neglect and Exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of the allegation. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. Role of Administrator: - If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. - The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. - The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of investigation. - The Administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. NJAC 8:39-27.1 (a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Based on record review and interview, it was determined that the facility failed to accurately assess Resident #74 for a behavior management program which would address the behavior of wandering and urinating on the floor/other residents's rooms. Resident #74 exhibited these behaviors since December 2023. The facility failed to revise the care plan to include meaningful interventions to address these behaviors. This deficient practice was observed for 1 of 3 residents reviewed for management of behaviors (Resident #74) and was evidenced by the following: On 07/15/24 at 8:30 PM, two awake and alert residents, reported that they were disturbed by Resident #74's behavior of wandering into their rooms and displacing their belongings. The wandering resident was identified as Resident #74 who resided on the back of the A Wing of the facility. A Certified Nursing Assistant (CNA) who reported that she had a good rapport with Resident #74 confirmed the behavior and informed the surveyor that the red stop signs were applied to prevent Resident #74 from entering other residents rooms. However that did not stop Resident #74 from entering other residents rooms. On 07/17/24 at 10:30 AM, the surveyor reviewed Resident #74's electronic medical record (eMR). A review of Resident #50's Admission Record (An Admission Summary) reflected that Resident #74 was admitted to the facility and had diagnoses which included but were not limited to; vascular dementia, major depressive disorder, cerebral infarction. and generalized anxiety disorder. A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 06/15/24, reflected that Resident #74 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident's cognition was severely impaired. A further review of the resident's MDS, Section E - Behavior indicated that E 0900 which referred to wandering was coded as zero. A review of Resident #74's Care Plan revised on 09/19/23, reflected a focus area that Resident #1 had impaired cognitive function/dementia or impaired thought processes related to Dementia. The goals of the resident's Care Plan was Resident #74 would improve current level of cognitive function through the review date of 06/06/24, initiated on 09/14/23. Resident #74 will maintain current level of cognitive function through the review date, initiated on 09/14/23. Resident #74 will be able to communicate basic needs on a daily basis through the review date, initiated on 09/14/23. Resident #74 will develop skills to cope with cognitive decline and maintain safety by the review date, initiated on 09/14/23. Resident #74 will maintain current level of decision making ability by review date, initiated on 09/14/23. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note dated 12/03/2023 timed 18: 23 [6:23 PM] Pacing up and down the hallways going into other residents room taking their belongings, difficult to redirect. A behavioral note dated 1/25/24 timed 07:21 AM, revealed: Resident #74 alert with confusion, continent and ambulatory. Monitored closely, 30 minutes watch, to ensure their safety and the safety of others. Resident #74 went to the hallway once and was redirected. At 4:35 AM, Resident #74 went into Room A 31's bathroom and was redirected by this writer into their bathroom. Left in their bed at 7:00 AM. On 02/29/24 at 13:55 [1:35 PM] a Progress Notes written by a Registered Nurse (RN) reflected that a CNA observed Resident #74 on the floor in room [ROOM NUMBER]. Resident #74 reported right hip and rib pain. The facility did not indicate how Resident #74 was able to wander into another resident's room and staff was not aware. According to the note, Resident #74 was placed on 2 hours monitoring. The facility did not investigate further to rule out abuse. On 03/25/24 at 00:56 [12:56 AM] the LPN documented a the behavioral note: Continues to wander into other residents rooms, touching their belongings, eat their food and urinate in hampers. On 03/27/24 at 07:28 AM the LPN documented, Resident #74 continues to wander into other resident's room and taking their stuff, eat their food and urinate in their rooms. Resident #74 is very difficult to redirect. Resident #74 starting on 2 hours monitoring. Resident likes to pacing up and down the unit. On 07/14/24 at 6:30 PM, and 07/18/24 at 9:30 AM, Resident #50 reported that Resident #74 continued to enter their room and urinated in their trash can. On 07/16/24 at 10:30 AM, the surveyor interviewed Resident #74's roommate regarding the behavior. The roommate confirmed the behavior, and added that Resident #74 kept them up most of the night which interfered with their sleep. Resident #74 will turn off their Bipap machine (machine that helps with breathing) and rummaging through their belongings. On 07/18/24 at 11:30 AM, the surveyor interviewed the LPN/Unit Manager. The LPN/UM confirmed the behavior. The LPN/UM stated that another resident resided in the room, prior to Resident #50 and she was aware that Resident #74 frequently entered the same room and urinated into their trash can. She was not aware that Resident #74 continued to enter Resident #50's room and continued to urinate into their trash can. When asked, how the behavior was addressed, she indicated that stop signs were placed at the door entrance for residents who expressed concerns over the wandering behavior. On 07/18/24 at 12:15 PM, the Nurse Practitioner and the LPN/UM confirmed the behavior of wandering and urinating in the room and in other residents' trash cans. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint #NJ 00175040 Based on observation, interview, review of records, and review of pertinent documents, it was determined that the facility failed to provide a.) appropriate incontinence care, and personal hygiene care for 8 of 23 residents (Resident #2 and #31) unsampled residents, #9, #24, #30, #39, #50, #63, and #64, sampled on 2 of 4 resident units. The deficient practice was evidenced by the following: On 07/14/24 around 6:15 PM, the surveyor toured the North Wing of the facility. At 6:30 PM the surveyors entered the A Wing, a strong malodorous odor of urine and feces was permeated in the hallway. The surveyor observed Resident #63 sitting in a recliner chair by their door. Resident #63 could not speak, was mumbling and scratching. Resident #63 was unable to answer any question. 1. On 07/14/24 at 6:24 PM, the surveyor observed Resident #39 in bed by the door. Resident #39, stated, I need help. The surveyor observed another resident exited the room, the resident hold their nose and stated that Resident #39 needed to be seen by a doctor. A strong feces odor was noted in the hallway leading to Resident #39's bed. The surveyor observed a Certified Nursing Assistant (CNA) in the next hallway and summoned her to the room. The surveyor informed the CNA that she would like to perform a care tour. The CNA entered the room, checked Resident #39 for incontinence. Resident #39 was soiled with feces and had some redness on the coccyx area. According to staff, Resident #39 was just readmitted to the facility on [DATE]. The CNA informed the surveyor that she reported to work at 4:30 PM, and had not provided care yet to some of the residents. Review of Resident #39's plan of care revealed a focus area for limited physical mobility related to weakness. The interventions were to provide supportive care, assistance with mobility as needed. Resident #39 although dependent on staff for care did not have a focus for their Activities of Daily living. (continued on next page)

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Autumn Lake Healthcare at Berkeley Heights	35 Cottage Street Berkeley Heights, NJ 07922

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. At 6:45 PM the surveyor entered Resident #50's room. Resident #50 was awake and alert. When asked how was the care at the facility, Resident #50 stated, Not good. The surveyor asked Resident #50 to elaborate. Resident #50 stated, I have been waiting to be changed since after lunch, and still nothing had been done. Resident #50 informed the surveyor that they were changed around 6:30 AM, this morning. They activated the call light to inform staff that they needed to be changed. A staff answered the call light and stated that they will provide incontinence care after lunch. They never come to the room to assist. Resident #50 stated that they have been sitting in their excrements since this morning and that was not right. The surveyor left the room and informed the Licensed Practical Nurse (LPN) observed on the medication cart. The LPN stated that she will be in with a CNA to provide care. The LPN and two CNAs entered the room to provide care. Resident #50 was soaked with urine, the bedding, gown, the pulled sheet, the bed protectors were yellow stained and soiled with urine. The surveyor asked the LPN to call the Director of Nursing (DON) in the room. At 6:45 PM, the DON entered the room and Resident #50 informed the DON that he had not been changed since 6:30 AM this morning. The DON asked the resident if they activated the call light. The resident informed the DON they activated the call light and was told that incontinence care will be offered after lunch. No staff reported to the room to offer incontinence care. The surveyor and the DON both observed that Resident #50 an awake and alert resident had double briefs on which were saturated with urine. The bedding, gown and under pads were all saturated with urine. 