STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315300	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at Hamilton Park	525 Monmouth Street Jersey City, NJ 07302

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to ensure a potential allegation of physical abuse by staff was reported timely to the State Survey Agency (SSA) when a resident sustained an injury during incontinence care for one of three residents reviewed for abuse (Resident (R) 5) out of 27 sampled residents. This failure increased the risk of other vulnerable residents being physically abused. Findings include: Review of R5's undated admission Record located in the electronic medical record (EMR) under the Profile tab, revealed R5 was admitted on [DATE]. Review of R5's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/26/24, located in the EMR under the MDS tab, revealed R5's Brief Interview for Mental Status (BIMS) score was six out of 15 which indicated he/she was severely cognitively impaired. Review of R5's IDT [Interdisciplinary Team] Note, dated 04/26/24, located in the EMR under the Prog Note tab, revealed . 5:45 AM [CNA (certified nurse aide) 2] called this nurse attention and as per [CNA2] that while she was changing him/her, the resident was kicking his/her legs too high towards [CNA#2] and suddenly she heard like a snap in the resident's knee area at left side of his/her leg; resident was not agitated nor provoked but sometimes has the tendency to kick his/her legs every time he/she is being changed; resident was unable to explain what really happened; assessment done; BP [Blood Pressure] 123/78, P [Pulse] 80, R [Respirations] 18, T [Temperature] 98.2 O2 [oxygen] SAT [saturation] 97% room air; resident c/o [complained of] moderate pain in his/her left leg, no sign of swelling observed; two Tylenol tab [tablets] 325mg [milligrams] given for pain, made comfortable to bed; instructed for safety measures, call light within reach for assistance, made comfortable to bed, nursing supervisor made aware, MD [medical doctor] called but unable to reach him, stat [immediate] X-RAY ordered, endorsed it accordingly to the next shift. Review of R5's Discharge Summary, dated 04/26/24, located in the EMR under the Assessment tab revealed admitted to the hospital for left femur fracture. Review of R5's IDT Note, dated 05/02/24, located in the EMR under the Prog Note tab, revealed [R5] was readmitted to the facility on [DATE] from [the hospital] with dx [diagnosis] of Left Femur Shaft Fracture. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R5's Hospital Record, dated 04/26/24, provided by the facility, revealed R5 was found to have a femur fracture and sent to the emergency department (ED), x-rays of the left femur showed a spiral distal 1/3 femoral shaft fracture, and R5 was admitted to the hospital. Traction was applied in the ED, and planning for pen reduction and internal fixation (ORIF) (surgical procedure used to treat broken bones that cannot be stabilized with a cast or splint) on 04/27/24. Review of the facility's Reportable Event Record/Report, dated 05/01/24, provided by the facility, revealed the event occurred on 04/26/24 at 6:51 AM, the significant event was called in to the SSA on 04/28/24 at 7:55 PM, the follow-up report was dated 05/01/24 and the type of incident was marked as Injury. The description of the event in the report revealed on 04/26/24 around 6:51 AM, [R5] was receiving AM care from CNA. When [CNA2] went to go change the patient, the patient tried to kick her from the side and missed. The CNA heard a cracking noise when he/she missed her with the kick. The nurse was alerted and an assessment was done. There was moderate pain to his/her L [left] leg and no signs of swelling were observed. MD was made aware and patient was sent out to [the hospital]. We received the results of the Xray back and the patient was positive for a L closed displaced spiral fracture of the femur. Patients' diagnosis includes, Osteoporosis, Afib [atrial fibrillation], HTN [hypertension], unspecified convulsions and abnormality of gait. Patient has a BIMS of 6 [six]. The interventions that were implemented after the incident listed in the report included 1. Body assessment was done, [R5] complained of L leg pain. 2. Patient was treated for his/her pain. 3. Physician and family were called. 4. Ombudsman notified. 5. Emotional support given. 6. Patient transferred to [the hospital] on 04/26/24, received results of fx [fracture] 04/28/24. 7. In-services done for: Sensitivity, safe transfer technique, and for patients who are exhibiting behaviors. 