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	03/13/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 REPEAT DEFICIENCY Based on interviews and record reviews, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 1 of 33 residents (Residents #32) reviewed for accuracy of MDS coding. This deficient practice was evidenced by the following: On 3/7/25 at 9:58 AM, the surveyor observed Resident #32 in bed awake, able to answer the surveyor's inquiry. On 3/12/25 at 8:25 AM, the surveyor reviewed the electronic Medical Record (eMR)/ hybrid medical record (paper and electronic) of Resident #32, which revealed the following: A review of the Admission Record (an admission summary) (AR) reflected that Resident #32 was admitted with diagnoses that included but were not limited to schizophrenia (a type of mental illness characterized by distortions in thinking, perception, emotions, language, sense of self and behavior). A review of the recent Annual MDS (A/MDS), with an assessment reference date (ARD) (the last day of the observation period) of 1/10/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated that the resident was moderately impaired in cognition. Further review of the A/MDS and quarterly MDS (Q/MDS) dated [DATE] revealed that both assessments in Section N0450-Antipsychotic Medication Review revealed that A0. No - Antipsychotics were not received. A review of the Order Summary Report (OSR) with an active order as of 3/12/25 revealed an order of Risperdal (risperidone) 0.5 mg (milligram) by mouth at bedtime related to schizophrenia with an order date of 9/20/24. A review of the electronic Medication Administration Record (eMAR) in January 2025 revealed that the above order was signed as given by the nurses from 1/4/25 to 1/10/25 at 9:00 PM, and the October 2024 eMAR was signed as given by the nurses from 10/4/24 to 10/10/24 at 9:00 PM respectively. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 10:12 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN), who confirmed to the surveyor that the resident was taking Risperdal starting on 9/20/24. On 3/12/25 at 10:34 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN), who stated that both psychotropic medication assessments were not captured because she accidentally passed the question. She added that the assessment should be yes because the resident had been taking antipsychotic medication since September 2024. The facility followed the RAI (Resident Assessment Instrument-a tool that helps gather information about a resident's strengths and needs, which is used to create an individualized care plan) Manual. On 3/12/25 at 11:57 AM, the surveyor met with the Licensed Nursing Home Administrator, Director of Nursing, Regional Director of Education and Quality, and Regional Quality Assurance Nurse but did not provide further information. NJAC 8:39-33.2 (c)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 Based on observation, interview, and record review, it was determined that the facility failed to follow a Physician's Order (PO) in accordance with professional standards of practice for 2 of 3 residents (Resident #156 and #67) reviewed for oxygen therapy. 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 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. 1. On 3/07/25 at 11:17 AM, the surveyor observed Resident #156 in bed with family at the bedside. The surveyor observed the resident receiving oxygen (O2) via nasal cannula (NC) (a medical device used to provide supplemental oxygen therapy to people with lower oxygen levels) at 4 liters per minute (L/min). A review of the Admission Record (an admission summary) (AR) revealed that Resident #156 had been admitted to the facility with a diagnosis that included hypoxic-ischemic encephalopathy (a brain injury that occurs when the brain doesn't get enough oxygen and blood flow), muscle weakness, and altered mental status. A review of the Admission Minimum Data Set Assessment (A/MDS), an assessment tool used to facilitate the management of care, dated 2/1/25, revealed that the resident scored 0 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated severely impaired cognition. The A/MDS also revealed that the resident received continuous oxygen therapy. A review of Resident #156's PO revealed a PO dated 3/4/2025 for 2 L continuous O2 via NC for Shortness of Breath (SOB). On 3/7/25 at 11:35 AM, the surveyor, in the presence of the 4th floor unit manager (UM#1), confirmed Resident #156's O2 was set at 4L/minute and should be set at 2L/minute. On 3/7/25 at 11:40 AM, the surveyor interviewed the Licensed Practical Nurse for Resident #156, who stated they had not checked the O2 yet. No further information was provided. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46889 2. On 3/7/25 at 10:25 AM, the surveyor observed Resident #67 sitting in the wheelchair inside the dayroom awake with oxygen at two (2) lpm via NC with the portable oxygen tank attached to the wheelchair. On 3/8/25 at 11:25 AM, the surveyor reviewed the electronic Medical Record (eMR)/ hybrid medical record (paper and electronic) of Resident #67, which revealed the following: A review of the AR reflected that Resident #67 was admitted with diagnoses that included but were not limited to acute respiratory failure (a condition when there's not enough oxygen in the body) with hypoxia (low level of oxygen). A review of the recent quarterly MDS (Q/MDS), dated [DATE], indicated that the facility assessed the residents' cognitive status using a BIMS score of 6 out of 15, which indicated that the resident was moderately impaired in cognition. Further review of the Q/MDS in Section O, Special Treatments, Procedures, and Programs, revealed that Resident #67 was receiving oxygen. A review of the Order Summary Report (OSR) with an active order as of 3/12/25 revealed an order of continuous