12 hours had elapsed since incontinence care was provided according to Resident #50. Resident #50 was dependent on staff for care. A review of Resident #50's comprehensive Care Plan did not address Activities of Daily Living (ADLs). On 7/14/24 at 7:00 PM, the surveyor continued with the incontinence tour. The surveyor and the CNAs observed Resident #64 in bed, soaked with urine. Resident #64 had two adult briefs on which were saturated with urine. The bedding was soaked with urine. Resident #64 informed the surveyor that they had not been changed since this morning. 3. On 7/14/24 at 7:10 PM, Resident #63 was still sitting in the hallway. 2 CNAs transferred Resident #63 in bed via the Hoyer Lift (assistive device that allows patients in hospitals and Nursing homes and people receiving home health care at home to be transferred between a bed and a chair or other similar resting places). The surveyor observed that the sling was soaked with urine. Resident #63's pants were soaked with urine. The Assistant Director of Nursing (ADON) was called to the room and verified the same. Upon removing Resident #63's pants to provide care, the CNAs, the ADON and the surveyor, we all witnessed that Resident #63 had 3 adult briefs on which were saturated with urine and feces. Resident #63 had some redness on the sacrum area and was scratching when the soiled briefs were removed. The surveyor then asked the ADON what was her expectations regarding incontinence care; the ADON stated, All residents should have on one adult brief. Resident #63 was totally dependent on staff for care. Resident #63 assessed by the facility as having impaired cognitive function related to Alzheimer's was totally dependent on staff for care. Resident #63 did not have a care plan in place to address incontinence care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. On 7/14/24 at 7:25 PM, two CNAs transferred Resident #24 to bed for incontinence care. The surveyor entered Resident #24's room. During incontinence care, Resident #24 was soiled with urine and feces. The staff could not indicate when Resident #24 was last changed. Review of Resident #24's care plan revealed a focus for aphasia (inability to speak). Resident #24 communicates through gestures. The goal was for Resident #24 will communicate needs and preferences throughout the day effectively through the next review. There was no care plan in place to address Resident #24's ADLs. 5. On 07/14/24 /24 at 7:45 PM, the surveyor observed Resident #31 sitting by the door in their room. When asked about the care received at the facility, Resident #31 stated, incontinence care was not provided in a timely manner, call light not answered timely. Resident #31 stated, it could take 45 minutes to one hour for staff to answer the call light. During the interview, Resident #31's nails were noted to be long and jagged. Resident #31 informed the surveyor that they would like their nails to be trimmed and cleaned. 6. On 07/14/24 at 08:15 PM, the surveyor entered Resident #2's room with the Unit Manager (UM) and the CNA. At the surveyor's request, Resident #2's incontinent brief was checked by staff. Resident #2 was soiled with feces and urine. The resident had redness all over the back and the buttocks area. The UM assisted with incontinence care and applied some ointment to the affected areas. 07/16/24 at 09:13 AM, the surveyor returned to the North Wing and observed Resident #3's nails not being trimmed and cleaned. The Surveyor again asked Resident #31 if they would like their nails to be trimmed and cleaned, Resident #31 stated clearly, That would be nice, I would look like a lady. 7. On 07/16/24 at 9:45 AM, the surveyor made another random care tour with a CNA. Resident # 63 and Resident #64 both were soaked with urine. Resident # 63 and Resident #64 both were dependent on staff for care. On 07/16/24 at 11:55 AM, the surveyor interviewed the Director of Nursing (DON)regarding the issues with incontinence care observed on 07/14/24 during the care tour. The DON stated that Resident #50 should not have had on two adult incontinence briefs. The DON acknowledged that Resident #50 needed assistance with care, hygiene, transferring and toileting, was incontinent of bowel and bladder. The DON further stated that she would investigate and address the above concerns. On 7/16/24 at 12:56 PM, the DON provided a statement from the CNA who worked the 7:00 AM-3:00 PM shift on 7/14/24. The CNA indicated in the statement that Resident #50 received care at 9:00 AM and she last checked Resident #50 at 2:00 PM. However, during an interview on 7/16/24 at 1:15 PM, the CNA informed the surveyor that she worked from 7:00 AM -1:30 PM everyday, and the facility was aware. The staffing Coordinator confirmed that CNA #1 was to work until 2:00 PM but if she took her break at the end of the shift, she would exit