8. Care plan will be updated upon return. Review of R5's Incident Report, dated 04/26/24, provided by the facility, revealed Licensed Practical Nurse (LPN) 4 was notified by CNA2 that while changing R5 he/she tried to kick her and suddenly heard a sound like a snap or click on the resident's left leg and complained of pain in his/her left leg. LPN4 asked R5 what happened, but he/she was unable to explain what happened. During an interview on 02/20/24 at 3:15 PM, CNA2 stated that R5 grabbed her by her scrubs, lifted his/her left leg and turned his/her body to the left, kicked his/her left leg in the air, and then CNA2 heard a click noise in the R5's left knee area. CNA2 also stated she notified LPN 4 of the injury immediately and then LPN 4 assessed R5 in the room. During an interview on 12/21/25 at 11:21 AM, the former Administrator indicated he did not identify the injury sustained to R5 during care by CNA2 as potential staff to resident abuse, so he did not call it in within two hours as required and did not submit the report until 05/01/24 via email to the SSA. The Administrator stated R5 was nonverbal and there were no witnesses when CNA2 was providing care to R5 so he should have reported and investigated the incident as potential staff to resident abuse. In a dual interview on 02/21/25 at 12:02 PM with the [NAME] President (VP) of Operations and Administrator, they indicated the former Administrator did not call in the injury within the required two hours and did not submit the reportable to the State Survey Agency (SSA) as staff to resident abuse because R5 sustained a fracture to the left femur due to trying to kick CNA2 during incontinence care and staff to resident abuse was not suspected. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Abuse Prevention Program, revised 02/08/23, provided by the facility, revealed . Abuse Prevention Program - Part VIII Reporting/Response Every staff member will report any allegation of abuse to the Administrator, DON or Supervisor/Designee. When an incident is reported to the Supervisor, the Supervisor is responsible for ensuring that the resident is safe and will notify the Administrator as well as the DON, or their designees . The Administrator and DON will initiate the investigation of the potential abuse incident, determine the necessary response, and report to the office of the Ombudsman, the Department of Health and Senior Services, and to all other required agencies such as, law enforcement with-in specified timeframes including Peggy's Law. Alleged violations involving abuse, neglect, ex-ploitation or mistreatment, including injuries of unknown source and misappropriation of resi-dent property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The results of the investigation are reported within 5 working days of the incident . NJAC 8:39-9.4(f)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to protect other residents by suspending the alleged perpetrator during the investigation for one of three residents reviewed for abuse (Resident (R) 5) out of 27 sampled residents. This failure increased the risk of other vulnerable residents being physically abused. Findings include: Review of R5's undated admission Record located in the electronic medical record (EMR) under the Profile tab, revealed R5 was admitted on [DATE]. Review of R5's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/26/24, located in the EMR under the MDS tab revealed R5's Brief Interview for Mental Status (BIMS) score was six out of 15 which indicated she was severely cognitively impaired. Review of R5's IDT [Interdisciplinary Team] Note, dated 04/26/24, located in the EMR under the Prog Note tab, revealed . 5:45 AM [Certified Nurse Aide (CNA) 2] called this nurse attention and as per [CNA2] that while she was changing him/her, the resident was kicking his/her legs too high towards her and suddenly she heard like a snap in the resident's knee area at left side of his/her leg; resident was not agitated nor provoked but sometimes has the tendency to kick his/her legs every time he/she was being changed; resident was unable to explain what really happened; assessment done; BP [Blood Pressure] 123/78, P [Pulse] 80, R [Respirations] 18, T [Temperature] 98.2 O2 [oxygen] SAT [saturation] 97% room air; resident c/o [complained of] moderate pain in his/her left leg, no sign of swelling observed; two Tylenol tab [tablets] 325mg given for pain, made comfortable to bed; instructed for safety measures, call light within reach for assistance, made comfortable to bed, nursing supervisor made aware, MD [medical doctor] called but unable to reach him, stat [immediate] X-RAY ordered, endorsed it accordingly to the next shift. Review of R5's Discharge Summary, dated 04/26/24, located in the EMR under the Assessment tab revealed admitted to the hospital for left femur fracture. Review of R5's IDT Note, dated 05/02/24, located in the