STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60A012	A. BUILDING: _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF RANDOLPH	648 ROUTE 10 RANDOLPH, NJ 07869

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Complaint Complaint #s: NJ 00186769, NJ 00186775, NJ 00186105 Census: 64 (6/4/2025), 63 (6/5/2025) Sample Size: 7 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administrator's Responsibilities (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/01/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #s: NJ 00186775, NJ 00186105, NJ 00186769

Based on interview and record review, it was determined that the Administrator failed to ensure the implementation and enforcement of the facility policies titled, "Incident and Event Reporting" and "Medication Oversight Program" for 1 of 7 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On [redacted], the Department of Health (DOH) received a Facility Reportable Event (FRE), (a document used by facilities to report events to the DOH), regarding [redacted] towards Resident #2 on [redacted]

1. On 6/4/25 at 11:38 a.m., the surveyor investigated and reviewed the facility's investigation report for the [redacted] incident on [redacted] The surveyor observed that after being notified of the [redacted], the Executive Director (ED) initiated an investigation. According to the investigation report, the [redacted] were notified and an assessment for Resident #2 was completed.

At 12:23 p.m., the surveyor reviewed Resident #2's closed medical record (MR), which indicated that the resident was admitted to the facility in [redacted] with diagnoses of [redacted] and [redacted] and resided in the [redacted]

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A 310	Continued From page 2 NJ Exec Order 26.4b1 Surveyor review of Resident #2's Progress Notes (PNs), did not observe documentation of the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 that occurred on NJ Exec Order 26. However, the surveyor observed a PN dated NJ Exec Order 26 at 11:09 a.m., written by a Registered Nurse (RN), which revealed, 'NJ Exec Order 26.4b1 completed with [Resident #2's responsible party] in attendance-NJ Exec Order 26.4b1 noted, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 On 6/5/25 at 9:55 a.m., the surveyor interviewed the Regional Nurse and inquired about the documentation regarding the NJ Exec Order 26.4b1 on NJ Exec Order 26. The Regional Nurse stated that the incident should have been documented in the resident's MR and stated that she would look for the documentation in Resident #2's PNs. At 1:24 p.m, the surveyor interviewed the Resident Care Director (RCD) and inquired about documentation regarding the NJ Exec Order 26.4b1 [redacted]. The RCD confirmed that there was no documentation regarding the incident, only Resident #2's assessment was documented in the MR. The surveyor reviewed a facility policy, updated on 4/24/25, titled, "Incident and Event Reporting" which indicated, " ... 7. The Team Member who witnesses, discovers or who is involved in the resident event/incident, will" ... b. Document the event in the electronic health record (EHR) ... 14. For resident events, the Resident Care Director (RCD)/designee will: ... Review resident progress notes and team member documentation ..." 2. On NJ Exec Order, the DOH received an FRE	A 310		

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A 310	Continued From page 3	A 310		

regarding prescribed NJ Exec Order 26.4b1 medication error discovered during medication administration for Resident #2.

On 6/4/25 at 12:12 p.m., the surveyor reviewed the facility's investigation report regarding the NJ Exec Order 26.4b1 dose that was administered to Resident #2. The investigation report revealed, "... [Resident #2] received NJ Exec Order 26.4b1 instead of the current order (NJ Exec Order 26.4) for approximately NJ Exec Order 26.4 in the NJ Exec Order of NJ Exec Order and NJ Exec Or ..."

Continued surveyor reviewed of Resident #2's MR, did not observe any documentation regarding the medication errors that were identified by the facility on NJ Exec Order 26.4b1.

On 6/5/25 at 10:03 a.m., the surveyor interviewed the Regional Nurse and inquired about the NJ Exec Order 26.4b1 error that was discovered on NJ Exec Order for Resident #2. The Regional Nurse stated that during the investigation, it was discovered that the facility never received the current dose of NJ Exec Order 26.4b1, therefore the staff contiuned to administer the previous NJ Exec Order 26.4b1 to Resident #2.