the facility at 1:30 PM. On 7/16/24 CNA #1 informed the surveyor that she provided care to Resident #63 at 10:30 AM and transferred Resident #63 to the chair at 12:30 PM on 7/14/24. Resident #63 received incontinence care at 7:15 PM, almost 9 hours later. According to the facility, incontinence care was to be provided every two hours and as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/18/24 at 10:30 AM, the surveyor interviewed the CNA who had Resident #50, 63, and 24 on their assignment on 7/14/24 during the 7:00 AM- 3:00 PM shift. The CNA confirmed that she applied extra briefs on the residents. When asked about the policy for incontinence care, she stated that all residents should have one incontinence brief on. In the statement provided, the CNA indicated that she provided care to Resident #50 at 9:00 AM and last checked Resident #50 at 2:00 PM. However, during the interview with the surveyors she stated that on 7/14/24 she exited the facility at 1:30 PM. The CNA further stated that she worked from 7:00 AM- 1:30 PM, every day and the facility was aware. On 07/18/24 at 10:38 AM, during an interview with the Staffing Coordinator, she confirmed that CNA #1 worked from 7:00 AM-1:30 PM. The staffing Coordinator added that if CNA #1 took their break at the end of the shift, CNA #1 would exit the facility at 1:30 PM. On 07/18/24 at 12:11 PM, the surveyor interviewed the Unit Manager (UM) and inquired regarding who was responsible to cover CNA #1's assignment after 1:30 PM, the UM did not have any comment. 8.) On 07/15/24 at 9:46 AM, the surveyor entered Resident #30's room and noted a strong odor of urine. Resident #30 was awake and alert at the time and informed the surveyor that they had been soiled with urine since 4:00 AM that morning. Resident #30 indicated that this situation was not an isolated incident and had occurred numerous times in the past. Additionally, Resident #30 stated that they were often left sitting in wet conditions throughout the day and they have used double diapers in the past. The resident activated the call bell, which was subsequently addressed by the Unit Manager Registered Nurse (UMRN) and Certified Nursing Assistant (CNA). During this observation and interview, both the UMRN and the CNA confirmed that the resident was found saturated in urine. The UMRN expressed that this situation is unacceptable and indicated that incontinence rounds should be conducted every two hours to prevent such occurrences. 9.) On 07/14/24 at 7:23 PM During an initial tour of A Wing Back, the surveyor identified a strong, pervasive odor in the hallway. Upon entering Resident #9's room, which was observed in the presence of another surveyor and a CNA, it was determined that the odor was originating from this resident's room. The surveyor observed that the resident's bed was visibly soaked with urine, and there was a noticeable brownish-yellow discoloration around the perimeter of the bed sheet. On 07/18/24 at 9:45 AM, the surveyor walked down the hallway of A Wing Back and detected a strong, pervasive odor that was coming from Resident #9's room. Upon entering Resident #9's room, the surveyor observed that the room was disorganized, with a cooler, a breakfast tray cover, and a trash bag on the bed. Additionally, the resident's sheets were saturated in urine and had a brownish-yellow discoloration. When the resident was asked if they needed to be changed, the response was, I have no idea if I'm wet. 07/19/24 09:48 AM, the surveyor observed Resident #9 lying in bed with a strong odor present in the room. A blue bed protector, which was saturated in urine, was stuffed in the corner of the bed against the wall beside the resident. The resident was laying on the bed without any sheets covering the mattress. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Bowel & Bladder Program Screen Quarterly for Resident #9 dated on 6/21/2024 revealed the following: Section E. Mentally aware of need to toilet -Sometimes aware of need toilet A review of the Psychotropic Monthly Quarterly Summary for Resident #9 dated 7/3/2024 revealed the following: Section 8. Include Sleep Patterns, Socialization, ADLs, Mood Changes, Severity of Behaviors ETC Resident #9 is out of bed daily and ambulates the hallway independently. They are able to make there needs known. They are usually pleasant but can become overwhelmed and shows signs of anxiety or aggression toward staff but can be redirected. They have a good appetite and sleeps on and off during the day and at night. They like snacks that are offered throughout the day and attempts to go on a search for more during the night. Requires assistance with ADL's. No unusual behaviors noted. Medication is effective and plan of care continues. On 07/16/24 at 10:48 AM, the surveyor conducted a resident counsel meeting with 11 residents. All 11 residents expressed concerns that the facility does not have adequate staffing to meet their