

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Alaris Health at Kearny		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Bergen Ave Kearny, NJ 07032	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to handle potentially hazardous foods and maintain kitchen sanitation practices as well as store, and label in a manner intended to prevent the spread of food borne illness for 2 of 2 days of kitchen observation. This deficient practice was evidenced by the following: On 2/5/26 at 9:48 AM, the surveyor, in the presence of the Food Service Director (FSD), and the Regional Director, toured the 3rd Floor kitchen. The FSD stated the main kitchen was offsite and arrived as cooked at the facility. The FSD further stated that the facility utilized the steam table, temperatures were taken and then food was served to the residents. The FSD also stated that the facility had two satellite kitchens, one on each floor (3rd and 4th). On that same date and time, the surveyor observed the following during the kitchen tour: On 2/5/26 at 10:11 AM, on the 3rd floor satellite kitchen, the surveyor observed the stand-up freezer with open boxes of strawberry and chocolate ice cream and no dates when they were opened, including an open box of lemon ice undated. The surveyor asked the FSD and Regional Director if the open boxes should have dates when they were opened. The FSD confirmed, Yes, there should be open dates on those. On 2/5/26 at 10:27 AM, the surveyor toured the basement dry storage room with the FSD and the Regional Director and observed the following: 1. In the back of the dry storage room, the surveyor observed 4 boxes of closed, plastic utensils on the top shelf, close to the ceiling, less than 18 inches. 2. On the right side of the room, the surveyor observed holiday decorations on the top shelves, covered with plastic, touching the ceiling. The Regional Director confirmed they should not be touching the ceiling. The FSD confirmed she was responsible for the items being stored properly. 3. In the back, by the left side of the room, the surveyor observed the ceiling vent with dust accumulation and the surrounding tile peeling. The surveyor asked the FSD how long it's been like that and the FSD did not respond. The Regional Director stated the Maintenance Director was responsible for the vents. 4. The surveyor observed on the racks, 2 cans of applesauce with dented lips, 1/2 inch each. The FSD confirmed the dented cans and that her supervisors were responsible for checking that every day. On 2/9/26 at 9:54 AM, the surveyor, in the presence of the FSD, inspected the Nourishment/Pantry Room on the 3rd floor. The surveyor observed the freezer had no thermometer and inside were two ice cream containers still frozen. The FSD confirmed there was no thermometer and stated that housekeeping was responsible for checking everything. The FSD further stated that housekeeping cleaned the freezer and probably forgot to put the thermometer back. On 2/9/26 at 11:30 AM, the surveyor observed the lunch meal preparation on the 3rd floor kitchen in the presence of the FSD and the Regional Director. The food from the offsite kitchen arrived and three dietary aides were present. The surveyor observed during the lunch tray prep for residents: 1. Dietary Aide #1 preparing food on resident trays with gloves on. The steam table with lasagna, broccoli, bread rolls, and a plate of fresh parsley on a shelf on top of the steam table. The surveyor observed the food on the steam table with serving utensils except for the bread rolls and the parsley. The surveyor observed Dietary Aide #1, touching the refrigerator handles, lids for the plates, and with the same gloves on touching the bread with her hand, and when cutting the lasagna with the serving utensil, she touched the cheese to separate it from the steam table. The Dietary Aide (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#1 during plating proceeded to touch the parsley garnish with the same gloved hand. The surveyor asked, should the food be handled and touched with the same gloves that touched other surface areas, and the Regional Director confirmed, No, the food should not be touched. The Regional Director provided tongs to Dietary Aide #1 to use for the bread rolls and the garnish. 2. On 2/9/26 at 12:10 PM, the surveyor observed Dietary Aide #1 dropped four plates from the dish warmer and she stated they were too hot. The surveyor observed Dietary Aide #2 remove her gloves and obtained supplies from the shelf with no hand hygiene, then applied new gloves, proceeded to pick up broken plates from the floor, and pushed them aside. Dietary Aide #2 did not perform hand hygiene when Dietary Aide #2 changed gloves again. At that time, the surveyor asked the FSD what the process was for removing and donning on new gloves during tray preparations and she responded, Handwashing should be done. The FSD confirmed no handwashing was done by the Dietary Aide #2. On 2/10/26 at 1:02 PM, the survey team met with Chief of Operations (COO), License Nursing Home Administrator (LNHA), and the Director of Nursing (DON), and the surveyor notified them of all the concerns found in the kitchen and Nourishment/Pantry observations. On 2/11/26 at 9:30 AM, the surveyor interviewed the Maintenance Director (MD) in the presence of the DON regarding the vent issues in the dry food storage room in the basement. The surveyor asked who was responsible to check on the vents and the MD stated We make rounds every day and we are responsible for that, but the dietary supervisors also if they see anything, they communicate with us if there were anything that needed to be done. He further stated that there was a new system since July 2025, in the computer where the supervisors and managers could enter work orders, before that it was a binder. The surveyor asked if anyone put a work order for the vent in the storage room and how long it had been like that, and the MD had no response. On 2/11/26 at 12:35 PM, the survey team met with the LNHA and the DON, and there were no additional information provided by the LNHA. A review of the facility's Food Storage Policy with a reviewed date of 1/2026, revealed under Policy Statement, food is stored in an area that is clean, dry, and free from contaminants . The procedure under dry storage rooms must be well ventilated. Canned food items will be inspected for indentations. Any dents found will be discarded . The refrigerated food storage revealed, each nursing unit with a refrigerator/freezer unit will be supplied with thermometers and monitored for appropriate temperatures. All foods are covered, labeled, and dated . The frozen foods revealed, all foods are covered, labeled, and dated . A review of the facility's Steam Table Policy dated 9/8/24, revealed under Purpose, all food being served out of the steam table should .clean utensils for each food served . Under the Procedure revealed, Employees must wash hands and wear gloves, all food is served using proper serving utensil, gloves should be changed as needed. A review of the facility's Handwashing/Hand Hygiene Policy reviewed date 1/2026, revealed under Policy, to provide guidelines for effective handwashing/hand hygiene, in order to prevent the transmission of bacteria, germs and infections . Under the Guidelines: Handwashing will be performed by staff as follows: Before gloving and after gloves are removed. NJAC 8:39-17.2(g)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure licensed staff credentials were verified upon hire. This deficient practice was identified for 1 of 17 newly hired licensed staff reviewed, Staff Member (SM) #35 evidenced by the following: On 2/5/26 at 9:56 AM, during entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) the personnel files of the facility's 36 new hire employees since their last recertification survey. A review of the facility provided documents, 1 of 17 licensed staff personnel files included the following: SM #35, a Registered Nurse (RN), with a date of hire (doh) of 1/30/26, had a License Verification Report which was dated 2/1/26. There was no documented evidence that SM #35's license was verified prior to the doh. On 2/10/26 at 12:29 PM, the surveyor interviewed the Business Office Manager (BOM) who stated that she verified licenses on the website. The surveyor asked the BOM when the license verification was done. The BOM stated that it was usually done before the doh. The surveyor asked the BOM to view SM #35's file. The BOM stated that SM #35 had her orientation on 1/30/26, and that she did not work on the unit until 2/3/26. The surveyor asked the BOM to print SM #35's time card. A review of the facility provided time card for SM #35 reflected that the RN punched in at 9:00 AM and punched out at 3:00 PM on 1/30/26. On 2/11/26 at 10:50 AM, the surveyor notified the LNHA and Director of Nursing (DON) the concern that SM #35 had their license verification done on 2/1/26, which was after their doh on 1/30/26. On 2/11/26 at 12:46 PM, in the presence of the DON, the LNHA stated that SM #35 attended a class on 1/30/26 and that they did not start on the unit that day. The LNHA did not provide any additional information. A review of the facility's Abuse Prevention Program Policy with a revised date of 2/8/23, included the following: Part II-Prevention Procedure: Staff shall be screened prior to hire (See Part III-Screening). Part III-Screening Procedure: Potential hires of professional staff will have their license verified by their licensing boards prior to hire. A review of the facility's Verifying Current Licensure and Certifications Policy with a reviewed date of 1/2026, included the following: Policy: it is the policy of this facility to ensure that all licensed and certified staff maintain a valid license or certification while employed. Procedure: Human Resources-Reviews candidate's file for employment and validates licensure or certification prior to employment by using the New Jersey Office of the Professions website. Prints a copy of the verification before date of hire and places in the candidate's employment folder. A review of the facility's New Hire Process Policy with a reviewed date of 1/2026, included the following: Policy: This facility hires qualified individuals in compliance with federal and New Jersey regulations. Employment is contingent upon successful completion of required background checks, license verification and health screenings. Procedure: 3. All offers of employment are conditional upon successful completion of the following: License and certification Verification. N.J.A.C. 8:39-43.15(a)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on the interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to provide the Resident or Resident Representative with written notification of the facility's bed hold policy for 1 of 2 residents, (Residents #126), reviewed for hospitalizations. This deficient practice was evidenced by the following: The surveyor reviewed the medical records of Resident #126, and revealed the following: The admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; personal history of transient ischemic attack (TIA), cerebral infarction (a type of ischemic stroke where a blockage in a blood vessel disrupts blood flow, causing brain or retinal cell death (necrosis) due to lack of oxygen) without residual deficits, unspecified atrial fibrillation, traumatic subdural