At 11:07 a.m., during surveyor interview with the Regional Nurse, the Regional Nurse stated that there was another medication error found for Resident #2. The Regional Nurse stated that Resident #2's NJ Exec Order 26.4b1) dose was NJ Exec Order 26.4b1 fromNJ Exec Order 26.4b1

During continued interview, the Regional Nurse stated that Resident #2 continued to receive the NJ Exec Order 26.4b1 dose of NJ Exec Order 26 instead of the NJ Exec O . The

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A 310	Continued From page 4 Regional Nurse explained that the pharmacy did not deliver the NJ Exec Order 26.4b1 until NJ Exec Order 2 therefore the NJ Exec Order 26.4b1 doses that were administered between NJ Exec Order 26.4b1 were the NJ Exec Order 26.4b1 . At 12:53 p.m., the surveyor interviewed the Regional Nurse and inquired about assessments performed after the medication errors. The Regional Nurse stated that there should have been an assessment completed after the medication errors were identified. At 1:24 p.m., the surveyor interviewed the former RCD regarding the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 medication errors assessment. The RCD stated that she did not assess the resident after the NJ Exec Order 26.4b1 medication error was identified. The RCD explained that since the NJ Exec Order 26.4b1 was as needed medication and it was administered five (5) times throughout a NJ Exec Order 26.4b1, there was "no reason to assess him/her" on the date that the medication error was identified. The surveyor also inquired about an assessment completed and the former RCD stated that an assessment was completed for Resident #2 after the NJ Exec Order 26.4b1 error was identified but could not recall if the assessment was documented in the resident's MR. The surveyor reviewed the facility policy, dated 4/2023, titled, "Medication Oversight Program" which indicated, " ... H. MEDICATION ERROR REPORTING ... When a medication error occurs, the RCD or licensed nurse: Assures the wellbeing of the resident ... Documents the incident in the resident's progress notes ..." 3. On 6/5/25 at 11:32 a.m., the surveyor reviewed the NJ Exec Order 26.4b1 Utilization Records	A 310		

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A 310	Continued From page 5 (CMURs) in Resident #2's MR. The surveyor observed that there was a subsection titled, 'NJ Exec Order 26.4b1 " located on the top left corner of each CMUR. The NJ Exec Order 26.4b1 included the following pieces of information regarding the disposition of the NJ Exec Order 26.4b1 medications: 1. Date of Discontinuance 2. Date of Disposition 3. Nurse 4. DON 5. Amount Remaining 6. Pharmacist 7. Administrator or Designee Further surveyor review of Resident #2's CMUR forms, the surveyor observed that two (2) of the forms were missing documentation that indicated the quantity of NJ Exec Order 26.4b1 disposed on NJ Exec Order 2 and NJ Exec Order 26.4b1 disposed on NJ Exec Order 2. At 1:24 p.m., the surveyor interviewed the former RCD who destroyed the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 The former RCD confirmed that the CMUR forms were missing the quantities of destroyed medications on both forms. The surveyor reviewed the facility policy, dated 4/2023, titled, "Medication Oversight Program" which indicated, " ... C. MEDICATION DESTRUCTION ... Drug Destruction/Disposition Record includes: ... Quantity of medication ..."	A 310		
A 615	8:36-5.15(b) Notification Requirements (b) Notification of any occurrence noted in (a)	A 615		

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A 615	Continued From page 6 above shall be documented in the resident's record. The documentation with regard to an occurrence noted in (a)4 above shall include confirmation and written documentation of that notification. This REQUIREMENT is not met as evidenced by: Complaint #s: NJ 00186105 & NJ 00186769 Based on interview and record review, it was determined that the facility failed to notify the resident's Responsible Party (RP) following a medication error for 1 of 7 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On NJ Exec Order 2 the Department of Health (DOH) received an Facility Reportable Event (FRE) regarding a medication error that occurred at the facility for Resident #2. On 6/4/25 at 12:12 p.m., the surveyor investigated and reviewed the facility's investigation report regarding the wrong dose of NJ Exec Order 26.4b1 that was administered to Resident #2. The investigation report revealed, "... [Resident #2] received NJ Exec Order 26.4b1 instead of the current order NJ Exec Order 26.4b1 for approximately NJ Exec Order 26.4 in the NJ Exec Order 26.4b1 ..." On 6/5/25 at 10:03 a.m., the surveyor interviewed the Regional Nurse and inquired about the morphine medication error that was discovered on NJ Exec Order for Resident #2. The Regional Nurse stated that during the investigation, it was discovered that the facility never received the	A 615		

