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	04/08/2026

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. COMPLAINT #2734880Based on observation, interview, medical record review, and review of pertinent facility documentation on 4/7/26 and 4/8/26, it was determined that the facility failed to consistently auscultate (listen for sounds) for Resident #5's bowel sounds prior to the administration of the resident's medications and tube feeding (a form of nutrition that is delivered into the digestive system through a tube). The deficient practice was identified for 1of 1 resident reviewed (Resident #5) and was evidenced by the following: Resident #5 was not at the facility at the time of the survey. A closed record review was conducted. A review of the admission Record revealed that Resident #5 was admitted to the facility with diagnoses that included but were not limited to: dementia, chronic kidney disease, and gastro-esophageal reflux disease. Review of Resident #5's comprehensive Assessment Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 11/9/25, indicated that Resident #5 was rarely/never understood and was severely cognitively impaired. Further review of the MDS revealed that the resident required a feeding tube for nutrition. A review of Resident #5's care plan (CP) indicated that Resident #5 had a focus related to the resident's reliance on tube feedings (TF) to meet their nutritional needs. Interventions for this focus, indicated that the resident was to be provided with TF and flushes as ordered. A review of Resident #5's Medication Administration Record (MAR) for January 2026 revealed that Licensed Practical Nurse (LPN #1) administered the following medications through tube feed to the resident on 1/28/26 at 9 AM:- Ascorbic Acid Liquid 500 MG/5ML- BusPIRone HCl Tablet 5 MG- QUEtiapine Fumarate Tablet 200 MG- Valproic Acid Oral Solution 250 MG/5ML- Ativan Oral Tablet 0.5 MG The MAR further revealed that Resident #5 also received the following on 1/28/26 at 10 AM:- Enteral Feed Order five times a day flush tube with 150ml of H2O after every bolus feed- Enteral Feed Order for Jevity 1.5 liquid via bolus feeding, five times a day. The MAR further revealed that LPN #1 signed off on the tube feed as administered to the resident on 1/28/26 at 7 AM as follows:-Enteral Feed Order flush tube with 30 ml [water] before and after each med pass and after completion of formula. A review of Resident #5's progress notes (PN) revealed a PN written by the Nurse Practitioner (NP), and dated 1/28/26 at 12:40 PM, which stated, .severe abdominal distention and absence of bowel sound on auscultation. A review of Resident #5's New Jersey Universal Transfer Form revealed that on 1/28/26, Resident #5 was transferred to a hospital for further evaluation due to altered mental status and abdominal distention. An interview was conducted on 4/7/26 at 12:21 PM with LPN #2 who stated that residents with enteral feeding (Tube feeding) should be checked for the presence of bowel sounds, and that if there were no bowel sound present, the tube feeding should be held and a supervisor notified.During a follow-up interview with the LPN #2 on 4/7/26 at 1:33 PM, he stated that he assessed residents for bowel sounds once a shift. He further stated that he recalled Resident #5, but that he did not remember any specifics related to the resident's care. An interview was conducted on 4/7/26 at 1:53 PM with LPN #1. She stated that there was no protocol for residents with TF to be assessed for bowel sounds, and that she assessed residents for bowel sound based on her own independent understanding. LPN #1 confirmed that she was assigned to Resident #5 on the morning of 1/28/26, and that she administered the resident's medications and feeding through the FT. She (continued on next page)

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated that when she went back to the resident's room, [she could not recall the time], she heard the resident groaning, and that she informed the NP who was on the unit at the time. LPN #1 stated that she did not recall checking Resident #5's bowel sounds the morning of 1/28/26. An interview was conducted on 4/7/26 at 2:24 PM with the Registered Nurse Unit Manager (RN/UM). She stated that although she expected nurses to assess residents with tube feed for bowel sounds prior to administration of medications and/or nutrition, checking for bowel sounds were not included in the physician orders or a part of facility policy. She further stated that the presence of bowels sounds meant that the bowel was functioning which was important to assess in residents that required TF. An interview was conducted on 4/8/26 at 11:12 AM with the NP. The NP stated that she expects nursing staff to listen for bowel sounds prior to administering any TF. She further stated that checking bowel sound was important to ensure that the bowel is functioning, especially for those residents that cannot express their needs. An interview was conducted via telephone on 4/8/26 at 11:55 AM with the Medical Director (MD) who stated that it was important to ensure that bowel functionality was present through the auscultation of bowel sounds. The MD stated that he expected that staff follow all policies and/or protocols that are in place. An interview was conducted on 4/8/26 at 2 PM with the Director of Nursing (DON) who provided a copy of the facility's Pre-enteral Administration Protocol. She stated that the protocol was supposed to be implemented prior to the administration of any medication and/or feeding through the TF. The DON stated that the protocol included auscultating for the presence of BS. When the surveyor informed the DON of what nursing staff stated regarding facility protocol and not auscultating for bowel sound before medication/feeding administration, the DON stated that the protocol was included in all new hire and annual trainings. She further stated, they will have to be re-inserviced. A review of the facility's policy titled: (use the title of policy) Tube Feeding, Medication Administration via revised 7/2025, revealed that tube placement and patency were to be verified, per facility protocol. A review of the facility's protocol titled: Pre-Enteral Administration (Medication and Feeding), revised 7/2025, revealed that the protocol was developed to ensure that enteral nutrition and mediations were administered safely. The protocol further described the steps on how