STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at Cedar Grove	110 Grove Ave Cedar Grove, NJ 07009

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJ 2594265 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to thoroughly investigate an incident/accident on 6/14/25 and 6/15/25, related to an allegation of being dropped by transport for Resident #182. This deficient practice was identified for one (1) of three (3) residents reviewed for accidents and was evidenced by the following:A review of the reportable event record/report (FRE; Facility Reported Event) was called in on 6/16/25 at 11:37 AM, with an event date of 6/14/25 and 6/15/25 at 12:24 PM. The incident was reported as an allegation of being dropped by ambulance transport and involved two (2) personnel on 6/14/25 and 6/15/25. The event was described as follows: On 6/14/25 the resident reported to the nurse while reaching for their urinal, the resident heard a pop and immediately experienced pain on their elbow and shoulder. The notified physician ordered to transfer the resident to the hospital. The transport [name redacted transport #1] arrived at the facility at 8:49 PM and transported the resident to the hospital. The hospital report did not reflect inconsistent injury from their current diagnosis. The resident returned to the facility on 6/15/25 at 3:47 AM, via Transport #2. On 6/15/25 after lunch the resident informed a staff member that they were dropped by both transport on to the floor and did not inform the facility staff because they did not want to get someone in trouble. The surveyor reviewed the closed medical record for Resident #182. The admission Record (AR; or face sheet; an admission summary) reflected that the resident had been admitted with diagnoses which included multiple myeloma (a type of cancer which affects the white blood cells that produces antibodies to fight infection) , fatigue fracture of the vertebrae (small crack on the bone due to repetitive, excessive stress), pathological fracture (bone fracture due to underlying condition that weakens the bone rather than external trauma) in neoplastic disease, malignant neoplasm of the bone (cancerous tumor that originated from the bone tissue). The Significant Change Minimum Data Set (SCMDS), an assessment tool used to facilitate the management of care, dated 7/18/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had a fully intact cognition. Section E. of the MDS did not reflect behaviors related to rejection of care. Further review of the SCMDS developed by the facility to identify resident's needs and implement care interventions, revealed that Resident #182 was dependent for all activities of daily living including all surface transfers. The individualized comprehensive Plan (CP) revealed a focus that included, Resident #182 was at risk for falls related to generalized weakness initiated on 1/7/25. The interventions included to anticipate and meet the resident's needs, initiated on 1/8/25. The goals were to the resident would be free of falls through the review date, initiated on 1/8/25. A review of the investigation revealed that after reporting a fall from transport the resident received a skin assessment by a Licensed Practical Nurse. The investigation and the medical record did not reflect that a Registered Nurse assessed the resident immediately after the fall was reported. Further review of the investigation did not reflect an effort was made to contact Transport #2 to completely investigate the incident/allegation of a fall during transport. On 9/17/25 at 1:34 PM, in the presence of the survey team, the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) and the Regional Registered Nurse (R/RN), the surveyor discussed the concern regarding the resident's missing assessment from a Registered Nurse and evidence that Transport #2 was contacted as part of the investigation of the alleged fall. On 9/17/25 at 1:34 PM, in the presence of the survey team, the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) and the Regional Registered Nurse (R/RN), the surveyor discussed the concern regarding the missing assessment after the reported fall and the missing statements from Trasport #2 as part of the investigation On 9/18/25 at 10:57 AM, during a meeting with the survey team, the DON, and the LNHA, the R/RN stated that they had tried to contact the former LNHA to learn more information regarding the investigation and if an interview had occurred. The R/RN also stated that Transport #2 was contacted and confirmed of the transport that occurred on 6/15/25 and would send information regarding the concern. The facility team acknowledged that the information received by the survey team and the investigation conducted by the previous LNHA was in-fact incomplete. A review of the facility policy for Accident/Incident Investigation dated/revised 1/2025 included that investigation would include interviewing staff, resident, and witness statements.The witness statements would be attached to the incident report and kept on file at the DON's office. No further information was provided. NJAC-8.39-4.1(a)5