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A 615	Continued From page 7 current order of NJ Exec Order 26.4b1 ordered on NJ Exec Order 26., therefore the staff continued to administer the previous order of NJ Exec Order 26.4b1 dose that was discontinued on NJ Exec Order 26.4. At 11:07 a.m., the Regional Nurse stated that there was another medication error found for Resident #2. The Regional Nurse stated that Resident #2's NJ Exec Order 26.4b1 dose was NJ Exec Order 26.4b1 fromNJ Exec Order 26.4b1 NJ Exec Order . According to the Regional Nurse, Resident #2 continued to receive the NJ Exec Order 26.4b1 The Regional Nurse explained that the pharmacy did not deliver the NJ Exec Order 26.4b1 therefore the staff administered the NJ Exec Order 26.4b1 a total of 4 days. On 6/5/25 at 9:55 a.m., the surveyor interviewed the Regional Nurse and inquired if the resident's RP was notified of the above medication error. The Regional Nurse stated that if the RP was notified, it would be documented in the internal incident report and the resident's MR as well. However, surveyor review of the MR revealed that there was no documentation of the RP notification of the above incidents. The surveyor reviewed a facility policy, last updated on 4/24/25, titled, "Incident and Event Reporting" which indicated, " ... 9. The ED/designee shall notify the resident's: ... b. Legally responsible party/Contact person ... 14. For resident events, the Resident Care Director (RCD)/ designee will: ... b. Ensure responsible party and health care practitioner are notified and notification is documented in the resident record ..."	A 615		

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A 925	Continued From page 8	A 925		
A 925	8:36-11.2 Provisions of Pharmaceutical Services The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations. This REQUIREMENT is not met as evidenced by: Complaint #s: NJ 00186105, NJ 00186769 Based on interview and record review, it was determined that the facility failed to ensure that resident was administered the prescribed dose of medication in accordance with the prescriber's orders for 1 of 7 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On [redacted], the Department of Health (DOH) received a Facility Reportable Event (FRE), (a document used by facilities to report events to the DOH), regarding a medication error that occurred while administering Resident #2's medications. On 6/4/25 at 12:23 p.m., the surveyor investigated and reviewed Resident #2's closed medical record (MR) and according to the MR, the resident was admitted to the facility in	A 925		

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A 925	Continued From page 9 NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. 1. On 6/4/25 at 12:12 p.m., the surveyor reviewed the facility's investigation report regarding the medication error of wrong NJ Ex Order 26.4(b)(1) dose that was administered to Resident #2 and was discovered on NJ Exec Order 2. The investigation report indicated that a Medication Manager questioned the Registered Nurse (RN) regarding Resident #2's NJ Exec Order 26.4b1 order. The investigation report revealed, " ... [Resident #2] received NJ Exec Order 26.4b1 for approximately NJ Exec Order 26.4 in the month of NJ Exec Order and NJ Exec O ..." On 6/5/25 at 10:03 a.m., the surveyor interviewed the Regional Nurse regarding the above NJ Ex Order 26.4(b)(1) error investigation that was discovered on NJ Exec Order 2 for Resident #2. The Regional Nurse stated that a Medication Manager noticed that the inventory of NJ Exec Order 26.4b1 did not match the NJ Exec Order 26.4b1 order. The Regional Nurse stated that during the investigation, it was discovered that the facility never received the NJ Exec Order 26.4b1 , therefore staff administered the NJ Exec Order 26.4b1 discontinued dose to the resident on NJ Exec Order 26.4b1 a total of NJ doses. Surveyor review of Resident #2's physician order for NJ Exec Order 26.4b1 revealed the following: a). NJ Exec Order 26.4b1 order, with "Start Date" of NJ Exec Order 26, indicated, "NJ Exec Order 26.4b1 ; Administer NJ Exec Order 26.4b1 every 3 hours as needed for NJ Exec Orde b). A prescription slip, dated NJ Exec Order 26.4b1 indicated,	A 925		

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A 925	Continued From page 10	A 925		

NJ Exec Order 26.4b1 "

c). NJ Exec Order 26.4b1 , inidcated, 'NJ Exec Order 26.4b1 every 2 hours as needed for NJ Exec Order 26.4b1 ."