oxygen at three (3) lpm via NC for SOB with an order date of 9/20/24. A review of the electronic Medication Administration Record (eMAR) in March 2025 revealed that the above order was signed as given by the nurses at 7:00 AM, 3:00 PM, and 11:00 PM daily. On 3/12/25 at 11:45 AM, the surveyor interviewed the Unit Manager/ Licensed Practical Nurse (UM/LPN), who stated that the resident was getting oxygen at 3 lpm via nasal cannula. The UM/LPN added that the nurse should check the oxygen to ensure the resident follows the doctor's order. On 3/12/25 at 9:30 AM, the Director of Nursing (DON) provided the surveyor with an Oxygen Therapy facility policy with a revised date of 1/2025. Under the procedure section of the policy, it states, 1. Review Physician's order for oxygen therapy .5. Connect oxygen tubing to source, date it, and turn on oxygen to prescribed flow rate. On 3/12/25 at 11:57 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), Regional Director of Education and Quality (RDEQ), Regional Quality Assurance Nurse (RQAN), and DON to review facility concerns and surveyor findings. On 3/13/25 at 11:00 AM, the surveyor met with the LNHA and DON for an exit conference. The facility did not provide any further pertinent information. NJAC 8:39- 27.1 (a)

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 46889 Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's primary physician (MD) accurately dated their physician progress notes (PPN) during their visit to ensure the resident's current medical regimen was up to date. This deficient practice was observed for 1 of 33 residents (Resident #129). This deficient practice was evidenced by the following: On 3/7/25 at 10:10 AM, the surveyor observed Resident #129 sitting in a wheelchair inside the day room, unable to answer the surveyor's inquiry. On 3/7/25 at 10:28 AM, the surveyor reviewed the electronic Medical Record (eMR)/ hybrid medical record (paper and electronic) of Resident #129, which revealed the following: A review of the Admission Record (an admission summary) (AR) reflected that Resident #129 was admitted with diagnoses that included but were not limited to dementia (loss of memory). A review of the recent quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care) with a date of 2/12/25 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the resident had a severe impairment in cognition. A review of the PPNs in the eMR reflected the following Effective Date, Created Date, and/or Late Entry (any documentation that is recorded in the eMR beyond 24-48 hours of the encounter is classified as a late entry) designation which indicated the PPN was not documented on the effective date (Date of Service): 1. PPN with an effective date of 7/23/24 and a created date of 8/2/24. 2. PPN with an effective date of 8/14/24 and a created date of 8/18/24. 3. PPN with an effective date of 10/30/24 and a created date of 1/18/25. 4. PPN with an effective date of 11/20/24 and a created date of 1/18/25. 5. PPN with an effective date of 12/19/24 and a created date of 1/18/25. 6. PPN with an effective date of 1/9/25 and a created date of 1/18/25. 7. PPN with an effective date of 2/4/25 and a created date of 2/13/25. On 3/11/25 at 11:15 AM, the surveyor interviewed MD over the phone. MD stated that she is too busy and does not have the time to write in the nursing home, but she will write the documentation a few days later. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/25 at 11:57 AM, the surveyor met with the Licensed Nursing Home Administrator, Director of Nursing, Regional Director of Education and Quality, and Regional Quality Assurance Nurse but did not provide further information. A review of the facility's policy titled Physician Visits and Services with a reviewed date of 1/2025 under Procedure: 5. Progress notes and orders must be written, signed, and dated at each physician visit, which may be done in a physical or electronic chart. NJAC 8:39-23.2(b)

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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. 46889 Based on observation, interview, and record review, it was determined that the facility failed to establish appropriate infection control practices for environmental cleaning for 1 of 33 residents (Resident #40). This deficient practice was evidenced by the following: On 3/12/25, at 9:45 AM, the surveyor observed Resident #40 awake inside the room with the head of the bed elevated with a tube feeding (TF) (nutrition received through a flexible tube surgically inserted into the stomach) formula hanging on a pole at a rate of 65 ml/hr. (milliliters per hour). The surveyor observed a splash of creamy substance on the suction canister lid and the feet of the feeding pole. On 3/12/25 at 9:58 AM, the surveyor interviewed the Registered Nurse (RN), who stated she did not observe the splashed milk onto the lid of the suction canister and the feeding pole feet. On 3/12/25 at 10:00 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN), who stated that the 11:00 PM to 7:00 AM shift usually cleans the pole. The UM/LPN added that there is no schedule for cleaning the pole but a monthly schedule for cleaning the room. On 3/12/25 at 11:57 AM, the surveyor met with the Licensed Nursing Home Administrator, Director of Nursing, Regional Director of Education and Quality, and Regional Quality Assurance Nurse but did not provide further information. A review of the facility policy titled Equipment Cleaning with a revised date of January 2025 revealed that It is the policy of this facility that staff will clean the equipment after use and as needed (which includes but is not limited to such items as glucometers, blood pressure cuffs, hoyer lifts, IV/feeding poles, shower curtains, nursing carts, thermometers, stethoscopes, etc.) between residents. NJAC 8:39-19.1(a)