hemorrhage without loss of consciousness, and unspecified dementia. A review of the most recent Discharge Return Anticipated Minimum Data Set (MDS) revealed in Section A-Identification Information, the resident had an unplanned transfer to hospital. A review of the Nurses Notes, with an effective date of 1/6/26, that was electronically signed by the Director of Nursing (DON), revealed a note that a call was placed to the hospital regarding the resident's status, and the ER (emergency room) nurse stated that the resident was admitted with intracranial hematoma (collection of blood within the skull. The blood may collect in the brain tissue or underneath the skull, pressing on the brain. It's usually caused by a blood vessel that bursts in the brain). Further review of the medical records revealed that there was no documented evidence that the written bed hold notifications were given to the Resident or Resident Representative (RR) of Residents #126 when the resident had an acute transfer to the hospital. On 2/6/26 at 9:42 AM, the surveyor interviewed the Director of Social Services (DSS), who stated that she was responsible for acute transfer notifications and bed hold. The DSS informed the surveyor that she sent the notices of bed hold and notice to the Ombudsman the next day of the discharge or transfer to the hospital, if weekend, she did it on Monday and sent it both by mail, and this was applicable to Long Term Care (LTC) residents only. On that same date and time, the DSS informed the surveyor that if the subacute residents had acute transfer to the hospital, the facility only notified the Ombudsman, and no bed hold notices given to the resident or RR. She also confirmed that was the reason why Resident #126 had no bed hold notice in resident's medical records. On 2/6/26 at 9:50 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) for the process for bed hold notices and if the facility provide bed hold notices to the resident or RR. The LNHA responded in the presence of the survey team that the facility did not give bed hold notices to subacute residents. He further stated that bed hold notices were given only to LTC residents. On 2/10/26 at 1:01 PM, the survey team met with the LNHA, DON, and COO (Chief Operating Officer), and the surveyor notified them of the above findings and concerns. On 2/11/26 at 12:35 PM, the survey team met with the LNHA and DON for responses. The LNHA stated Resident #126 was at the facility for less than 24 hours, and the bed hold notice was only for Medicaid residents. The LNHA further stated that the information he looked up did not reflect anything for short term residents when providing bed hold notice. On that same date and time, the surveyor notified the LNHA of the updated regulation that facilities must provide written information about these policies to residents prior to and upon transfer for such absences; information must be provided to all facility residents, regardless of their payment source; and these provisions require facilities to issue two notices related to bed-hold policies. The surveyor also notified the LNHA and DON that the provided facility's bed hold notice binder also indicated that it should be provided to Medicare residents, and their policy discussed the same thing. The LNHA did not provide additional information. A review of the facility's Bed Hold Policy that was provided by the LNHA, with last reviewed date of 01/26, revealed, it is the policy of the facility to inform residents and/or family representative of the facility's bed hold policy. Under Procedure: A. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Temporary Discharge (bed hold). During Resident's temporary leave from the facility to a hospital or any other facility, facility agrees as follows: 3. Medicare: If a Resident's secondary payor is private, the bed hold provisions in 3A1 above shall apply. If Resident's secondary payor is Medicaid, the bed hold provisions 3A2 above shall apply. A review of the facility's provided copy of Bed Hold Notification by the LNHA revealed in the letter that was signed by the DSS that the letter was to inform of the bed hold policies of the facility. In accordance with NJ (New Jersey) Medicaid guidelines, the facility will reserve your bed for a period of 10 days if you are a Medicaid recipient. For short term resident whose payment is Medicare or private insurance, the bed hold provisions noted above for private pay residents will apply. On 2/11/26 at 1:30 PM, the survey team met with the LNHA, DON, Regional Nurse, and QA (Quality Assurance) Nurse for an exit conference, and there was no additional information provided by the LNHA. N.J.A.C. 8:39-4.1(a)(31);5.1 (a)(b); 5.2 (a)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, it was determined that the facility failed to accurately complete a portion of the Minimum Data Set (MDS), an assessment tool that facilitate the plan of care, to accurately reflect the resident's status for 1 of 26 residents reviewed (Resident #2). The deficient practice was evidenced by the following: On 2/5/26 at 11:54 AM, Surveyor #1 (S #1) observed Resident #2 being wheeled into the resident's room coming from an activity. The resident stated that they were okay. On 2/9/26 at 12:25 PM, Surveyor #2 (S #2) was given the assignment sheet in which indicated Resident #2 was on the list as a feeder. On 2/9/26 at 12:36 PM, S #2 observed Resident #2 seating in the wheelchair with lunch tray untouched and uncovered. On 2/9/26 at 12:40 PM, S #2 notified the Registered Nurse/Unit Manger (RN/UM) the concern that no one fed the resident when the lunch was served and left uncovered at the bedside when the Certified Nursing Assistant (CNA) assignment showed that the resident was a feeder. The RN/UM stated that the resident was a set up and not a feeder. S #2 then asked why it was in the assignment of the CNA that the resident was a feeder, and she did not respond. On 2/9/26 at 12:44 PM, S #2 interviewed the License Nursing Practical Nurse (LPN) after feeding Resident #2. The LPN informed S #2 that the resident at times needs assistance with feeding. On 2/9/26 at 3:30 PM, S #1 reviewed the medical records of Resident #2 and revealed: A review of the admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; metabolic encephalopathy, heart failure, dementia in other diseases classified elsewhere, severe, with agitation and recurrent depressive disorders. A review of the Significant Change MDS with an assessment reference date (ARD) of 1/12/26, reflected a Brief Interview of Mental Status (BIMS) score of 5 out of 15 indicating severe cognitive impairment. Under section GG in the MDS revealed eating as supervision or touching assistance. A review of the Care Plan revealed: Self-Care/Mobility Performance Deficit related to weakness, immobility, date initiated: 10/9/25; Revision on 11/3/25. The intervention included resident required staff participation to eat. A review of the Registered Dietician's note dated 1/12/26, revealed, . dependent on staff for feeding. On 2/10/26 at 12:02 PM, S #1 interviewed the MDS Coordinator (MDSC), regarding the 1/12/26 Significant Change MDS assessment. S #1 asked the MDSC what was the process on coding the functional ability of the resident for eating, and the MDSC replied, There was an interim GG assessment done by nursing (Unit Manager) and rehab staff. She further stated that I also interview the staff and Unit Manager, sometimes I will ask the aides if they were regular and rehab staff, try to see the look back period (7 days from ARD), and observe the resident. S #1 asked the MDSC if she would look at the Tasks (CNA supportive documentation) to include that in her coding on what type of assistance the resident received for eating and she replied, Yes. At that time, S #1 and the MDSC reviewed the Tasks for eating from 1/6/26 to 1/12/26, with legends of 3-partial/moderate assistance; 2-substantial/max assist;1-dependent. Both S #1 and the MDSC saw that Resident # 2 was plotted by CNAs as provided 2-substantial/maximal assistance on look back period for seven days, a total of 10 meals. The MDSC stated, Going by what was documented, I would code eating as substantial/maximal according to the CNA documentations. The MDSC confirmed the MDS was done inaccurately for the ARD of 1/12/26, and that she would modify the assessment. On 2/10/26 at 1:02 PM, the survey team met with the Chief of Operations (COO), the License Nursing Home Administrator (LNHA) and the Director of Nursing (DON, and S #1 notified them of the concern for MDS inaccuracy. On 2/11/26 at 12:35 PM, the survey team met with the LNHA and the DON for their responses. S #1 asked the LNHA and DON what the expectation was for completing MDS accurately, should the CNAs documenting that the resident needed assistance for eating be coded in the MDS and the DON replied, I only include in my assessment what I see personally. Those days that the CNAs assisted (name redacted) were because of behavior, but resident does feed self at times. A review of the facility's MDS 3.0 Assessment Process Policy, reviewed on 1/2026 revealed under Policy, the most current RAI (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Resident Assessment Instrument-provides guidance for appropriate care for nursing home and long-term care residents) will serve as the reference for completion of the MDS . Under Purpose, the purpose of the MDS 3.0 is to accurately assess residents to guide the development of a plan of care using an interdisciplinary approach .to gather definitive information on a resident's strengths and needs which must be addressed in an individualized Care Plan .Decision-Making is carried out from the information obtained by determining the severity, functional impact and scope of the resident's problems .and discovering the impact on their functional ability. NJAC 8:39-33.2(d)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to ensure a resident with severe cognitive impairment, who was at risk for elopement and had a known history of wandering was appropriately supervised and monitored to ensure safety, prevent elopement, and/or exiting of the building for 1 of 1 resident reviewed for elopement (Resident #44). This deficient practice was evidenced by the following: On 2/5/26 at 10:25 AM, the surveyor observed Resident #44 asleep in their bed. A review of Resident #44's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; delirium due to known physiological condition (an acute, fluctuating disturbance in attention, awareness, and cognition directly caused by an underlying medical condition, such as infection, metabolic imbalance, or organ failure), hypertension (high blood pressure), and bipolar disorder (a chronic mental health condition characterized by extreme mood swings, alternating between emotional highs (mania/hypomania) and lows (depression)). A review of Resident #44's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which reflected that the resident's cognition was severely impaired. Further review indicated under section P for Restraints and Alarms, Wander/elopement alarm was used daily. A review of Resident #44's Elopement Risk Evaluation dated 11/13/25, indicated that the resident was a high risk for elopement and the interventions included utilize wander guard as needed. A review of Resident #44's February 2026 electronic Treatment Administration Record (eTAR) included the