2. On 6/5/25 at 10:03 a.m., during the surveyor interview with the Regional Nurse, the Regional Nurse stated that after discovering the NJ Exec Order 26.4b1 medication error, the facility completed a full audit of Resident #2's medications. The surveyor inquired if any other medication errors were identified during the audit and the Regional Nurse stated that she would have to confirm and get back to the surveyor.

At 11:07 a.m., the Regional Nurse informed the surveyor that there was another medication error identified for Resident #2 upon completion of the full audit. The Regional Nurse stated that on NJ Exec Order 2 Resident #2's NJ Exec Order 26.4b1 dose was decreased from NJ Exec Order 26.4b1 . The Regional Nurse explained that the pharmacy did not deliver the NJ Exec Order 26.4b1 until NJ Exec Order 2 therefore staff continued to administer the NJ Exec Order 26 dose to the resident on NJ Exec Order 26.4b1

Surveyor review of Resident #2's Physician Order Sheet (POS) for the NJ Exec Order 26.4b1 revealed the following:

a). NJ Exec Order 26.4b1 order, dated NJ Exec Order 26.4 , indicated, 'NJ Exec Order 26.4b1 tablet 1 tab(s) NJ Exec Orde once a day at bedtime."

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A 925	Continued From page 11 b). NJ Exec Order 26.4b1 order, dated NJ Exec Order 2 indicated that the NJ Exec Order 26.4b1 tablet was discontinued. c). NJ Exec Order 26.4b1 order, dated NJ Exec Order 26. indicated, 'NJ Exec Order 26.4b1 by mouth at bedtime." The surveyor reviewed the facility policy, dated 4/2023, titled, "Medication Oversight Program" which indicated, " ... H. MEDICATION ERROR REPORTING ... Right dose - ... Medications must be administered in the dose that is ordered by the prescriber ..."	A 925		
A 999	8:36-11.7(e) Storage and Control of Medications (e) Discontinued or expired medications shall be destroyed within 30 days in the facility, or, if unopened and properly labeled, returned to the pharmacy for credit, if allowable, and in conformance with N.J.A.C. 13:39 and other State and Federal laws, codes, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #s: NJ 00186105, NJ 00186769 Based on interview and record review, it was determined that the facility failed to destroy discontinued NJ Exec Order 26.4b1 within 30 days for 1 of 7 residents reviewed, Resident #2. This deficient practice was evidenced by the following:	A 999		

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A 999	Continued From page 12	A 999		

On 6/4/25 at 12:23 p.m., the surveyor reviewed Resident #2's closed MR, which indicated that the resident was admitted to the facility in NJ Exec Order 26.4b1 of NJ Exec Or with diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

On 6/4/25 at 12:12 p.m., the surveyor reviewed the facility's investigation report regarding the NJ Exec Order 26.4b1 doses that were administered to Resident #2. The investigation report indicated that a Medication Manager questioned a Registered Nurse (RN) regarding Resident #2's NJ Exec Order 26.4b1 dose order. The report also indicated that the RN investigated the medication error which revealed, "... [Resident #2] received NJ Exec Order 26.4b1 instead of the current order NJ Exec Or for approximately NJ doses in the NJ Exec Order of NJ Exec Order and NJ Exec Or ..."

On 6/5/25 at 10:03 a.m., the surveyor interviewed the Regional Nurse and inquired about the NJ Exec Order 26.4b1 medication error that was discovered on NJ Exec Order for Resident #2. The Regional Nurse stated that a Medication Manager noticed that the inventory of NJ Exec Order 26.4b1 did not match the NJ Exec Order 26.4b1 order. The Regional Nurse stated that during the investigation, it was discovered that the facility never received the NJ Exec Order 26.4b1 from the pharmacy, therefore staff continued to administer the NJ Exec Order 26.4b1 to Resident #2.

At 12:10 p.m., the surveyor reviewed Resident #2's NJ Exec Order 26.4b1 orders which revealed NJ Exec Order 26.4b1 was prescribed on NJ Exec Order 26., and the dose was NJ Exec Order 26.4b1 .