to assess a resident, which included auscultating for bowel sounds.N.J.A.C. 8:39-27.1(a)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of medical records and other pertinent facility documentation on 4/7/26, and 4/8/26, it was determined that the facility failed to maintain an accurate and complete medical record in accordance with acceptable professional standards of practice when staff failed to consistently bladder and bowel continence in the Documentation Survey Report v2 (DSR). This deficient practice was identified for 3 of 3 residents reviewed (Resident #1, Resident #2, & Resident #5) and was evidenced by the following:a). A review of the admission Record revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: traumatic subdural hematoma, gastrotomy status, and benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland). Review of Resident #1's comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated 3/21/26, indicated that Resident #1 was rarely/never understood. Further review of the MDS revealed that the resident was dependent on staff in all areas of ADL care. A review of Resident #1's care plan (CP) indicated that Resident #1 had a focus related to the resident having a self-care performance deficit. A review of Resident #1's Documentation Survey Report v2 (DSR) for January 2026 included that the following should be documented during each shift. There was no evidence of documentation on the following dates and shifts: -Bladder Continence:1/1/26 Evening & Night shifts1/16/26 Day shift1/19/26 Day shift1/25/26 Evening & Night shifts -Bowel Continence and Movements:1/1/26 Evening & Night shift1/16/26 Day shift1/19/26 Day shift1/25/26 Evening & Night shifts1/31 /26 Night shift b). A review of the admission Record revealed that Resident #2 was admitted to the facility with diagnoses that included but were not limited to: protein-calorie malnutrition, gastrotomy status, and hypertension. Review of Resident #2's comprehensive MDS, dated [DATE], indicated that Resident #2 was rarely/never understood. Further review of the MDS revealed that the resident was dependent on staff in all areas of activities of daily living (ADL) care. A review of Resident #2's care plan (CP) indicated that Resident #2 had a focus related to the resident having a self-care performance deficit. A review of Resident #2's Documentation Survey Report v2 (DSR) for January 2026 included that the following should be documented during each shift. There was no evidence of documentation on the following dates and shifts: -Bladder Continence:1/1/26 Night shift1/2/26 Night shift1/11/26 Day shift1/12/26 Night shift1/15/26 Night shift1/16/26 Day & Night shifts1/19/26 Night shift1/20/26 Day & Night shifts1/22/26 Night shift1/27/26 Day shift1/31/26 Night shift -Bowel Continence and Movements:1/1/26 Night shift1/2/26 Night shift1/11/26 Day shift1/12/26 Night shift1/15/26 Night shift1/16/26 Day & Night shifts1/19/26 Night shift1/20/26 Day & Night shifts1/22/26 Night shift1/27/26 Day shift1/31/26 Night shift c). A review of the admission Record revealed that Resident #5 was admitted to the facility with diagnoses that included but were not limited to: dementia, chronic kidney disease, and gastro-esophageal reflux disease. Review of Resident #5's comprehensive Assessment Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated 11/9/25, indicated that Resident #5 was rarely/never understood. Further review of the MDS revealed that the resident was totally dependent on staff to provide toileting hygiene and required partial assistance with toilet transfers. A review of Resident #5's care plan (CP) indicated that the resident had a focus related to incontinence and that the resident was totally dependent on staff to assist with toileting needs. A review of Resident #5's New Jersey Universal Transfer Form revealed that on 1/28/26 Resident #5 was transferred to a hospital for further evaluation due to, altered mental status and abdominal distention. A review of Resident #5's Documentation Survey Report v2 (DSR) for January 2026 included that the following should be documented during each shift. There was no evidence of documentation on the following dates and shifts: -Bladder Continence:1/4/26 Day shift1/11/26 Day shift1/16/26 Day shift1/19 /26 Day (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift1/20/26 Day shift1/22/26 Night shift1/24/26 Day shift1/25/26 Day, Evening, & Night shifts1/27/26 Day shift -Bowel Continence and Movements:1/4/26 Day shift1/11/26 Day shift1/16/26 Day shift1/19/26 Day shift1/20/26 Day shift1/22/26 Night shift1/24/26 Day shift1/25/26 Day, Evening, & Night shifts1/27/26 Day shift An interview was conducted on 4/8/26 at 11:12 AM with the Nurse Practitioner (NP) who stated that all care provided by staff should be documented in each resident's medical record. She further stated that that documentation was important to ensure that everyone was aware of a resident's status. An interview was conducted via telephone on 4/8/26 at 11:55 AM with the Medical Director (MD) who stated that monitoring a resident's bowel and bladder function was an important factor that confirmed that the resident's body was functioning properly. He further stated that he expected that documentation be fully completed and accurate. An interview was conducted on 4/8/26 at 1:01 PM with the Certified Nursing Assistant (CNA #1) who stated that all care provided should be documented in each resident's electronic medical record to confirm that it was done. She further stated that there are times when they get so busy providing the care that they forget to document. An interview was conducted on 4/8/26 at 2 PM with the Director of Nursing (DON) who stated that CNAs were responsible for providing and documenting all ADL care in each resident's medical record. She expected that there would be no blanks. The DON further stated that signing off was their way of showing proof that care was provided. A review of the facility's Incontinence Care Management Policy revised 07/2025, revealed that residents would be provided with .individualized and clinically appropriate care. The policy further revealed that staff would document the care provided in each resident's medical record. A review of the facility's Documentation, General policy, dated 07/2025, revealed that the facility would ensure that all care provided to residents would be documented .accurately, timely, and completely. N.J.A.C. 8:39-27.1(a)