needs. One resident indicated they are very reluctant to change your diaper unless its closer to 5 AM in the morning. The same resident reported that staff typically change residents' diapers before the shift change. In the morning, when getting them out of bed they are changed, but then do not provide further changes until 2 PM. On the 3-11 PM shift staff are often late and do not perform necessary changes until the resident is in bed. Another resident stated that staff during the 3-11 PM shift are rarely around, and the situation is so severe that they can smell the urine and feces in the hallways. A review of the facility's policy for Incontinence care reviewed October 2023, revealed the following: Policy Statement Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Policy Interpretation and Implementation #4 The facility must ensure that residents that are incontinent of bladder and bowel will receive appropriate treatment to prevent infections and restore continence to the extent possible. The facility's policy for Activities of Daily Living (ADLs) updated October 2023, revealed: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL do not deteriorate unless deterioration is unavoidable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care. Transfer and ambulation. Toileting. Policy Explanation and Compliance Guidelines A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. All ADLs will be documented at a minimum daily in resident record. On 07/18/24 at 11:30 AM, the DON provided in-serviced education that was done on 7/14/24 to address double incontinence brief. The DON stated that the staff was -in-serviced. The DON also added that her expectations were that all residents would be turned and changed every two hours and as needed. The facility management indicated that they were not aware of concerns with incontinence care and residents wearing double incontinence brief. The above concerns with nails and incontinence care were discussed with the facility management during the survey and again on 07/18/24 prior to the exit conference. The DON indicated that the staff were in -serviced. NJAC 8:39-27.1(a), 27.2(g)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Complaint#'s NJ159619, NJ173589 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure residents received treatment and care in accordance with professional standards of practice that meet each resident's physical, mental and psychosocial needs by failing to: a) ensure a procedure was in place prior to caring for a resident who required an Inotropic (intravenous medication used for heart failure) medication that required specific monitoring and b) to ensure a system was in place to provide physician ordered cardiac medications for a newly admitted resident. This deficient practice was identified for two 2 of closed records reviewed for quality of care, (Resident #296 and #297) and was evidenced by the following: Refer 755 D a) Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure residents received treatment and care in accordance with professional standards of practice that meet each resident's physical, mental and psychosocial needs by failing to: a) ensure a procedure was in place prior to caring for a resident who required an Inotropic (intravenous medication used for heart failure) medication that required specific monitoring and b) to ensure that staff were trained to monitor and administer the medication according to the physician's order for a newly admitted resident. This deficient practice was identified for two 2 of closed records reviewed for quality of care, (Resident #296 and #88) and was evidenced by the following: Refer 755 D a) On 07/15/24 at 9:00 PM, the surveyor reviewed Resident #88's Electronic Medical Record (EMR) which revealed: On 7/2/2024 15:52 [3:52 PM] MD/APRN/PA/NP General Note revealed: Note Text: PHYSICIAN PROGRESS NOTE (completed by the physician who was also the medical director) DATE OF SERVICE: 07/02/ 24 admitted : 06/11/ 24 Patient is a 75 y/o PMH of dilated CM (cardiomyopathy- heart has difficulty pumping blood) and chronic systolic CHF (Congestive Heart Failure) EF (ejection fraction) 15-20% with CAD hex CABG (heart bypass) 2007, HTN, hyperlipidemia, DM type 2. was admitted to [hospital] from 05/15 to 06/10 with fatigue and SOB [shortness of breath] and found to have fixed defect on stress test. underwent left and right heart cath [catherization], wide complex tachy [fast heart beat] given amiodarone, low BP on pressors and VDRF. was initiated on milrinone (Inotropic) . PICC (percutaneously inserted central catheter- in arm to give intravenous medications to central vein) line RUE for milrinone drip. Now admitted for SAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	REASON FOR VISIT AND INTERVAL HX: f/u [follow up DM (diabetes mellitus, management monitor, CHF(Congestive Heart Failure management and milrinone . DC planning Patient seen in rehab