EMR under the Prog Note tab, revealed [R5] was readmitted to the facility on [DATE] from [the hospital] with dx [diagnosis] of Left Femur Shaft Fracture . Review of R5's Hospital Record, dated 04/26/24, provided by the facility, revealed R5 was found to have a femur fracture and sent to the emergency department (ED), x-rays of the left femur showed a spiral distal 1/3 femoral shaft fracture, and R5 was admitted to the hospital. Traction was applied in the ED, and planning for pen reduction and internal fixation (ORIF) (surgical procedure used to treat broken bones that cannot be stabilized with a cast or splint) on 04/27/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Reportable Event Record/Report, dated 05/01/24, provided by the facility, revealed the significant event was called in on 04/28/24 at 7:55 PM and the type of incident was marked as Injury. The description of the event revealed on 04/26/24 around 6:51AM, [R5] was receiving AM care from CNA. When [CNA2] went to go change the patient, the patient tried to kick her from the side and missed. The CNA heard a cracking noise when he/she missed her with the kick. The nurse was alerted and an assessment was done. There was moderate pain to his/her L [left] leg and no signs of swelling were observed. MD was made aware and patient was sent out to [the hospital]. We received the results of the Xray back and the patient was positive for a L closed displaced spiral fracture of the femur. Patients' diagnosis includes, Osteoporosis, Afib [atrial fibrillation], HTN [hypertension], unspecified convulsions and abnormality of gait. Patient has a BIMS of 6 [six]. The listed interventions that were implemented after the incident were 1. Body assessment was done, [R5] complained of L leg pain. 2. Patient was treated for his/her pain. 3. Physician and family were called. 4. Ombudsman notified. 5. Emotional support given. 6. Patient transferred to [the hospital] on 04/26/24, received results of fx [fracture] 04/28/24. 7. In-services done for: Sensitivity, safe transfer technique, and for patients who are exhibiting behaviors. 8. Care plan will be updated upon return. Review of the resident interviews, dated 04/26/24, provided by the facility, revealed the Social Services Director (SSD) interviewed three residents on 04/26/24 and they reported no issues with care or abuse by CNA2. Review of CNA2's Personnel File provided by the facility revealed there were no disciplinary warning notices or evidence CNA2 was suspended during the investigation. Review of CNA2's Time Card Report provided by the facility revealed she worked on 04/26/24, 04/29/24, 04/30/24, and on 05/01/24, during the dates of the investigation. During an interview on 02/20/24 at 3:15 PM, CNA2 stated R5 grabbed her by her scrubs, lifted her left leg and turned his/her body to the left, kicked his/her left leg in the air, and then CNA2 heard a click noise in the R5's left knee area. CNA2 stated she was interviewed and provided a handwritten statement. CNA2 indicated she was not suspended during the investigation, she worked on the same floor after R5 returned from the hospital to the facility, however, she was not assigned to R5 again. During an interview on 02/21/25 at 11:21 AM, the former Administrator indicated he was the abuse coordinator when he worked at the facility and that he did not identify the injury sustained to R5 during care by CNA2 as potential staff to resident abuse, so he investigated it as an injury. The Administrator stated he did not suspend CNA2 during the investigation because he did not suspect staff to resident abuse based on interviews with staff of R5's behaviors of hitting and kicking while providing care, discussions with the Director of Nursing (DON) and review of the R5's EMR. Review of the facility's policy titled Abuse Prevention Program, revised 02/08/23, provided by the facility, revealed . Abuse Prevention Program - Part VI - Protection Procedure: When a potential abuse incident is reported, the immediate priority is the safety of the resident(s), who is to be removed from potential danger. The alleged victim will be immediately examined for any sign of injury, including a physical examination or psychosocial assessment if needed and provided with medical treatment as necessary. Staff members being investigated for possible involvement in abuse will be immediately suspended pending the results of the investigation . NJAC 8-39-27.1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure one (Resident (R) 13) out of three residents reviewed for pressure ulcers had timely assessments and monitoring of the pressure ulcers out of a total sample of 27 residents. This had the potential for the pressure ulcer to worsen and delay treatment. Findings