On 6/5/25 at 11:32 a.m., the surveyor reviewed the Controlled Medication Utilization Record (CMUR) for Resident #2's which revealed that the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF RANDOLPH	648 ROUTE 10 RANDOLPH, NJ 07869

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 999	Continued From page 13 NJ Exec Order 26.4b1 were not destroyed until on NJ Exec Order 26 almost NJ Exec Ord months later. The surveyor reviewed the facility policy, dated 4/2023, titled, "Medication Oversight Program" which indicated, " ... A. CART CHECKS ... the monthly cart audit includes ... no discontinued medications are left in the cart ... C. MEDICATION DESTRUCTION All medications are disposed of or destroyed promptly ..."	A 999		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: Complaint #s: NJ 00186105, NJ 00186769 Based on interview and record review, it was determined that the facility's Registered Professional Nurse (RN) failed to document medication errors in the resident's medical record (MR) for 1 of 7 residents reviewed, Resident #2.	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60A012	A. BUILDING: _____ B. WING _____	C 06/05/2025

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SUNRISE ASSISTED LIVING OF RANDOLPH	648 ROUTE 10 RANDOLPH, NJ 07869

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A1073	Continued From page 14 This deficient practice was evidenced by the following: On 6/4/25 at 12:23 p.m., the surveyor reviewed Resident #2's closed MR which indicated that the resident was admitted to the facility in NJ Exec Order 26.4b1 of NJ Exec Ord with diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . On 6/4/25 at 12:12 p.m., the surveyor reviewed the facility's investigation report regarding the NJ Exec Order 26.4b1 that was administered to Resident #2. The investigation report indicated that a Medication Manager questioned a Registered Nurse (RN) regarding Resident #2's NJ Exec Order 26.4b1 dose order. According to the report, the RN investigated the medication error which revealed, "... [Resident #2] received NJ Exec Order 26.4b1 for approximately NJ doses in the month of NJ Exec Order and NJ Exec O ..." Surveyor review of Resident #2's MR, did not observe any documentation regarding the above medication error for Resident #2. On 6/5/25 at 10:03 a.m., the surveyor interviewed the Regional Nurse and inquired about the NJ Exec Order 26.4b1 medication error that was discovered on NJ Exec Order for Resident #2. The Regional Nurse stated that a Medication Manager noticed that the inventory of NJ Exec Order 26.4b1 did not match the NJ Exec Order 26.4b1 . The Regional Nurse stated that upon the investigation, it was discovered that the facility never received the correct dose of NJ Exec Order 26.4b1 , therefore staff administered the NJ Exec Order 26.4b1 dose on NJ Exec Order 26.4b1 , a total of NJ doses.	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60A012	A. BUILDING: _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1073	Continued From page 15 Additionally, the Regional Nurse informed the surveyor that there was another medication error identified for Resident #2 upon the full audit of the resident's medications. The Regional Nurse stated that Resident #2's [NJ Exec Order 26.4b1] dose was [NJ Exec Order 26.4b1] from NJ Exec Order 26.4b1 [redacted]. According to the Regional Nurse, Resident #2 continued to receive the [NJ Exec Order 26.4b1] [redacted] instead of the current order of [NJ Exec Order 26.4] ordered on [NJ Exec Order]. At 12:53 p.m., the surveyor interviewed the Regional Nurse and inquired about the documentation of the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] medication errors in the resident's MR. The Regional Nurse stated that she was not sure if the above incidents were documented in the resident's medical record and explained that the medication errors should be documented in the resident's MR and the facility's internal incident tracking system. The surveyor then inquired if the internal incident report would be placed in the resident's MR and the Regional Nurse stated that the incident report would not be placed in the resident's MR. The facility failed to document Resident #2's medication errors that were discovered on [NJ Exec Order] in the resident's MR. The surveyor reviewed the facility policy, dated 4/2023, titled, "Medication Oversight Program" which indicated, " ... H. MEDICATION ERROR REPORTING ... When a medication error occurs, the RCD or licensed nurse: ... Documents the incident in the resident's progress notes ..." Refer to 8:36-11.2 (A 0935)	A1073		

POC#1 received 7/28/25
Accepted 8/1/25

Sunrise Senior Living

Plan of Correction

Name of Facility: Sunrise of Randolph
Address of Facility: 648 Route 10 West Randolph, NJ 07869
License number: 60A012
Inspection date(s): 06/05/2025
Name and Title of Legal Entity Representative Signing the Plan of Correction: NJ Exec Order 26.4b1 CALA, Dining Service Coordiantor