following orders: Wanderguard bracelet on right ankle every shift check for function (replace if not functioning). Wanderguard bracelet on right ankle every shift check placement. A review of Resident #44's individualized comprehensive care plan indicated that the resident had the potential for wandering related to Dementia and was at risk for elopement/wandering as evidenced by being disoriented to place and impaired safety awareness. On 2/9/26 at 10:44 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the process for checking the function of a resident's wander guard bracelet. The LPN stated that the resident was taken by the door to see if it alarmed. On 2/9/26 at 10:46 AM, the surveyor interviewed the Registered Nurse (RN) regarding the process for checking the function of a resident's wander guard bracelet. The RN stated that the resident was walked to the elevator to check that it was working and that the Certified Nursing Assistants (CNAs) also would bring the residents to the elevator. On 2/9/26 at 10:54 AM, the surveyor interviewed the fourth floor RN/Unit Manager #1 (RN/UM #1) regarding the process for checking the function of a resident's wander guard bracelet. RN/UM #1 stated that the CNAs or nurses would place the resident near the elevator to see if the bracelet would [trigger the] alarm. On 2/9/26 at 11:14 AM, the surveyor interviewed Resident #44's CNA who stated that when she would take any of her residents that had a bracelet to the activity room and if their bracelet did not trigger the alarm when passed the elevator that she would tell someone. The surveyor asked the CNA about Resident #44. The CNA stated that Resident #44 stayed in their room for the most part. She added that if she were to check the bracelet then she would pass the resident by the elevator to check it. The CNA stated that she would let the nurse know if it did or did not work. On 2/9/26 at 11:49 AM, the surveyor requested the RN to show the surveyor Resident #44's wander guard bracelet. While the RN showed the surveyor Resident #44's wander guard bracelet on their right ankle, Resident #44 stated that they wanted to get out of here. On 2/9/26 at 11:57 AM, the surveyor interviewed the Maintenance Director (MD) who stated that there was a device that was a little box that the unit managers had to test the function of the wander guard bracelet that was on a resident. The MD stated that he checked the function of the alarm daily by taking a wander guard bracelet (not in use by a resident) by the elevator to make sure the alarm worked. On 2/9/26 at 12:01 PM, the surveyor asked the RN/UM if (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was a device that tested the function of the wander guard bracelet. RN/UM #1 stated that she was not aware of a tester. On 2/9/26 at 12:02 PM, the surveyor asked the Assistant Director of Nursing (ADON) if there was a device that tested the function of the wander guard bracelet. The ADON stated that she was not aware of a tester device. The ADON stated that to check the function, the resident was taken by the elevator to see if alarm [went off]. On 2/9/26 at 12:24 PM, the surveyor interviewed the Director of Nursing (DON) regarding the process for checking the function of a resident's wander guard bracelet. The DON stated that the wander guard bracelet was checked every shift for placement and also functioning by taking the resident to the elevator. The surveyor asked the DON if they had a device to check the function. The DON stated that they did not have a device and that they used the elevator. The surveyor asked the DON what the purpose of the wander guard bracelet was. The DON stated that if a resident was exit seeking and confused it was put on for exit seeking behavior. On 2/9/26 at 12:39 PM, the MD showed the surveyor the testing device for the wander guard bracelet that was in the third floor RN/UM #2 office in a drawer of the desk. On 2/9/26 at 12:42 PM, the surveyor interviewed RN/UM #2 who stated that there was a machine to check the function of the wander guard bracelet. On 2/10/26 at 1:18 PM, the surveyor notified the LNHA, DON and Chief Operating Officer (COO), the concern that Resident #44's wander guard bracelet was not appropriately checked by staff for function by using a testing device and not directing the resident to the exit. The DON stated that the facility had a testing device. On 2/11/26 at 9:50 AM, the DON stated that they had one testing machine for both floors. She added that they checked the function in two ways. The DON stated that they tell the CNAs to bring the resident near elevator to make sure it alarms and works. The DON stated that they have not had any elopements. On 2/11/26 at 12:47 PM, in the presence of the LNHA, the DON stated that they had the machine to test the function and that they also make sure the elevator was functioning. She added that they never had any elopement. On 2/11/26 at 1:00 PM, in the presence of the DON, the LNHA stated that they bring the resident in the direction of the elevator and that if look at our past that they did not have an elopement. The LNHA stated that Resident #44 ambulated and would go by the elevator. The surveyor asked the LNHA Resident #44 was going by the elevator should the resident be redirected from the elevator. The LNHA stated that the staff do redirect the resident. The LNHA did not provide any additional information. A review of the facility's [Company Name Redacted] Wander Management Transmitters User Guide Policy with a release date of 11/2018, included the following:PrefaceOverview: The [Name redacted] monitors doors, elevators, hallways, and stairwells to assist staff in monitoring residents in a facility. The transmitter is placed on the wrist or ankle of the resident. If a transmitter is detected in an Exit Alarm Zone and the door is open, an alarm sounds at the exit. Depending upon which equipment you have installed, the [Name redacted] can automatically lock doors and deactivate elevators.Testing and CareOperationTest the operation of the transmitter using the Transmitter Tester. The transmitter tester will detect whether or not a transmitter is emitting a signal, but cannot indicate the strength of the signal.1. Place the transmitter tester directly on the transmitter.2. Press and hold the button on the left side of the transmitter tester.3. The device beeps once when you initially press the button.4. While holding the button in, the indicator light flashes and a tone sounds once per second.5. Wait for at least 3 flashes of the indicator light and 3 tones from the transmitter tester to verify that the transmitter is functioning correctly.Weekly Testing: The following testing is required for all transmitters in use on residents.1. Test the operation of transmitters using the transmitter tester.NOTE: Never take a resident to a door to test their transmitter. A review of the facility's Wander Guard Policy with a reviewed date of 1/2026, included the following:PolicyIt is the policy of the facility to utilize wander guard system for selected residents with a known behavior of wandering beyond their unit of residence as an adjunct to safety measures typically in place i.e. door alarms on stairways.Procedure:.3. Initiating the System: The bracelet will be obtained.It will be applied to the resident's wrist. NOTE: occasionally, residents display a tendency to remove bracelets in which case the team may decide to apply to the ankle.Daily every shift testing is required to ensure it is (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Alaris Health at Kearny		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Bergen Ave Kearny, NJ 07032	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functional.4. Activating the system: Elevator doors are secured with Wander Guard alarm system. When either elevator doors are open and a resident with a wander guard bracelet walks through, the alarm will sound. Should the rear door be closed and a resident with a wander guard walks by, the door will sound and hold in place. Should the doors hold in place or alarm, any other nearby personnel should then redirect the resident. The nurse of the resident's floor should be notified and should document the attempted elopement making all caregivers on the floor aware so that they can increase their awareness of resident's location.5. Resetting the system: Punch in the code on the alarm panel and press *. This will shut off the alarm (after the resident was redirected away from the area). N.J.A.C. 8:39-27.1(a)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews, record review, and review of pertinent facility documents, the facility failed to ensure the indwelling urinary catheter drainage tubing was stored in a manner to prevent Urinary Tract Infection (UTI) for 1 of 1 resident reviewed for urinary catheter care or UTI (Resident #88). The deficient practice was evidenced by the following: On 2/5/26 at 10:46 AM, the surveyor observed Resident #88 seated in a wheelchair (w/c) in their room with a visitor seated in the room. There were no staff members in the room. The surveyor observed that there was a urinary catheter tubing and drainage bag that was hung on the side of the bed that was not connected to Resident #88. Further observation of the tubing that was leaning against part of the bed frame reflected that the end of the tubing was not capped. The urinary catheter drainage bag and tubing was not properly stored. Resident #88 stated that the staff changed the drainage bag to a leg bag but was not sure what they did. On 2/5/26 at 10:48 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the process for urinary catheter drainage bags. The LPN stated that the drainage bag was changed weekly by the nurses and Certified Nursing Assistants (CNAs). The LPN stated that when the drainage bag was changed to a leg bag that the tubing on the drainage bag was wiped and capped and placed in a bag in the bathroom. On 2/5/26 at 10:51 AM, the surveyor interviewed Resident #88's CNA regarding the process for the storage of the drainage bag. The CNA stated that the tubing was capped and then placed in a plastic bag. On 2/5/26 at 10:52 AM, the surveyor interviewed the fourth floor Registered Nurse/Unit Manager (RN/UM) who stated that every Sunday night the drainage bag was changed. The RN/UM stated that if the drainage bag was changed to leg bag for when the resident was in chair then the drainage bag tubing would be capped and put in a bag in the bathroom. The surveyor asked the RN/UM to enter Resident #88's room to observe the drainage bag. The surveyor observed the CNA and another nurse exit Resident #88's room. On 2/5/26 at 10:56 AM, the RN/UM stated that she did not see a urinary drainage catheter bag and tubing in the resident's room. The surveyor showed the RN/UM the picture of the observed bag and tubing that was not stored correctly. The RN/UM stated that the bag and tubing should not be left there that way. A review of Resident #88's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; cerebral infarction (a type of stroke caused by a blockage in a blood vessel supplying the brain, resulting in tissue necrosis (death) from lack of oxygen), neuromuscular dysfunction of bladder (the loss of bladder control caused by nerve damage from diseases or injuries), and hypertension (high blood pressure). A review of Resident #88's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which reflected that the resident's cognition was intact. Further review indicated the resident had an indwelling catheter (tube that is inserted for continuous drainage of the bladder). A review of Resident #88's February 2026 electronic Treatment Administration Record (eTAR) included the following order: Change urinary drainage bags every night shift every Tue (Tuesday) with a start date of 11/26/24. On 2/9/26 at 11:28 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the urinary catheter drainage bag and tubing were changed weekly and as needed. The DON stated that if a resident was being seated in a w/c then the drainage bag and tubing was changed to a leg bag. The surveyor asked the DON what was done with the drainage bag and tubing [when it was disconnected from the resident], the DON stated that honestly it should be thrown out because of infection control but was not sure what the policy was. The surveyor asked if the bag and tubing should be left in the room when the staff member leaves the room. The DON stated that when the staff member left the room, they should throw it out and not leave it there. The surveyor showed the DON the picture of Resident #88's drainage bag and tubing that was not properly stored. The DON stated that the staff member told her that she made a mistake. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated that it should not have been left there. On 2/9/26 at 11:44 AM, the DON stated that the drainage bag and tubing should be recapped and that if the cap could not be found then the bag and tubing should be thrown out. On 2/10/26 at 1:17 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON and Chief Operating Officer (COO), the concern that Resident #88's removed urinary catheter drainage bag was not properly stored on 2/5/26. The DON stated that the CNA had thrown out the urinary catheter drainage bag. The surveyor asked the DON if it was thrown out after surveyor inquiry. The DON confirmed that it was thrown out after surveyor inquiry. On 2/11/26 at 12:46 PM, in the presence of the LNHA, the DON stated that the CNA was called to help another resident after she had transferred Resident #88 to w/c and that she could not find the cap to recap the tubing. The DON stated that the CNA left the bag and tubing when she went to help the other resident and that when she returned to Resident #88's room, she had thrown out the bag and tubing. The LNHA did not provide any additional information. A review of the facility's Catheter Care, Urinary Policy with a reviewed date of January 2026, included the following: Policy: It is the policy of the facility to prevent catheter-associated urinary tract infections and to maintain the dignity and privacy of our residents utilizing urinary catheters. Catheter care: 5. Maintain clean techniques when handling or manipulating the drainage system. 9. Unless visibly soiled or contaminated, the drainage bag should be changed on a weekly basis. The policy did not contain any information on storing drainage bags. N.J.A.C. 8:39-27.1 (a)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to a.) ensure that the comprehensive care plan and nursing documentation were updated to reflect a physician's order for oxygen therapy for 1 of 2 residents (Resident #9) and b.) ensure that a resident receiving oxygen therapy had their oxygen saturation monitored as a standard of practice for 1 of 2 residents (Resident #11) reviewed for respiratory care. This deficient practice was evidenced by the following: 1. On 2/10/26 at 10:55 AM, Surveyor #1 (S #1) observed Resident #9 was lying in bed with oxygen (O2) in place via nasal cannula (n/c) at 2 liters per minute (2LPM) delivered by concentrator. The O2 tubing and humidifier on the O2 concentrator were labeled. S #1 reviewed the medical records of Resident #9 and revealed: A review of the admission Record or face sheet (an admission summary) reflected that Resident #9 was admitted at the facility with diagnoses that included but were not limited to; pneumonia, dysphagia (difficulty swallowing), failure to thrive, dementia, and gastrostomy (medical procedure that creates a small opening (stoma) through the abdominal wall directly into the stomach to insert a feeding tube, commonly known as a tube feeding) status. A review of an active physician order (PO) for respiratory care, dated 1/29/26, for O2 inhalation via n/c at 2LPM every shift for shortness of breath (SOB), and an order to change O2 tubing weekly, scheduled for every Tuesday night shift. A review of the electronic Medication Administration Record (eMAR) revealed that the above PO for 2LPM and O2 tubing change were transcribed and signed by nurses as administered. A review of the personalized care plan (CP) revealed that there was no documented evidence that the O2 therapy was identified in the CP. The resident's CP was last reviewed and completed on 1/22/26. A review of the Monthly Nursing Summary dated 2/6/26 did not reflect that the resident was on O2. There were no further documentation in the Progress Notes (PN) reflective of resident's O2 therapy. On 2/10/26 at 1:02 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) of the above findings and concerns. On 2/11/26 at 1:30 PM, the survey team met with the LNHA, DON, Regional Nurse, and QA (Quality Assurance) Nurse for an exit conference, and there was no additional information provided by the LNHA. 2. On 2/5/26 at 10:11 AM, Surveyor #2 (S #2) observed Resident #11 lying in bed with the head of the bed elevated. S #2 observed that the resident had a tracheostomy (trach) and was receiving O2 therapy via a humidified trach collar which was connected to a O2 concentrator and a high-performance, portable medical air compressor (used to provide continuous, reliable air for aerosol therapy). A review of Resident #11's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; tracheostomy (a surgical procedure creating an opening (stoma) in the neck into the trachea (windpipe) to provide an alternative airway), anoxic brain damage (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(occurs when the brain is completely deprived of oxygen, causing brain cells to begin dying within roughly four minutes), and hypertension (high blood pressure). A review of Resident #11's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which reflected that the resident's cognition was severely impaired. Further review indicated the resident received trach care and continuous O2. A review of Resident #11's personalized CP indicated that the resident had a trach to maintain adequate airway and O2 delivery related to diagnosis of respiratory failure and that the interventions included but was not limited to: Monitor O2 saturation q (every) shift. A review of Resident #11's February 2026 eMAR and electronic Treatment Administration Record (eTAR) included the following orders: CHECK VITAL SIGN AND MONITOR SIGN AND SYMPTOMS FOR COVID SUCH AS COUGH, FEVER, SORE THROAT, RESPIRATORY AND GI SYMPTOM AND NOTIFY MD IF PRESENT q day shift every Sat (Saturday). Trach care q shift and as needed q shift with a start date of 7/19/24. There was no further instructions on the order. The nurses wrote a check mark to indicate the order was administered. There was no documentation of any O2 saturation result. There was no order for monitoring O2 saturation q shift. On 2/11/26 at 9:29 AM, S #2 reviewed Resident #11's electronic medical record under the weights and vitals section for February 2026 which included the following for O2 saturation results: 2/7/26 15:09 97 % (Trach) 2/5/26 17:43 97 % (Trach) 2/5/26 9:00 97 % (Trach) 2/4/26 17:42 97 % (Trach) 2/4/26 8:36 97 % (Trach) 2/3/26 17:57 97 % (Trach) 2/3/26 8:13 97 % (Trach) 2/2/26 16:40 97 % (Trach) 2/2/26 8:45 95 % (Trach) 2/1/26 17:41 95 % (Trach) 2/1/26 8:49 95 % (Trach) (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	S #2 then reviewed Resident #11's PN for February 2026. There was no documented evidence of any O2 saturation results in the February 2026 PN. Resident #44's O2 saturations were not documented q shift and had not been documented at all since 2/7/26. On 2/11/26 at 9:52 AM, S #2 interviewed the DON regarding the process for O2 saturation for resident that had a trach and received O2. The DON stated that trach care was done q shift and that it was in the eMAR and eTAR. The DON stated that O2 saturation was checked during the process of trach care. S #2 notified the DON that Resident #11 did not have an order for checking O2 saturation and that the last documented O2 saturation result was 2/7/26 in the resident's electronic medical record. The DON stated that she was going to check. On 2/11/26 at 10:07 AM, the DON stated that Resident #11 was a Long Term Care stable trach resident and that q shift during trach care the staff checked the O2 saturation. The DON stated that part of the trach care order meant that the O2 saturation should be checked but that it was not a separate documentation. S #2 asked the DON about the O2 saturations that were under the vital sign section that were documented twice a day prior to 2/5/26. The DON stated that if a nurse had done an assessment check and vital signs then the nurse would put it there. S #2 asked the DON if an assessment was done, was the expectation that it would be documented. The DON stated yes and that if vital signs were done then document it. The DON stated that if it was not done then it was not documented. On 2/11/26 at 10:52 AM, S #2 notified the LNHA and DON the concern that Resident #11, a resident receiving O2 therapy, did not have a PO to monitor O2 saturations and that the last documented O2 saturation result in the electronic medical record was 2/7/26. The DON stated that the resident was improving and that they were doing everything right. She added that maybe the documentation was not there but that they were checking the O2 saturation during trach care. The DON stated that the resident's family was asking us to see if the physician could get the resident off O2. On 2/11/26 at 12:52 PM, in the presence of the LNHA, the DON stated that since Resident #11 came to the facility, their amount of O2 has been decreased from 6LPM to 2LPM. The DON stated that she had spoken with the consultant physician and that they would decrease the O2 to 1 LPM and check O2 saturations and then maybe stop the O2 if the primary physician agreed. The DON stated that the resident had been at the facility for more than two years and had not had any respiratory distress. The DON stated that maybe everything not there (documentation). The LNHA did not provide any additional information. A review of the facility's Oxygen Therapy Policy with a reviewed date of 4/6/23, included the following: Policy: To provide guidelines for safe O2 administration. Preparation and Observation: The licensed nurse shall: 4. Before administering O2, and while the resident is receiving O2 therapy, observe for the following:. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitor O2 saturation as per MD (Medical Doctor) orders. A review of the facility's Tracheostomy Care Policy with a reviewed date of 1/2026, included the following: .9. Check resident for respiratory distress. 19. Assess resident's tolerance to procedure and place resident in comfortable position. 