include: Review of R13's admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] and discharged [DATE]. Review of R13's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an assessment reference date (ARD) of 08/22/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating the resident was cognitively intact. The MDS further revealed the resident had two stage three pressure ulcers (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) noted on admission. Review of R13's Admit/Readmit Screener - V3 dated 08/18/23 and located in the EMR under the Assessment tab revealed the resident was admitted from the hospital with a diagnosis of a hip fracture that required surgical repair. The Assessment revealed the resident had a surgical incision to his/her left hip (no measurement due to dressing was not to be removed until resident was seen by the surgeon), a stage three pressure ulcer to the right buttock measuring 1.0 centimeters (cm) by 1.5 cm with 0.2 cm in depth, and a stage three pressure ulcer to sacrum measuring 1 cm by 1 cm with 0.2 cm in depth. There was no description in the assessment of the two stage three pressure ulcers. Review of R13's Care Plan located in the EMR under the Care Plan tab with an initiated date of 08/19/23 revealed the resident had a break in skin integrity due to two stage three pressure ulcers, one on the sacrum and one to the right buttock. The goal revealed the pressure ulcers would remain free of infection. Interventions included to assess and to monitor the wounds for signs and symptoms of infection; assess, record, and monitor wound healing; weekly wound report; and notify physician for any changes. Review of R13's Wound Report dated 08/24/23 and located in the EMR under the Assessment tab revealed the resident had a sacrum stage three pressure ulcer to the sacrum measuring 1.0 cm by 1.0 cm with 0.2 cm in depth, and a stage three pressure ulcer to the right buttock measuring 1.0 cm by 1.5 cm with 0.2 cm in depth. The Wound Report indicated there were no signs or symptoms of infection and both pressure ulcers were present upon admission. Both pressure ulcers were noted to be treated with Silvadene (cream to prevent and treat wound infections). Review of R13's Physician Progress Note dated 08/29/23 and located in the EMR under the Progress Notes tab revealed the resident was seen in his/her room on wound rounds. The note revealed R13 had a left buttock pressure ulcer measuring 1 cm by 1 cm that had a light yellowish slough base and a right buttock wound measuring 0.5 cm by 2.0 cm with a similar base. Will treat with collagenase (topical ointment used to clean skin ulcers) twice a day. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R13's Physician Progress Note dated 08/30/23 at 1:55 PM and located in the EMR under the Progress Notes tab revealed the resident was seen at the bedside. R13 reported low back pain around the sacral decubitus. The note revealed to continue wound care and pain management. There was no description of the wound or measurements noted. Review of R13's Skilled Need Note - V1 dated 08/30/23 at 10:42 PM located in the EMR under the Misc tab revealed the resident was started on Keflex (antibiotic) 500 milligrams (mg) for a wound infection. There was no documentation to indicate which wound was infected or any other assessment of the wound noted. Review of R13's EMR revealed no further complete wound assessments since 08/24/23 had been completed. Review of R13's Medication Administration Record (MAR) for August 2023 located in the EMR under the Orders tab revealed the resident received the oral antibiotic Keflex as ordered on 08/30/23 and 08/31/23. Review of R13's Treatment Administration Record (TAR) for August 2023 located in the EMR under the Orders tab revealed the orders for treatment to the resident's pressure ulcers were completed as ordered, however, there was no description of either pressure ulcer. During an interview on 02/21/25 at 9:20 AM, Licensed Practical Nurse/Unit Manager (LPN3/UM) confirmed R13 was admitted to the facility with two stage three pressure ulcers, one to the sacrum and one to the right buttock. LPN3/UM confirmed there were no further complete wound assessments of the pressure ulcers since 08/24/23 and there should have been one completed at least on 08/31/23 and/or when the treatments were completed. She further confirmed the resident was started on an antibiotic on 08/30/23 for a wound infection, however there was no documentation to show what the pressure ulcers showed to indicate they were infected. She revealed she would interview the nurses who took care of the resident and report any further information on R13's pressure ulcers. There was no further information received regarding R13's pressure