NJ Exec Order 26.4b1

Signature of Sunrise Representative:
Date of Submission: 07/28/2025

A310 - 8:36-3.4(a)(1) – Administrator's Responsibilities

Target Completion Date: 7/25/2025

Resident # 2 NJ Ex Order 26.4(b)(1)

All residents in the facility have the potential to be affected. Upon receipt of the survey on 6/5/2025, the Regional Director of Resident Care, RN, initiated a re-education process. As part of this process, the Executive Director and the Resident Care Director, RN, received re-training on the following policies: *Incident and Event Reporting* and *Medication Oversight Program*. This re-training was successfully completed on July 16, 2025.

Upon receiving the survey on 6/5/2025, the Executive Director provided re-training on the following policies: *Incident and Event Reporting* and *Medication Oversight Program* to the RNs, Department Coordinators, LPNs, and frontline team members. This re-education was completed on 7/23/2025. The Executive Director or designee will ensure that all new team members receive this training upon hire, or as needed.

This Plan of Correction will ensure compliance of the policies, *Incident and Event Reporting* and *Medication Oversight Program* and will be discussed and evaluated quarterly for two quarters by the ED or designee and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violations does not occur again. QAPI meeting initiated on 7/24/2025 by the ED with the coordinators

NJ Exec Order 26

approved
8/1/25

A615 - 8:36-5.15(b) – Notification Requirements

Target Completion Date: 7/24/2025

Resident # 2 NJ Exec Order 26.4b1

All residents in the facility have the potential to be affected. Upon receipt of the survey on 6/5/2025, the Regional Director of Resident Care, RN, initiated a re-education process. As part of this process, the Executive Director and the Resident Care Director, RN, received re-training on *'Documentation Guidelines: Standards for Resident Record Documentation'*. This re-training was successfully completed on July 16, 2025.

Upon receiving the survey on 6/5/2025, the Executive Director provided re-training on *Documentation Guidelines: Standards for Resident Record Documentation'* to the RNs, Department Coordinators, and LPNs, This re-education was completed on 7/23/2025. To ensure ongoing compliance, the Executive Director or designee will provide this training to all new team members upon hire and as deemed necessary. Additionally, on 7/24/2025 the RN conducted a review of resident records associated with recent incidents to verify that accurate and timely notifications were appropriately documented.

Executive Director or designee and/or the RN will review resident records associated with recent incidents for accurate notification and documentation weekly during Interdisciplinary meetings. This Plan of Correction is to ensure compliance with '*notification'* will be discussed and evaluated quarterly for two quarters by the ED or designee and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violations does not occur again. QAPI meeting initiated on 7/24/2025 by the ED with the coordinators.

NJ Exec Order 26.4 approved 8/1/25

A925 - 8:36-11.2 – Provision of Pharmaceutical Services

Target Completion Date: 7/22/2025

Resident # 2 NJ Exec Order 26.4b1

All residents receiving medication administration assistance in the facility have the potential to be affected. Upon receipt of the survey on 6/5/2025, the Regional Director of Resident Care, RN, initiated a re-education process. As part of this process, the Executive Director and the Resident Care Director, RN, received re-training on policy "*Medication Program: Medication Administration, Six Rights'*. This re-training was successfully completed on July 16, 2025.

On 7/21/2025 the Resident Care Director, RN, successfully conducted re-training for facility staff—including Certified Medication Aides, Licensed Practical Nurses (LPNs), and Registered Nurses (RNs)—on the *Medication Administration Program.* This session placed heightened emphasis on following the *Six Rights of medication administration* to reinforce best practices and promote resident safety.

In addition to the re-training, on 7/21/2025, the RN observed LPNs and Certified Medication Aides during medication passes to evaluate compliance and provide immediate feedback as necessary.

The RN will ensure that all appropriate team members responsible for administering medications have up-to-date medication pass observations completed. Additionally, the RN will conduct skills re-evaluation and validation as deemed appropriate to maintain competency and compliance with medication administration standards. This Plan of Correction is to ensure compliance with '*Medication administration*' will be discussed and evaluated quarterly for two quarters by the ED or designee and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violations does not occur again. QAPI meeting initiated on 7/24/2025 by the ED.