22. Sign trach orders on the TAR, record observation data and how the resident tolerated the procedure in the resident's medical record. The policy did not contain any information regarding monitoring O2 saturation. A review of the facility's Vital Signs Policy with a reviewed date of 1/2026, included the following: Policy: It is the policy of this facility to ensure consistent, accurate, and timely assessment, documentation, and reporting of resident vitals signs in order to identify changes in condition early, promote resident safety, and support clinical decision-making. Vital signs monitoring shall be performed according to PO, clinical condition, facility protocols, and professional standards of nursing practice. N.J.A.C. 8:39-27.1(a)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication times to accommodate for dialysis scheduled times and documenting accurate medication administration times. This deficient practice was identified for 1 of 2 residents, (Resident #12), reviewed for dialysis services. The deficient practice was evidence by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The surveyor reviewed the electronic medical record (EMR) for Resident #12 which revealed. A review of the admission Record face sheet (an admission summary) reflected diagnoses which included, but not limited to, end stage renal disease (when the kidneys no longer work sufficiently to meet the body's needs) and essential hypertension (high blood pressure). A review of Resident #12's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 11/14/25, under section C, had a Brief Interview Mental Status (BIMS) score of 3 out of 15, which indicated the resident has severe cognitive impairment. Section O reflected that the resident was receiving dialysis. A review of the resident's comprehensive Care Plan (CCP) revealed a focus that the resident had hypertension, and Interventions that reflected to give hypertensive medications (meds) as ordered. A review of the resident's physician orders (PO) revealed an Order Audit Report (OAR) which reflected that the resident had an order for dialysis every Tuesday, Thursday, and Saturday with a chair time of 6:00 AM. A review of the resident's electronic medication administration record (eMAR) for January and February 2026, revealed that the resident had orders that reflect the following:Carvedilol Tablet (tab) 3.125 mg (milligram) give 1 tab by mouth two times a day every Mon (Monday), Wed (Wednesday), Fri (Friday), Sun (Sunday) for hypertension (HTN) give with food on non-dialysis days. Scheduled for 8:00 AM and 8:00 PM. Carvedilol Tab 3.125 mg give 1 tab by mouth two times a day every Tue, Thu, Sat for HTN give with food on dialysis days. Scheduled for 8:00 AM and 8:00 PM. The eMAR also reflected that the Carvedilol (a medication given for high blood pressure) that was ordered on dialysis days was documented as being given during the 8:00 AM medication (med) time interval. A review of the resident's Progress Notes (PN) revealed Consultant Pharmacist (CP) PN dated 11/11/25, 12/9/25, and 1/13/26. The CP PN reflected Med Regimen Reviewed (MRR). No recommendations made. On 2/6/26 during tour of the facility, the surveyor asked the Licensed Practical Nurse (LPN) assigned to Resident #12 what time they usually return from dialysis. The LPN stated that it can vary, but usually between 11:30 AM and 12 noon. On 2/10/26 at 8:44 AM, the surveyor interviewed the Director of Nursing (DON) regarding when Resident #12 dialysis schedule. The DON confirmed to the surveyor that the resident had a 6:00 AM chair time and comes back approximately 11:30 AM to 12 noon. The surveyor asked if the resident could receive any meds that were scheduled for 8:00 AM on dialysis days. The DON stated no, unless the resident refused to go out to dialysis that day. The surveyor asked if residents' meds should be scheduled times be adjusted to accommodate dialysis. The DON stated yes. On 2/10/26 at 1:02 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), DON, and Chief Operating Officer (COO), and (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the surveyor notified them of the above concerns. The DON stated that maybe the resident was at the hospital or refused dialysis. The surveyor requested that the DON provide documentation if that occurred. The surveyor notified the facility that there was no mention of this irregularity by the CP. On 2/11/26 at 12:08 PM the surveyor spoke to the facility Regional Consultant Pharmacist (RCP). The RCP stated that the regular CP was unavailable. The surveyor asked the RCP if there was an expectation for the CP to review med times so they do not conflict with times when a resident may not be in the facility such as dialysis. The surveyor notified the RCP about the carvedilol orders at 8:00 AM on both dialysis and non-dialysis days. The RCP stated that the CP should be reviewing eMAR for med times to accommodate dialysis and they probably did not see the carvedilol orders it because it was documented as given. The RCP did admit that this should be looked at by CP and was a valid concern. On 2/11/26 at 12:37 PM, the survey team met with the LNHA and DON and there was no additional information provided by the LNHA. A review of the facility's Consultant Pharmacy Reports Policy, reviewed 1/2026, reflected under Policy: .Any irregularities will be reported and documented to the attending physician and DON. Under Procedure: 4. Any med irregularities identified will be documented. A review of the facility's Medication Administration Policy, reviewed 1/2026, reflected under Procedure 3. Meds must be administered in accordance with the orders, including any required time frame. 6. The individual administering the med must check the label to verify right time. NJAC: 8:39-11.2(b); 27.1(a); 29.2(a)(d)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Alaris Health at Kearny		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Bergen Ave Kearny, NJ 07032	
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure residents received feeding assistance in accordance with residents' plan of care. This deficient practice was identified for 2 of 4 residents (Resident#2 and Resident #8) observed during meal time, and was evidenced by the following:1.On 2/5/26 at 10:44 AM, Surveyor #1 (S #1) observed the Nursing Home Resident Care Staffing Report (NHRCSR) for 2/5/26, 7 AM-3 PM (7-3) shift with a census of 111, and the ratio of the Certified Nursing Aid (CNA) to Resident was 1:9.3, and was posted on the 3rd floor bulletin board. On 2/6/26 12:34 PM, S #1 reviewed the provided 2/6/26, 7-3 shift CNA Assignment sheet of 3rd floor nursing unit that was provided by the Work Clerk/Central Supply Staff (WC/CSS) and revealed the following: -Assignment #1, CNA #1 with 11 residents and included in the assignment three resident who needed assistance with feeding or eating. -Assignment #2, CNA #2 with 10 residents and included in the assignment three residents who needed assistance with feeding. -Assignment #3, CNA #3 with 10 residents and included in the assignment two residents who needed assistance with feeding. -Assignment #4, CNA #4 with 11 residents and included in the assignment three resident who needed assistance with feeding. -Assignment #5, CNA #5 with 11 residents and included in the assignment two residents who needed assistance with feeding that included Resident #2. -Assignment #6, CNA #6 with 10 residents and included in the assignment three resident who needed assistance with feeding. On 2/9/26 at 11:28 AM, S #1 reviewed the provided 2/9/26, 7-3 shift CNA Assignment sheet of 3rd floor nursing unit that was provided by the WC/CSS and revealed the following: -Assignment #1, CNA #1 with 11 residents and included in the assignment three resident who needed assistance with feeding. - Assignment #2, CNA #2 with 10 residents and included in the assignment three residents who needed assistance with feeding. -Assignment #3, CNA #7 with 11 residents and included in the assignment two residents who needed assistance with feeding. -Assignment #4, CNA #4 with 10 residents and included in the assignment three resident who needed assistance with feeding. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assignment #5, CNA #8 with 11 residents and included in the assignment two residents who needed assistance with feeding that included Resident #2. -Assignment #6, CNA #6 with 10 residents and included in the assignment three resident who needed assistance with feeding. On 2/9/26 at 12:25 PM, S #1 observed Resident #2 was served a lunch tray, set up provided, lunch meal was uncovered, while Resident #2 was seated in a wheelchair (w/c). The resident was not eating. The resident was left alone, and no one was feeding the resident. On 2/9/26 at 12:36 PM, S #1 observed Resident #2 seated in the w/c and was not eating. The resident was not assisted with feeding. At that time, S #1 asked the Food Service Director (FSD) to check Resident #2's lunch meal and the FSD confirmed that the resident's food was untouched, uncovered, and the resident did not eat the food. On 2/9/26 at 12:40 PM, S #1 notified the Registered Nurse/Unit Manager (RN/UM) about the concern that no one fed Resident #2 according to the 7-3 shift CNA Assignment sheet that the resident was a feeder. The RN/UM stated that the resident was a set up and not a feeder. S #1 then asked why it was in the assignment of the CNA that the resident was a feeder, and the RN/UM did not respond. The surveyor asked for copy of the resident's care plan (CP). On 2/9/26 at 12:44 PM, S #1 observed Licensed Practical Nurse #1 (LPN #1) feeding Resident #2 and the resident responded with the feeding assistance provided by LPN #1. During an interview of S #1 with LPN #1, LPN #1 informed S #1 that Resident #2 at times required assistance with feeding that was why the resident was being fed. Afterward, S #1 asked the WC/CSS for CNA #8 for an interview, and WC/SS responded that CNA #8 was busy feeding other resident in their assignment. CNA #8 was assigned to Resident #2. S #1 did not observe CNA #8 assisted Resident #2 with feeding or stayed with the resident during mealtime. The surveyor reviewed the medical records of Resident #2 and revealed: A review of the admission Record (AR; an admission summary) reflected that the resident had diagnoses that included but were not limited to; metabolic encephalopathy (a broad term for brain dysfunction caused by systemic illness, metabolic imbalances, or toxin buildup in the blood, rather than a direct brain injury), unspecified heart failure, type 2 diabetes mellitus without complications, dementia in other diseases classified elsewhere, severe, with agitation, unspecified glaucoma (a group of eye diseases that damage the optic nerve&mdash;responsible for transmitting visual information to the brain), dysphagia (difficulty swallowing), and presbycusis unspecified ear (age-related hearing loss that develops gradually). A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference (ARD) date of 1/12/26, revealed a Brief Interview Mental Status (BIMS) score of 5 out of 15, which indicated the resident's cognition was severely impaired. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the personalized CP revealed a focus that Resident #2 with nutritional risk related to (r/t) therapeutic/mechanically altered diet, dysphagia, obese BMI (body mass index), presence of multiple comorbidities including CHF (congested heart failure), dementia, and diuretic therapy that was initiated on 10/9/25 and revised on 1/9/26. The CP interventions included but was not limited to, provide 1:1 (one on one) feeding assistance with all meals, that was initiated on 10/9/25 and revised on 10/9/25. Further review of CP revealed a focus that Resident #2 had a self-care/mobility performance deficit r/t weakness and immobility that was initiated on 10/9/25 and revised on 11/3/25. The CP interventions included but was not limited to, eating: required staff participation to eat that was initiated on 10/23/25. A review of the Progress Notes (PN), a nutrition-follow up general note that was electronically signed by the Dietician on 1/12/26, related to weight/significant change note, reflected that Resident #2's diet continued as NAS (no added salt), mechanical soft consistency, thin liquids, seen by SLP (Speech Language Pathologist) on 1/11/26. The note also included that Resident #2 was consuming 75% of meals served, dependent on staff for feeding. The Dietician had recommended to continue to observe resident's intake, weight .and CP remained in place. On 2/10/26 at 8:21 AM, the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) met with S #1. The DON stated that Resident #2 was able to feed self-post set up and there were times that resident required staff assistance due to behavior. The DON further stated that the CNA Assignment sheet was incorrect because the resident was not a feeder. even though the DON confirmed that resident at times due to behavior, resident required staff physical assistance when eating. At that same time, S #1 notified the LNHA and the DON of the above findings and concerns that according to the CNA accountability log in the task tab of the electronic medical record, the resident had episodes of set up, maximum assistance with staff, and dependent with feeding at times. S #1 also notified the LNHA and DON of the Dietician's notes on 1/12/26 that the resident was dependent on staff with feeding, and the care plan intervention included but was not limited to 1:1 staff assistance with feeding. On 2/10/26 at 8:56 AM, S #1 interviewed the Registered Dietician (RD) who informed S #1 that Resident #2 was alert with confusion. The RD stated that the resident's appetite was good and there were days you have to feed him and needed a lot of cuing. The RD further stated that the day I did the note on 1/12/26, was the day I spoke to the nurse and CNA but unable to remember who the CNA was, and confirmed that the resident needed assistance with feeding. She further stated that was why she documented that the resident was dependent with staff with feeding. The RD also stated that it was the LPN who she spoke to on how the resident was with eating. On that same date and time, the RD stated that the expectation was for the CNA to bring the resident's tray in the room, come back, see if the resident was eating, and then provide feeding assistance because there were days that the resident required staff assistance. On 2/10/26 at 10:07 AM, S #1 interviewed CNA #8 via phone conference. CNA #8 confirmed that yesterday (2/9/26) she was assigned to Resident #2, had total of 11 residents in their assignment, and had two feeders that included Resident #2. CNA #8 stated that she took about 20 minutes to feed Resident #5 in her assignment. She further stated that when she set up Resident #2's lunch in their (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room she thought that the resident was eating and left the room. CNA #8 also stated that Resident #2 was able to feed self at times and there were times when the resident was a feeder and needed assistance that was why you have to keep checking the resident. She further stated that the nurse had checked the resident. At that same time, CNA #8 was unsure how much the resident ate on 2/9/26 at lunch because she did not feed the resident and did not pick up the tray. She was unaware of the NJ mandated law for staffing and did not know about the staffing ratio. On 2/10/26 at 12:13 PM, S #1 asked the Registered Nurse (RN) to accompany S #1 to Resident #2's room. Outside the resident's room, the visitor of Resident #2's roommate informed the RN that they were trying to help Resident #2 with feeding because Resident #2 was not eating and needed assistance. There was no staff assisting resident during lunch. At that same time, the RN stated that at times the resident needed assistance with feeding. The RN also stated that the resident's was able to consume 75% of the brownies and 50% of coffee and did not touch the main entree which was ground pan fried pork chop, yellow rice, and spinach. The RN left the resident. On 2/11/26 at 12:18 PM, S #1 interviewed CNA #5 who confirmed that he worked on 1/16/26, 1/17/26, 1/18/26, 7-3 shift and took care of Resident #2. CNA #5 stated that the resident at times were able to feed self and there were times needed physical assistance when feeding due to cognitive impairment. He further stated that even though he had a lot of residents in their assignment, he was able to take care of all resident, though my only break was to go the bathroom. CNA #5 was unable to state if he was aware of the NJ Mandated law for staffing and unable to state how many total residents he had from those identified days. On 2/10/26 at 1:01 PM, the survey team met with the LNHA, DON, and COO (Chief Operating Officer), and the surveyor notified them of the above findings and concerns. On 2/11/26 at 12:35 PM, the survey team met with the LNHA and DON for responses. The DON stated that the resident was able to feed self. The DON further stated that staff was providing staff assistance with feeding due to resident's behavior and at times required staff to feed resident. A review of the facility's Policy and Procedure: Staffing that was provided by the LNHA, with a reviewed date of 12/25, revealed under policy statement, facility provides adequate staffing to meet needed care and services for resident population. Policy Interpretation and Implementation, 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met .2. CNAs are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive CP . A review of the facility's ADL Care Policy with a reviewed date of 1/2026, revealed, residents shall receive assistance with activities of daily living (ADLs) every shift, as appropriate. ADL's include bathing, grooming, eating. On 2/11/26 at 1:30 PM, the survey team met with the LNHA, DON, Regional Nurse, and QA (Quality Assurance) Nurse for an exit conference, and there was no additional information provided by the LNHA. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 2/6/26 at 12 noon, Surveyor #2 (S #2) observed Resident #8 seated in a w/c in their room and had a lunch tray in front of them on an overbed table. The resident was observed picking at their food, eating small amounts. S #2 asked the resident how their lunch was, and the resident stated, not very good. S #2 asked the resident if they knew that they could ask for something else, and the resident did not respond. S #2 did not observe any staff assisting the resident in eating. At that time, S #2 left the resident and notified Licensed Practical Nurse #2 (LPN #2) assigned to Resident #8 that the resident had stated they did not care for the food. LPN #2 stated that she would check on the resident, and that they were frequently confused and would say that sometimes. LPN #2 also stated that the resident gets a bolus feeding (a way to give a certain amount of nutritional food through a tube at one time that mimics normal meals). S #2 observed Resident #8 in their room at approximately 12:10 PM, seated as before but the lunch tray was removed. S #2 reviewed the electronic medical record for Resident #8 which revealed the following: A review of the AR reflected that the resident was admitted with diagnoses including but not limited to; failure to thrive (a syndrome marked by a progressive, often rapid, decline in physical and cognitive function), protein calorie malnutrition, and essential hypertension (high blood pressure). A review of Resident #8's comprehensive MDS with an ARD of 11/30/25. Under Section C, BIMS score of 3 out of 15, which indicated the resident has severe cognitive impairment. Section GG, Functional Abilities, A. Eating: Dependent- Helper does all the effort. Section K, Nutritional Status, that the resident has a feeding tube and gets 51% or more of total calories from the tube feeding. A review of the resident's CP revealed a focus that the resident has nutritional problems and interventions to encourage PO (oral) intake. The CP also reflected a focus and interventions that the resident has a behavior of refusing to eat which was initiated and revised on 2/8/26, after surveyor inquiry. On 2/9/26 at 12:15 PM, S #2 observed Resident #8 seated in a w/c in their room and had a lunch tray in front of them on an overbed table. S #2 did not observe any staff assisting the resident in eating. S #2 asked the resident if they needed any help with lunch and Resident #8 stated, no. On 2/10/26 at 8:41 AM, S #2 interviewed the DON and asked the DON if they were familiar with Resident #8 and how the resident eats. S #2 notified the DON that the resident was observed eating by themselves. The DON stated that resident does eat by themselves, but may need assistance, redirection or other aid as they get distracted due to confusion and dementia. The DON stated that the resident was variable day to day with confusion, some days very clear, other days more confused. On 2/10/26 at 9:04 AM, S #2 interviewed the RD about Resident #8. The RD stated that the resident did much better when they were assisted with feeding or fed with total assistance. The RD stated that the resident recently had their diet upgraded to a thicker consistency as well. The RD further stated that the resident eats between 25% to 50% of the meal tray. S #2 notified the RD that the resident was observed twice with no assistance with eating. On 2/10/26 at 1:01 PM the survey team met with the LNHA, DON, and COO, and S #2 notified them of two observations of Resident #8 without any assistance with eating, and that the comprehensive (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS indicated that the resident was dependent on others for assistance. S #2 also notified the DON that the facility provided assignment sheet for the floor that Resident #8 was listed as to be assisted with eating. S #2 also notified the DON that S #2 observed LPN #2 assigned to the resident removed the meal tray with no more than approximately 30% consumed with no further encouragement. S #2 asked the DON if it was possible that resident may have eaten more with redirection. The DON stated that it was possible. The LNHA did not provide any further pertinent information. NJAC 8:39-5.1 (a); 17.4(d); 27.1 (a)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure proper documentation of 3 controlled dangerous substances (CDS) medications for 3 residents; 1 Unsampled Resident (Unsampled Resident #1), Resident #44, and Resident #89, by 1 of 3 nurses observed during the medication storage task. The deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 2/9/26 at 10:21 AM, the surveyor, in the presence of the Registered nurse (RN) assigned to the side 2 medication cart (med cart) on the 4th floor, observed the CDS storage and CDS declining inventory documents for the side 2 cart. At that time, the RN stated they still had to sign the