gym tolerating exercises and feeling well . Appetite is good. BP and HR in usual control. DC planning in progress may be for end of this week . MEDICATIONS: reviewed and reconciled PHYSICAL EXAM: Vital Signs BP 113/80 HR 64 RR 18 TEMP 98.5 O2 97% ASSESSMENT/PLAN: -ongoing monitor on milrinone drip with VS (vital signs) q (every) 4 hours and weekly labs and send to cardio . thus far BP (blood pressure) ok and no c/o (complaints of) lightheadedness DC planning in progress, DW UM [Discussed with Unit Manager] script for milrinone from cardio, other scripts were completed. Planned home care on DC. FACE TO FACE DOCUMENTATION FOR HOMECARE: Need for skilled services: PT and OT for ongoing gait and ambulation training and strengthening and endurance. RN for med education and oversight and BP and HR monitor on cardiac med and monitor on IV milrinone coordination of care with cardio. RN for healthcare teaching, DM mngt, wound care. Pt deemed homebound because: Needs assuasive device for safe ambulation with decreased endurance and limited mobility. Therefore, needs assist of another to leave home safely and taxing effort to leave the home. Follow up with PCP and cardiology and specialists as directed. A 7/2/2024, 07:51 eMAR- Medication Administration Note Note Text: Weigh every am at 6am. If weight gain or loss of ten pounds, call cardiologist for milrinone adjustment. one time a day (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A 7/3/2024 08:21 General Nurses Note Note Text: Patient alert and speaking this AM, no complaints voiced on 7AM rounds. At approximately 8am, patient non responsive. BP 57/27, so2 90%. Milrinone pump running as ordered. 911 called for transfer to ER [emergency room] for evaluation. Oxygen applied via non-rebreather. Patient improved some, opening eyes. MD [medical doctor] and [spouse] made aware. A 7/3/2024 08:47, General Nurses Note Note Text: 7:30am- Nurse went into room to check BS [Blood Sugar], pt [Patient] was responsive and alert. BS 285, 7 units [insulin] administered per order, 8:15am Nurse called into room pt was cyanotic (bluish skin discoloration resulting from poor blood oxygen level), unresponsive, vitals checked 56/27 [blood pressure] p. 42 [pulse] 02 [oxygen] 67% [oxygen level %- normal 100%]. Non rebreather [emergency oxygen mask] applied and vital checked continuously. Once 02 applied pt become responsive with physical tactile stimuli. 911 was called by UM [unit manager] and ADON [assistant director of nursing]. Nurse stayed with pt until EMS [emergency medical services] arrived. Vitals as pt left 70/43 p.64 02 98% 8:50 am Patient transported to [Hospital Name] via EMS. 7/3/2024 08:52 General Nurses Note Note Text: 911 arrived on scene, assessed patient, and decided to transport him to MMC, due his cardiac program. His wife, MD and heart wellness were all made aware of the transfer The Order Summary Report: June 11, 2024- July 3, 2024, revealed: Order Start Date: 06/28/24: Milrinone Lactate in Dextrose Intravenous Solution 20-5 MG/100ML-% (Milrinone Lactate in Dextrose) Use .25 mcg intravenously every 48 hours for Hear failure .25 mcg/min Intravenously every 48 hrs. change bag/make sure the IV bag does not go empty. The Medication Administration Record for June and July 2024 revealed an order for Vitals Signs Every 4 [6 times] Hours X 7 Days, every day and evening shift for monitoring Routine 2 to start after Route 1, Order Dated: 06/11/2024 17:10 [5:10 PM]. The Vitals, which included, Blood Pressure, Temperature, Pulse, Respirations, and O2 Saturation were documented from 6/12/24 through 06/18/24 on the MAR. There was no documentation on the MAR from 06/19/24 through 06/30/24 for the Vitals, the MAR was left blank, and there were no specific parameters to contact physician regarding Blood Pressure levels. The 3-page Vitals Report, Blood Pressure Summary Dated 6/11/24 through 07/03/24 revealed: 06/19/24-2 Readings: 15:29: 94/66 mm/hg [millimetre of mercury; unit of pressure] 16:15: 110/62 mm/hg, 06/20/24-1 Readings: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11:23, 100/59 mm/hg *Diastolic Low of 60 exceeded 06/21/24-3 Readings: 1:49 100/49 mm/hg 14:22, 89/52 mm/hg * Systolic low of 90 exceeded, Diastolic Low of 60 exceeded -16:44 105/53 mm/hg Diastolic Low of 60 exceeded 06/22/24-2 Readings: 8:30 100/58 mm/hg, 19:23 102/57 mm/hg * Diastolic Low of 60 Exceeded 06/23/24-2 Readings: 11:56 114/63 mm/hg 21:51 122/73 mm/hg 06/24/24-2 Readings: 16:20 100/58 mm/hg, *Diastolic Low of 60 Exceeded 21:32 100/55 mm/hg * Diastolic Low of 60 Exceeded 06/25/24-2 Readings: 8:29 164/99 mm/hg *Systolic high of 139 exceeded. Diastolic high of 89 exceeded. 