NJ Exec Order 26 approved 8/1/25

A999 - 8:36-11.7(e) – Storage and Control of Medications

Target Completion Date: 7/22/2025

Resident # 2 NJ Exec Order 26.4b1

All residents receiving medication administration assistance in the facility have the potential to be affected. Upon receipt of the survey on 6/5/2025, the Regional Director of Resident Care, RN, initiated a re-education process. As part of this process, the Executive Director and the Resident Care Director, RN, received re-training on policies "*Medication Program' and 'Controlled Drug Security and Reconciliation'* This re-training was successfully completed on July 16, 2025.

On 7/21/2025 the Resident Care Director, RN, successfully conducted re-training for facility staff—including Certified Medication Aides, Licensed Practical Nurses (LPNs), and Registered Nurses (RNs)—on the '*Medication Administration Program*' and *'Controlled Drug Security and Reconciliation'*. This training placed heightened focus on discontinuation or expired medication(s) shall be destroyed properly and/or returned to the pharmacy accurately and timely to promote resident safety. In addition to the re-education, on 7/21/2025, the RN completed a comprehensive medication cart audit to ensure that no discontinued medications were stored in the medication cart and to support regulatory compliance.

RN will ensure that 'Monthly Cart Audits are completed timely. This Plan of Correction to ensure compliance with '*Storage and Control of Medications*' will be discussed and evaluated quarterly for two quarters by the ED or designee and Resident Care Director at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violations does not occur again. QAPI meeting initiated on 7/24/2025 by the ED with the coordinators

NJ Exec Orde approved 8/1/25

A1073 - 8:36-15.6(b) – Resident Records

Target Completion Date: 7/24/2025

Resident # 2 [redacted]

All residents in the facility have the potential to be affected. Upon receipt of the survey on 6/5/2025, the Regional Director of Resident Care, RN, initiated a re-education process. As part of this process, the Executive Director and the Resident Care Director, RN, received re-training on the following policies: *'Documentation'* and *Assessing and Evaluating Residents'*. This re-training was successfully completed on July 23, 2025.

On 7/24/2025 the Resident Care Director, RN, successfully conducted re-training for facility RNs on the *'Assessing and Evaluating Residents'*. This training placed a heightened focus on the importance of assessments and documentation in resident records, particularly in relation to resident incidents. On 7/24/2025 the RN conducted a review of resident records associated with recent incidents to verify that accurate documentation of resident assessment was entered into resident's electronic health records.

Executive Director or designee and/or the RN will review resident records associated with recent incidents for accurate documentation weekly during Interdisciplinary meetings. This Plan of Correction to ensure compliance and will be discussed and evaluated quarterly for two quarters by the ED or designee and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violations does not occur again. QAPI meeting initiated on 7/24/2025 by the ED with the coordinators.

[redacted] approved 8/1/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60A012 Y1	A. Building B. Wing Y2	8/1/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF RANDOLPH	648 ROUTE 10 RANDOLPH, NJ 07869

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0615	Correction	ID Prefix A0925	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.15(b)	Completed	Reg. # 8:36-11.2	Completed
LSC	07/25/2025	LSC	07/24/2025	LSC	07/22/2025
ID Prefix A0999	Correction	ID Prefix A1073	Correction	ID Prefix	Correction
Reg. # 8:36-11.7(e)	Completed	Reg. # 8:36-15.6(b)	Completed	Reg. #	Completed
LSC	07/22/2025	LSC	07/24/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/5/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60A012 Y1	A. Building B. Wing Y2	8/1/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF RANDOLPH	648 ROUTE 10 RANDOLPH, NJ 07869

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0615	Correction	ID Prefix A0925	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.15(b)	Completed	Reg. # 8:36-11.2	Completed
LSC	07/25/2025	LSC	07/24/2025	LSC	07/22/2025
ID Prefix A0999	Correction	ID Prefix A1073	Correction	ID Prefix	Correction
Reg. # 8:36-11.7(e)	Completed	Reg. # 8:36-15.6(b)	Completed	Reg. #	Completed
LSC	07/22/2025	LSC	07/24/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/5/2025	☐ YES ☐ NO