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJ 404793 Based on observations, interviews, records review, and review of other facility documentation, it was determined that the facility failed to ensure Resident #178's care plan was individualized, reflective of the resident's assessment, consistently provided full assistance to a resident who was dependent when eating, and the nutritional status was monitored by following the weekly weights intervention. This deficient practice was identified for one (1) of one (1) resident reviewed for nutrition (Resident #178) and was evidenced by the following: The surveyor reviewed the medical record of Resident #178 The resident's admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included dementia (decline in cognitive abilities), diabetes (high blood sugar), congestive heart failure (a condition of weakened, stiffened heart muscle causing the heart to ineffectively pump blood leading to fluid buildup in the lungs and other parts of the body) and pulmonary embolism (clot travels from one part of the body and blocks an artery in the lungs. The resident's most recent comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, dated 10/014/24, reflected that a Brief Interview for Mental Status was not conducted since the resident was rarely/never understood. The resident had no indicators of hallucination and delusion. Section GG revealed that the resident was dependent (wherein the helper is required for the resident to complete the activity) for activities of daily living that included eating. Section K reflected that the resident complained of difficulty or pain when swallowing. The resident received mechanically altered diet (a change in texture of food or liquids such as pureed food, thickened liquid). A review of the resident's comprehensive individualized Care Plan (CP) included a focus on the resident's nutritional problem related to diagnoses, impaired mobility, advanced age, textured modified diet, body mass index (measurement used to assess a person's weight status and potential health risk) and underweight (UW) status, started on 10/4/24. The interventions included to monitor, record, and report to MD signs and symptoms of malnutrition, emaciation, muscle wasting significant weight loss of three (3) pound (lbs.) a week. Further review of the CP reflected that the resident required assistance with meals as needed, which was inconsistent with the comprehensive assessment that reflected the resident was dependent when eating. A review of the electronic Medical Record (eMR) reflected one weight measurement; (wheelchair) on 10/3/2024 that equaled to 113.8. No other weights were recorded for this resident. A review of the Documentation Survey Report (the report of the electronic point-of-care system (POCS) where the Certified Nursing Assistants (CNAs) electronically document patient care activities). The POCS revealed that during the resident's stay, 24 of the 73 shifts the CNAs documented the resident was independent while eating and 3 of the 49 shifts, the resident received set-up or clean-up assistance. On 9/11/25 during an interview with the surveyor, the Speech-Language Pathologist (SLP) stated that the resident from admission was on puree and nectar thick and had not changed Resident #178's diet texture. On 9/15/25 at 12:29 PM, during an interview with the surveyor the Registered Dietician (RD) stated that all residents admitted received a nutritional assessment, medical record review to ensure a resident was on a proper diet. The RD stated the hemodialysis and CHF residents are monitored for diet, food consumption, labs, signs of fluid overload. At that time, the surveyor and the RD reviewed the formed RD's progress note that indicated the previous RD spoke with the resident's family who requested nutrition supplement for Resident #178. The record reflected the RD increased the resident's nutritional supplement from twice a day to three times a day. At that time, the RD stated that the assessment for Resident #178 was made by the former RD. The RD confirmed and acknowledged the record reflected the resident was underweight, was on puree and thickened liquid, had dementia, diagnosis of CHF and had an increase of nutrition as part of the family's request. At that time, the RD stated that the increase of supplement was reflective of the resident's status of not eating well and acknowledged that the record did not reflect how the effectiveness of the nutritional intervention was measured. On 9/16/25 at 1:22 PM, in the presence of the survey team, the DON, the Licensed Nursing Home Administrator (LNHA) and the Regional Nurse, the surveyor discussed the concern regarding the care plan that reflected the resident required assistance with meals, opposed to the assessment that reflected the resident was dependent for activities of eating and the POCs that reflected the resident did not receive full assistance 27 out of 73 shifts. Additionally, the surveyor discussed the concern that the former RD increased the resident's nutritional supplement with no method of measurement for the effectiveness of the intervention, and the care plan intervention to monitor, record and report greater that three (3) pound weight loss to the Medical Doctor (MD) was not followed. On 9/17/25 at 10:15 AM, during a