18:16 105/69 mm/hg 06/26/24-2 Readings: 16:12 105/66 mm/hg 17:19 96/54 mm/hg * Diastolic Low of 60 Exceeded 06/27/24-2 Readings: 7:02 105/60 mm/hg 17:07 121/89 mm/hg 06/28/24-2 Readings: 12:24 93/56 mm/hg *Diastolic Low of 60 Exceeded (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	18:43 95/58 mm/hg *Diastolic Low of 60 Exceeded 06/29/24-2 Readings: 10:20 106/62 mm/hg 18:22 87/58 mm/hg *Systolic low of 90 exceeded, Diastolic Low of 60 exceeded 06/30/24-3 Readings: 10:59 105/63 mm/hg 12:24 107/63 mm/hg 17:46 95/54mm/hg *Diastolic Low of 60 Exceeded 07/01/24-2 Readings: 10:57 104/55 mm/hg *Diastolic Low of 60 Exceeded 18:29 113/80 mm/hg 07/02/24-1 Reading: 15:20 116/61mm/hg 07/03/24-2 Readings: 1:42 145/88 mm/hg *Systolic high of 139 exceeded 14:47 56/27 mm/hg *Systolic low of 90 exceeded, Diastolic Low of 60 exceeded. Based on the physician order for vitals every four hours from 06/19/24 to 07/02/24 (Resident was transferred to the hospital on 07/03/24) there should have been a total of 84 blood pressure readings taken and the EMR reflected that only 28 blood pressure readings were taken. (continued on next page)

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	315195	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Berkeley Heights	35 Cottage Street Berkeley Heights, NJ 07922

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/16/24 at 2:02 PM, the surveyor interviewed the Director of Nursing (DON) regarding if the facility administered Intravenous Therapy (IV). The DON stated that Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) do IV therapy and only RNs can administer Milrinone. The DON stated we had one resident on Milrinone and we had an in-service from someone from the pharmacy and the nurses had been educated. The DON stated we only took that admission during the week and the facility had to monitor their blood pressure. The DON stated, when one IV bag was finished, the other bag had to be ready to be administered. The surveyor asked if there was a policy related to the administration of Milrinone and the DON stated, most likely. The DON stated that Resident #88's Milrinone must be changed and checked by 2 RN's every four hours which was also confirmed by the Assistant Director of Nursing (ADON) who joined the interview. The ADON stated that every 4 hours the resident's blood pressure needed to be checked. The surveyor requested the blood pressure monitoring. The ADON, who was also the staff educator, stated there had to be 2 set ups and 2 bags of Milrinone ready at all times. The surveyor asked the ADON was the blood pressure checked every four hours and the surveyor requested a policy for checking the blood pressure every four hours. The ADON stated it wasn't because of the milrinone (re: Resident #88) it was running. The surveyor asked if there was an investigation, and the ADON stated, no investigation. The ADON stated there are other parameters that needed to be watched, and the surveyor asked why, because [Resident #88] could die. The DON then brought in same parameter of blood pressure readings that the surveyor had already reviewed, and stated, I see what you mean regarding the blood pressures not being monitored 6 times per day. The ADON then provided the surveyor with information from the consultant pharmacy that the ADON stated staff were in-serviced on. The surveyor asked if all staff were in serviced and she stated, they should have been. The surveyor reviewed the document which revealed: Nursing assessment: Monitor heart rate and BP (blood pressure) continuously during administration. Slow or discontinue if BP drops excessively. Monitor intake and output and daily weight. Assess patient for resolution of signs and symptoms of HF (Heart Failure) (Peripheral edema, dyspnea, rales/crackles and weight gain) . Monitor ECG [Electrocardiogram) continuously during infusion. Arrythmias are common and may be life threatening . The surveyor asked the ADON about the required monitoring and the ADON stated that was for the hospital only. On 07/17/24 at 10:58 AM, the surveyor conducted an interview with the Medical Director (MD) who was also Resident #88's physician. The surveyor asked the MD if they reviewed policies related to administering the Milrinone. The MD stated, I haven't really reviewed policies. The surveyor asked if there was a discussion regarding a policy and she stated, no, discussion. The MD stated she reviewed Resident #88's medication upon admission and that is when she found out that the resident was on Milrinone. The MD confirmed that she was not aware prior to admission. The MD stated she questioned the facility regarding how to handle the Milrinone and to make sure the correct monitoring was in place, and she spoke with the ADON. The MD stated she felt comfortable about the monitoring and she spoke with the cardiologist also. The MD stated the vitals, every 4 hours and weekly labs were specifically what needed to be monitored. The MD clarified the vitals to include blood pressure and heart rate, and full vitals and daily weights. When asked about the facility policy on Milrinone administration, she stated, I don't know if they had a policy, they did not inform me of that. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/18/24 at 9:25 AM, the DON handed the surveyor a paper and stated it was the Milrinone policy because we didn't have one. The surveyor asked the DON if you should have had a policy regarding the administration of Milrinone before and she stated, no. The DON stated, you asked for a policy and we didn't have one, so I put one together. b.) A review of the closed medical record revealed an Admission Record that Resident #296, was admitted to the facility with diagnoses which included but were not limited to; paroxysmal atrial fibrillation (type of irregular heartbeat, chronic obstructive pulmonary disease (COPD; constriction of the airways making it difficult or uncomfortable to breathe), hypercholesterolemia (high cholesterol), malignant neoplasm (cancerous tumor or cancer) and anxiety. Review of the Admission Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care, dated 5/4/24, reflected the resident's Brief Interview for Mental Status (BIMS) was not conducted since the resident was rarely/never understood. The resident did not exhibit behaviors associated with hallucination or delusions. Further review of the MDS revealed the resident was occasionally incontinent of bladder. A review of the nurses' admission Progress Note (PN) dated 5/4/24 at 5:53 PM reflected late entry and indicated the resident arrived at 4:30 PM from the hospital via stretcher with a primary diagnosis of diarrhea. The resident was documented as alert and oriented to person only and was confused, forgetful and high risk for falls; the call bell was placed [at an undescribed location]. The resident was incontinent of bowel and bladder. The PN included that the resident was assisted to bed and the head of the bed was elevated. While in the facility, the resident was to continue receiving chemotherapy through a right port catheter on the upper right chest wall for the diagnosis of cancer that had spread to the bone. The PN also included that the resident had numerous bruises to the upper and lower abdomen, an old skin tear to the arm, a scabbed area on the left heel, and redness to the sacrum wherein a protective barrier was applied and left open to air. The resident was receiving 5 liter of oxygen and a CPAP machine (continuous positive air pressure to keep breathing airways open) at bedtime. The medications were confirmed and verified by the physician. A review of the electronic Medical Record did not reflect a baseline care plan was initiated for Resident #296. A review of the resident's electronic Medication Administration Record included the following physician's orders that was marked x and was not documented as administered, unavailable, refused by the resident and/ or acted upon by the staff on the ordered date of 5/4/24. 1) Pacerone (Amiodarone), give 1 tablet by mouth two times a day, for antiarrhythmic, ordered on 5/4/24 at 9:14 PM. The eMAR was not opened for administration until 5/5/24 at 9:00 AM. 2) Advair (Fluticasone-Salmeterol) Discuss inhalation 250-50 milligram (mg), 2 puffs orally two times a day for shortness of breath, ordered on 5/4/24 at 10:11 PM. The eMAR was not opened for administration until 5/5/24 at 9:00 AM. 3) Dexamethasone 2 mg, give 1 tablet by mouth two times a day, for five days, ordered on 5/4/24 at 11:59 PM. The eMAR was not opened for administration until 5/5/24 at 9:00 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At that time, the surveyor and the DON reviewed the resident's PN together. The DON confirmed that the communication made by the nurse to the physician that allowed for a missed dose should have been documented in the progress notes and it was not. The DON acknowledged that since it was not documented, there was no evidence that the nurse had called the physician for the resident. At that time, the surveyor and the DON reviewed the resident's eMAR together. The DON stated that the x meant that the order for Magnesium Oxide was not opened for administration on the same date as the order date of 10/29/22 at 6:55 PM and was instead opened for administration on 10/29/22 at 9:00 AM and at 5:00 PM. At that time, in the presence of the surveyors, and the DON, the surveyor discussed the reviewed concerns for Resident #297. On 7/19/24 at 1:48 PM, in the presence of the survey team, the corporate nurse, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), the surveyor discussed the failure to acquire routine medications without delay, for timely administration to Resident #297. On 7/19/24 at 2:15 PM, during a meeting with the survey team, the corporate nurse, the DON and the LNHA did not present further information regarding the discussed concerns. A review of the facility provided job description for the DON included the following: Monitor medication passes and treatments schedules to ensure that medications are being administered as ordered and that treatments are provided as scheduled. NJAC 8:39-27.1 (a)