ulcers and the lack of complete assessments of her two stage three pressure ulcers by the exit of the survey. Review of the facility policy titled, Pressure Ulcer (Injury) Prevention Program Policy, last revised in 2025 revealed, This facility shall have a system in place that assures assessments are timely and appropriate; interventions are implemented, monitored, and revised as appropriate; and changes in condition are recognized, evaluated, reported to the residents attending practitioner and other healthcare professionals as appropriate . Procedure: Nursing Staff shall include . Daily monitoring of Pressure Ulcer (Injury) shall include . observe for signs of increasing area of ulceration or soft tissue infection, i.e., increased redness or swelling around the wound or increased drainage from the wound . with each dressing change, or at least weekly, the pressure ulcer (injury) wound shall be assessed and documented . staff shall remain alert to potential changes in residents' skin condition and shall evaluate and document identified changes on a daily basis . Documentation: document treatment, dressing changes, location, and size of pressure ulcer (injury), depth (if applicable), exudate, staging or unstageable or deep tissue injury, presence of tunneling or undermining, condition of skin . note any change in the condition or size of the ulcer (injury). NJAC 8:39-25.2(b); 27.1(e)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure indwelling urinary catheter care was completed and urinary output was monitored as ordered for one of three residents (Resident (R) 8) reviewed for catheter care out of a total sample of 27 residents. This had the potential for the resident to be susceptible for a urinary tract infection (UTI) and possible fluid status issues. Findings include: Review of R8's admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was readmitted from the hospital on [DATE] and discharged on 03/31/24. Diagnoses included local infection of the skin and pressure ulcers of the right and left hip, and sacral region. Review of R8's Care Plan revised on 03/17/24 located in the EMR under the Care Plan tab revealed the resident had an indwelling urinary catheter for wound healing. Interventions include to change the catheter every 15th day of each month and as needed; position catheter bag and tubing below the level of the bladder; change catheter drainage bag every week and as needed; check tubing for kinks each shift; and monitor/record/report to the physician for signs and symptoms of UTI, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color. Review of R8's significant change Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 03/24/24 revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating severe cognitive impairment. The MDS revealed the resident had an indwelling catheter. Review of R8's Treatment Administration Record (TAR) for the month of March 2024, located in the EMR under the Orders tab, revealed orders for catheter care and monitoring of urinary output was not ordered until 03/27/24. During an interview on 02/21/25 at 10:35 AM, Licensed Practical Nurse/Unit Manager (LPN3/UM) confirmed R8 was readmitted to the facility on [DATE] with an indwelling catheter for wound healing. She confirmed there were no orders or documentation of catheter care and urinary output ordered until 03/27/24. She confirmed the Care Plan included interventions for the catheter care. LPN3/UM said the order for the TAR must have been missed when the resident was readmitted from the hospital on [DATE]. Review of the CDC guidelines at https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations for the management of indwelling catheters revealed to empty the collection bag regularly, clean the catheter and surrounding area daily, and to monitor urine output and drainage system regularly. A request for catheter care policy was not received by the exit of the survey. NJAC 8:39-27.1(f)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the Centers for Disease Control and Prevention (CDC) guidance criteria for wound infections, and facility policy review, the facility failed to ensure one of one resident (Resident (R) 13) reviewed for antibiotic stewardship out of a total sample of 27 residents had documentation to support the resident met the criteria before being prescribed an antibiotic for a wound infection. This had the potential to cause the resident to be prescribed an antibiotic that was potentially unnecessary. Findings include: Review of R13's admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] and discharged [DATE]. The resident was admitted from the hospital after a fall at home which required surgery of his/her left hip. Review of R13's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 