declining inventory for three residents. The surveyor observed the RN sign and date the declining inventory sheets for the three residents. Unsampled Resident #1 CDS med, Suboxone (a med normally used to treat addiction, sometimes pain), Resident #44 CDS med, alprazolam (a med normally used to treat anxiety), and Resident #89 CDS med, lacosamide (a med used to treat seizures). The surveyor asked why they still had to sign for the meds and what is the normal process for signing out CDS meds. The RN stated that they were running late today and forgot to sign the declining inventory. The usual process was to sign for them when they give them. The surveyor asked what time the medications (meds) were administered. The RN stated that they gave them around 8:30 AM. The surveyor concluded the observation. On 2/10/26 at 1:02 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Chief Operating Officer (COO), and the surveyor notified them of the above concerns. The surveyor asked the DON what the usual procedure was for signing the declining inventory sheets for CDS. The DON stated that the declining inventory should be signed immediately upon removal of the med. On 2/11/26 at 12:37 PM, the survey team met with the LNHA and DON, and there was no additional information provided by the LNHA. A review of the facility's Storage of Medications Policy, reviewed 1/2026, the policy did not reflect anything regarding signing out of CDS meds on a declining inventory. A review of the facility's Inventory of Controlled Substances Policy, reviewed 1/2026, reflected, under Policy: Controlled drugs are inventoried and documented under proper conditions with regard to security and state/federal regulations. The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. A review of the facility's Medication Administration Policy, reviewed 1/2026, the policy did not reflect anything regarding signing out CDS meds on a declining inventory. NJAC 8:39-29.7(c)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of pertinent documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication by lack of indication, reason for use or benefit versus risk analysis for 1 of 5 (Resident #6) residents reviewed for unnecessary medications. The deficient practice was evidenced by the following: The surveyor reviewed the electronic medical record (EMR) for Resident #6 which revealed the following: A review of the admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but was not limited to type 2 diabetes (high blood sugar due to the body's inability to use insulin properly) and chronic obstructive pulmonary disease (COPD) (a common lung disease causing restricted airflow). The AR did not reflect a diagnosis of seizures or essential tremors. A review of Resident #7's quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 6/30/26, under section C, had a Brief Interview Mental Status, (BIMS) score of 6 out of 15, which indicated the resident has severe cognitive impairment. A review of the resident's medication (med) orders revealed an Order Summary Report, (OSR), a listing of the resident's active Physician (MD) orders which reflected the following order, dated 3/4/24: Primidone Oral Tablet (tab) 50 mg (milligram) Give 0.5 tab by mouth at bedtime for overactive nerves 50 mg 1/2 tab = 25 mg. (a medication used for seizure control or sometimes for essential tremors) A review of the resident's Progress Notes (PN), revealed a Physician's Progress Note (PPN) dated 1/21/26. The PN did not reflect the use of Primidone, nor did it reflect a diagnosis or indication for the use of Primidone. The resident's PN also revealed a PPN dated 12/15/26, entered by a Nurse Practitioner (NP). The PN did not reflect the use of Primidone, nor did it reflect a diagnosis or indication for the use of Primidone. The resident's PN also revealed PN entered by the facility Consultant Pharmacist (CP), dated 11/11/25, 1/13/26, 2/11/26, which reflected that the CP conducted the Medication Regimen Review (MRR) and there were no recommendations made to the facility. A CP PN dated 12/9/25, reflected that a recommendation was made, a review of that note did not reveal any mention of Primidone. A review of the resident's Psychiatrist Consult dated 1/12/26, did not reveal any mention of the use of Primidone, nor any diagnosis associated with the use of Primidone. On 2/11/26 at 11:43 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified them of the lack of documentation for the use of Primidone or effectiveness for Resident #6. On 2/11/26 at 12:08 PM, the surveyor spoke to the facility Regional Consultant Pharmacist (RCP). The RCP stated that the regular CP was unavailable. The surveyor asked the RCP if there was an expectation for the CP to look for appropriate diagnoses, indications or other documentation or rationale for the medications (meds) that the resident was taking. The RCP stated yes, that was an expectation. The surveyor asked if the RCP was familiar with Primidone, and would that med be included in a MRR. The RCP stated yes it would be, but the CP tends to focus on meds that are more psychiatric oriented. The surveyor asked the RCP if the CP documented 12/9/25, could they have included a recommendation for Primidone then. The RCP stated yes, but since the CP company was relatively new to the facility, they did not want to [NAME] the facility with excess recommendations. The RCP did admit to the surveyor that this should have been looked at by CP and were valid concerns. On 2/11/26 at 12:37 PM, the survey team met with the LNHA and DON stated that they would try to obtain a diagnosis from the resident's neurologist consult. There was nothing else provided at this time. The surveyor reviewed the neurologist consult, dated 5/9/23. The consult did not reveal any contributory information, diagnosis or indication for the use of Primidone. A review of the facility's Consultant Pharmacy Reports dated reviewed 1/2026, reflected under Policy: Any irregularities will be reported and documented to the attending physician and DON. Under Procedure: 4. Any medication irregularities identified will be documented. NJAC 8:39-27.1(a)		

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NAME OF PROVIDER OR SUPPLIER Alaris Health at Kearny		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Bergen Ave Kearny, NJ 07032	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure the menu (or diet slip) was followed and b.) ensure that residents received food and beverage in accordance with their preferences. This deficient practice was identified for 1 of 15 residents (Resident #92) observed in the dining room and 1 of 3 residents (Resident #3) observed in the 3rd floor unit during meals, and was evidenced by the following: 1. On 2/6/26 11:40 AM, during lunch observation in the 4th floor dining room, the surveyor observed the Licensed Practical Nurse (LPN) was feeding Resident #92 and there was no 4 fluid ounces of whole milk served to the resident which was according to the dietary slip that was on top of the resident's table. On 2/6/26 at 12:00 PM, the surveyor asked the Infection Preventionist Nurse (IPN) who were at the dining area regarding the concern that Resident #92 did not receive their milk according to the diet slip, and the IPN did not respond. The LPN confirmed that the resident did not receive the milk. On that same date and time, the Dietician stated that Resident #92 probably did not want milk for lunch and that there was no way in the diet slip they can remove milk. The surveyor asked the Dietician if that was in the resident's care plan (CP) that Resident #92 would not want milk at lunch time, and the Dietician responded that she was unsure. The surveyor asked the Dietician for resident's copy of the CP. The surveyor also observed that the resident did not receive the two oatmeal raisin cookies and ice cream according to the diet slip. On 2/6/26 at 12:23 PM, the surveyor observed Resident #92 did not receive ice cream and cookies. The LPN in the presence of the IPN confirmed the resident was not given ice cream and cookies. The surveyor reviewed the medical records of Resident #92 and revealed: A review of the admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses (dx) that included but were not limited to; epileptic seizures related to (r/t) external causes, not intractable, with status epilepticus, unspecified cataract (a common age-related eye condition involving the clouding of the eye's normally clear lens, which blocks light from reaching the retina and causes blurry, dim, or faded vision), and dementia in other diseases classified elsewhere, unspecified severity, with agitation. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 11/7/25, revealed a Brief Interview Mental Status (BIMS) score of 00 out of 15, which indicated the resident's cognition was severely impaired. A review of the active personalized CP revealed a focus that Resident #92 with potential for nutritional problem r/t dx of psychosis, depression, dementia, variable appetite, and history of non-significant weight loss that was initiated on 10/23/18 and revised on 2/3/26. The CP interventions included but were not limited to; encourage PO (per os feeding; or by mouth) and fluid intake that were initiated on 10/23/18 and revised on 4/17/20; honor food preferences, likes vanilla ice cream and sandwiches that was initiated on 10/23/18 and revised on 5/30/24; and provide and serve supplements as ordered: oral nutrition supplement as ordered and monitored supplement intake that was initiated on 5/11/23 and revised on 2/3/26. 2. On 2/9/26 at 12:13 PM, the surveyor observed the Certified Nursing Aid (CNA) was feeding Resident #3 inside their room. Resident #3 did not receive the sherbet according to the diet slip that was in resident's tray. The CNA acknowledged and stated that the resident did not receive the sherbet. Outside Resident #3's room, the surveyor notified the Registered Nurse (RN) that Resident #3 did not receive the sherbet. The RN stated that she would call the kitchen to send it because the resident likes it. The surveyor reviewed the medical records of Resident #3 and revealed: A review of the AR reflected that the resident was admitted to the facility with dx that included but were not limited to end stage renal disease and unspecified protein-calorie malnutrition. A review of the most recent quarterly MDS with an ARD of 12/12/25, revealed a BIMS score of 5 out of 15, which indicated the resident's cognition was severely impaired. A review of the active personalized CP revealed a focus that Resident #3 with potential for nutritional problem r/t dx (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of dysphagia, mechanically altered diet, and MNA score (Mini Nutritional Assessment (MNA) score is a validated, 10-minute screening tool used to identify malnutrition or risk of malnutrition in older. Less than 17 points: Malnourished) that was initiated on 4/2/25 and revised on 1/31/26. The CP interventions included but were not limited to; encourage PO (or per os feeding; or by mouth) and fluid intake that were initiated on 6/27/22, and honor food preferences that was initiated on 6/24/22. On 2/10/26 at 1:01 PM, the survey team met with the LNHA, DON, and COO (Chief Operating Officer), and the surveyor notified them of the above findings and concerns. On 2/11/26 at 12:35 PM, the survey team met with the LNHA and DON for responses. There was no additional information provided by the LNHA and DON with regard to the above concerns. A review of the facility's Meal Identification and Preference Cards/Tickets Policy that was provided by the LNHA, with an approved date of 1/2026, revealed under policy, a meal identification and food preferences card (meal ID card/ticket) (or diet slip) will be used to properly identify each individual's needs including food and beverage preferences.Procedure:1.The Director of food and nutrition services or designee will visit a newly admitted individual to obtain food and beverages preferences, dislikes and food allergies/intolerances before a permanent meal ID card/ticket is written.3. The permanent meal ID card/ticket should include the name of the individual, diet order, beverage preferences, food dislikes and any other applicable diet information.4. Meal ID cards/tickets will be used during meal service to assure the correct diet is being served and food preferences are honored. NJAC 8:39-17.2(b); 17.4(a)3;(e)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene practices for 4 of 7 residents, (Residents #39, #52, #70, and #104) during meal observation and b.) follow appropriate hand hygiene and use of personal protective equipment (PPE) for 1 of 4 nurses (1 Registered Nurse), observed during medication administration pass (med pass), and follow appropriate infection control practices to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and the facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24, revealed. Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient .Before moving from work on a soiled body site to a clean body site on the same patient .After touching a patient or the patient's immediate environment, After contact with blood, body fluids, or contaminated surfaces, Immediately after glove removal. According to the Infection Control Today, July/August 2024 (Vol 28 No.4), Dining Recommendations for Long-Term Care Facilities, revealed.it is crucial to acknowledge that residents in LTC (Long Term Care) are at an increased risk of infection due to factors such as their advanced age, underlying health conditions, and compromised immune systems. Hand hygiene: Ensure that both residents and staff wash their hands thoroughly with soap and water or use hand sanitizer before meals. Hand hygiene stations should be easily accessible in the dining area. Many LTC facilities use hand sanitizing wipes because patients in wheelchairs often cannot access the sink to adequately scrub off germs. Also, hand hygiene reminders should be displayed in these areas. Encourage residents and staff to wash their hands thoroughly with soap and water or use hand sanitizer after the meal. 1.On 2/6/26 at 11:40 AM, Surveyor #1 (S #1) observed Resident #70 entered and exited the elevator from 3rd floor to 4th floor, and able to self-propel their wheelchair (w/c). S #1 observed Resident #70 self-propelled their w/c from 4th floor elevator to 4th floor dining room at the end of the hallway and joined the other resident on one table for lunch. There were total of 11 residents including Resident #70 inside the dining room with the Licensed Practical Nurse (LPN), Regional Food Service Director (RFSD), and three Dietary Staff (DS). The three DS were distributing water, coffee, milk, and juices. Resident #70 was not offered hand hygiene prior to the meal. There was no disinfecting wipes or hand wipes at that time. Afterward, S #1 observed the Dietician propelled Resident #104's w/c to the dining room, while passing, Resident #104 pulled S #1's blazer. Resident #104 was not offered and/or assisted with hand hygiene prior to meal was served. On 2/6/26 at 12:00 PM, S #1 notified the Infection Preventionist Nurse (IPN) about the above concerns that the residents were not offered hand hygiene prior to meal. The IPN stated that there should be a handwipes container which they use for hand hygiene of the residents before and after eating. The IPN then went to check if there was a container of handwipes in the dining room and she confirmed that there was no container of handwipes. On 2/6/26 at 12:18 PM, S #1 observed Resident #70, Resident #39, and Resident #52 left the dining area, and the staff did not offer hand hygiene after meal. S #1 then notified the IPN of the concern that (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents were not offered hand hygiene after meal. On 2/6/26 at 12:20 PM, during an interview with Resident #52, the resident stated that they were not offered hand hygiene prior to meal. Resident #52 also confirmed that they were not offered hand hygiene after meal today. On 2/10/26 at 1:01 PM, the survey team met with the LNHA, DON, and COO (Chief Operating Officer), and S #1 notified them of the above findings and concerns. On 2/11/26 at 12:35 PM, the survey team met with the LNHA and DON for responses. The LNHA stated, I did not find hand hygiene guidelines that it would be offered, or residents should be assisted after the meal for hand hygiene. He further stated, only prior to meal that hand hygiene be done for residents. Both the DON and LNHA stated that they admitted hand hygiene should be provided prior to meal. A review of the facility's Dining Policy that was provided by the LNHA with the last reviewed date of 1/2026, revealed that there was no information about hand hygiene. 2. On 2/6/26 at 8:44 AM, Surveyor #2 (S #2) observed the Registered Nurse (RN) assigned to the 4th floor side 2 medication cart (med cart) prepared and administered medications (meds) for Resident #29. S #2 observed the RN applied gloves prior to entering Resident #29's room. S #2 did not observe the RN perform any hand hygiene practices, including but not limited to hand washing or ABHR. S #2 observed the RN administered the resident's due meds which included Refresh Tears Ophthalmic Solution 0.5 % (a lubricating eye drop). S #2 observed the RN returned to the med cart after med administration and removed the gloves. S #2 did not observe the RN performed any hand hygiene after removing the gloves. S #2 asked the RN if there was anything in policy and procedures about what to do when using gloves, and the RN stated that gloves should not be worn in the hallways. S #2 concluded the observation. On 2/10/26 at 9:33 AM, S #2 interviewed the DON about infection control practices and use of PPE such as gloves. The DON stated that handwashing should be performed both before and after use of gloves. S #2 asked if use of ABHR would be appropriate, and the DON stated yes if the hands were not soiled after removing gloves. On 2/10/26 at 1:01 PM, the survey team met with the LNHA, DON, and COO, and S #2 notified them of the above concerns. to inform of concerns. The DON acknowledged the prior interview with S #2 regarding gloves and hand hygiene. A review of the facility's Handwashing/Hand Hygiene Policy that was provided by the LNHA, with a revised date of 6/28/24, revealed, the policy: to provide guidelines for effective handwashing/hand hygiene, in order to prevent the transmission of bacteria, germs and infections. Guidelines: Handwashing/Hand hygiene will be performed as follows.before and after contact with patients (also known as residents) and between patient contacts.after contact with a source that is likely to be contaminated with microorganisms.before gloving and after gloves are removed.before and after eating.before and after serving residents meal trays. A review of the facility's Personal Protective Equipment, reviewed 1/2026, which reflected under When removing PPE: 3. Perform hand hygiene immediately after removing gloves. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/26 at 1:30 PM, the survey team met with the LNHA, DON, Regional Nurse, and QA (Quality Assurance) Nurse for an exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-19.4(a)(1)(n)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a clean, safe, and sanitary environment for a.) 1 of 2 tub (shower) rooms (3rd floor), b.) 2 of 5 residents' rooms privacy curtains (rooms [ROOM NUMBERS]), and c.) 1 of 1 nourishment area observed during environmental tour. This deficient practice was evidenced by the following: 1. On 2/5/26 at 10:50 AM, the surveyor with the Registered Nurse/Unit Manager (RN/UM) toured the 3rd floor Tub Room, also known as the shower room of the residents in the unit as per the RN/UM. Both the surveyor and the RN/UM observed in the middle of the tub room the ceiling vent with accumulation of grayish substances which the RN/UM confirmed accumulation of dust, and the RN/UM stated that the Housekeeper would be notified to clean it. The 1st and 2nd shower cubicles with ceiling vents also observed with accumulation of dust which the RN/UM confirmed. The 3rd shower cubicle had no privacy curtain and with no posted sign if the room was being used or not, there was a shower chair inside the 3rd cubicle. The RN/UM stated that the 3rd shower cubicle was not being used, acknowledged that there was no privacy curtain, and there were accumulation of dust on the ceiling vent. On that same date and time, inside the tub room was the toilet room, and both the surveyor and the RN/UM observed the ceiling vent with accumulation of dust. The RN/UM stated it should not be like that, and she would notify housekeeping to clean the room. 2. On 2/5/26 at 10:55 AM, the surveyor with the RN/UM observed room [ROOM NUMBER] (R343) privacy curtain rod not properly hooked. On 2/5/26 at 10:57 AM, the surveyor with the RN/UM observed room [ROOM NUMBER] (R342) privacy curtains rods not properly hooked. 3. On 2/5/26 at 11:00 AM, the surveyor went to the 4th floor and upon exiting the elevator, observed the nourishment area with wooden cover under the sink was uneven. Next to the sink was the ice machine and below was a cabinet with chipped wood and a piece of wood was sticking out. Afterward, the Regional Maintenance (RM) came, and the surveyor showed and notified the RM of the above findings and concerns with the 4th floor nourishment area. The RM acknowledged the surveyor's concerns that could be a safety issue for the residents, staff, and visitors of the facility due to area being open and part of the common area of the residents. The RM stated that it was his 1st day at the facility and there was a maintenance person in charge of the facility. The RM further stated that he would notify the Maintenance Director about it. On 2/10/26 at 1:01 PM, the survey team met with the LNHA, DON, and COO (Chief Operating Officer), and the surveyor notified them of the above findings and concerns. On 2/11/26 at 12:35 PM, the survey team met with the LNHA and DON for responses. The LNHA stated that the 3rd floor tub room cubicle without privacy cubicle was not being used by the residents. The LNHA stated that the dusty vents that were mentioned were immediately cleaned. A review of the facility's Facility Environment Policy that was provided by the LNHA with a revised/reviewed date of January 2026, revealed, it is the policy of the facility to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Procedures. A. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. 2. Housekeeping and maintenance shall maintain sanitary, orderly and comfortable environment. On 2/11/26 at 1:30 PM, the survey team met with the LNHA, DON, Regional Nurse, and QA (Quality Assurance) Nurse for an exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-31.4 (a)(f)		