08/22/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating the resident was cognitively intact. The MDS further revealed the resident had two stage three pressure ulcers (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) noted on admission. Review of R13's Care Plan located in the EMR under the Care Plan tab with an initiated date of 08/19/23 revealed the resident had a break in skin integrity due to two stage three pressure ulcers, one on the sacrum and one to the right buttock. The goal revealed the pressure ulcers would remain free of infection. Interventions included to assess and monitor the wounds for signs and symptoms of infection. Assess, record, and monitor wound healing. Weekly wound report and notify physician for any changes. Review of R13's Wound Report dated 08/24/23 located in the EMR under the Assessment tab revealed the resident had a stage three pressure ulcer to the sacrum and a stage three pressure ulcer to the right buttock. The Wound Report indicated there was no signs or symptoms of infection. Review of R13's Physician Progress Note dated 08/29/23 located in the EMR under the Progress Notes tab revealed the resident was seen in his/her room on wound rounds. The note revealed the resident had a left and right buttock pressure ulcers. The ulcers were noted with a light yellowish slough base. There was no further documentation to indicate either pressure ulcer was infected. Review of R13's Physician Progress Note dated 08/30/23 at 1:55 PM located in the EMR under the Progress Notes tab revealed the resident was seen at the bedside. The resident reported low back pain around the sacral decubitus. The note revealed to continue wound care and pain management. There was no description of the wound or measurements noted. Review of R13's Skilled Need Note - V1 dated 08/30/23 at 10:42 PM located in the EMR under the Misc tab revealed the resident was started on Keflex (antibiotic) 500 milligrams (mg) for a wound infection. There was no documentation or assessment of the wound to indicate the wounds were infected. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315300	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at Hamilton Park	525 Monmouth Street Jersey City, NJ 07302

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Infection and Antibiotic Start Log dated August 2023 and provided by the facility revealed R13 was started on Keflex 500 mg, once a day for a right buttock and sacral wound infection. There was no other documentation noted on the log to indicate what signs and symptoms were noted to show the wounds were infected. Review of R13's Medication Administration Record (MAR) for August 2023 located in the EMR under the Orders tab revealed the resident received the oral antibiotic Keflex as ordered on 08/30/23 and 08/31/23. During an interview on 02/21/25 at 9:20 AM, Licensed Practical Nurse/Unit Manager (LPN3/UM) confirmed R13 was ordered the antibiotic Keflex for a wound infection, however there was no documentation to indicate what the signs and symptoms were to indicate the wound was infected and there should have been. During an interview on 02/21/25 at 3:15 PM, the Infection Preventionist (IP) revealed he had only been at the facility for six months and was not employed during the time R13 was a resident of the facility. The IP revealed that in order for an antibiotic to be ordered for a wound infection the wound would have to meet the revised McGeer criteria. The IP revealed the criteria would show the wound had pus from the site, redness, and warmth from the site. The IP further confirmed there should be documentation of a wound assessment which showed signs and symptoms of infection and if there was not, he would talk to the nurse and/or physician to ensure the criteria was met for the ordered antibiotic. Review of the facility policy titled, Antibiotic Stewardship, last revised January 2025 revealed, Antibiotic Stewardship is the act of using antibiotics appropriately which means only when they are medically necessary . overuse of antibiotics allows drug-resistant strains of bacteria to emerge. When this occurs, the result is increased hospitalizations, higher mortality and escalating costs. Review of the CDC's "Surveillance Definitions for Specific Types of Infections found at https://www.cdc.gov, dated January 2025, revealed, Decubitus ulcer infections must meet the following criterion: 1. Patient has at least two of the following signs or symptoms: erythema [redness], tenderness, or swelling of decubitus wound edges, AND Organism(s) identified from needle aspiration of fluid or biopsy of tissue from decubitus ulcer margin by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment. NJAC 8:39-19.4(d)