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	07/09/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 46049 Based on observation, interview, and record review it was determined that the facility failed to provide full visual privacy when providing wound care treatment, for one (1) of 28 residents, Resident #103. The deficient practice was evidenced by the following: On 6/27/24 at 10:15 AM, the surveyor observed the Licensed Practical Nurse (LPN) perform a treatment to the sacral wound of Resident #103. The Certified Nurse Aide (CNA) was assisting the LPN with the positioning of Resident #103 during the wound treatment. On 6/27/24 at 10:31 AM, during the wound treatment, Resident #103 with the assistance of the CNA was lying on their left side on the bed facing away from the door. The back of the resident's body was exposed. The privacy curtain was partially pulled, around the foot of the resident's bed. The resident's bed was visible to the door of the room, which was closed. The LPN after cleansing the resident's wound, removed her gloves and went to the door of the room. LPN #1 fully opened the door, went to the treatment cart positioned in front of the door to get gloves from the box on top of the cart. The back side of the resident's body was visible to the hallway as the privacy curtain was not closed fully and the resident's door was widely open. LPN #1 retrieved the gloves from the top of the treatment cart, came back in room, put the gloves on the bedside table, next to the resident's bed and then closed the door of the resident's room. On 6/27/24 at 10:50 AM, the surveyor interviewed the LPN after the wound treatment about privacy for residents. The LPN stated visual privacy should be provided and maintained for residents. The surveyor discussed the observation during the wound treatment. The LPN acknowledged that she should have drawn the resident's curtain further or closed the door of the room when she went to the treatment cart to ensure that the resident was not visible from the hallway. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #103 which revealed the following: According to the Admission Record (an admission summary), Resident #103 had diagnoses that included but were not limited to, urinary tract infection, sacral pressure ulcer wound, and epilepsy (a seizure disorder). (continued on next page)

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
	315357	A. Building B. Wing	07/09/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Annual Minimum Data Set (MDS), an assessment tool to facilitate management of care, dated 5/10/24, indicated the facility assessed the resident's cognition using a Brief Interview for Mental Status (BIMS) test. Resident #103 scored a 9 out of 15, which indicated the resident had moderate cognitive impairment. On 6/27/24 at 12:41 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the [NAME] President of Operations (VPoO). The surveyor notified the LNHA, DON, and VPoO of the concern observed during the wound treatment of the resident's full visual privacy not being maintained. There was no verbal response by the facility at this time. On 6/28/24 at 11:30 AM, the LNHA, DON, and VPoO met with the survey team. The VPoO stated in-service education about resident's privacy was being provided to all staff. There was no additional information provided by the facility. A review of the facility's Resident Rights To Privacy and Confidentiality with a reviewed date of 01/2024. Under Procedure it read, Every nursing home resident has the right to personal privacy of not only his/her own physical body, but also of his/her personal space, including accommodations and personal care. A review of the facility's Resident's Rights, which was undated. Under I. Each resident shall be entitled to the following rights .16) To have physical privacy. The resident shall be allowed, for example, to maintain the privacy of his or her body during medical treatment and personal hygiene activities, such as bathing and using the toilet, unless the resident needs assistance for his or her own safety . NJAC 8:39-4.1(a)12,16

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	07/09/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39885 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 three (3) of five (5) newly hired licensed staff reviewed, (Staff #5, #8 and #10). This deficient practice was evidenced by the following: 1. On On 6/27/24 at 12:00 PM, the surveyor reviewed five of ten randomly selected new employee files. The review for license verification for one of the new licensed employees revealed the following: Staff #5, a Social Worker, hired 8/21/23, had a New Jersey Division Consumer Affairs license verification printout was dated 10/02/23. The verification was completed after the staff member was hired. There was no documented evidence that Staff #5's license was verified prior to the date of hire (doh). On 6/28/24 at 10:00 AM, the surveyor interviewed the Business Office Manager (BOM) regarding license verification. The BOM stated that she would check the license and print a copy and that it had to be done before orientation. The surveyor showed the BOM Staff #5's license verification dated after the doh. The BOM stated that she was not employed at the facility at that time. She added that the license should be verified prior to doh. On 6/28/24 at 10:04 AM, the surveyor interviewed the Director of Nursing (DON) regarding license verification. The DON stated that the BOM checked the license prior to doh. On 6/28/24 at 12:06 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON and [NAME] President of Operations (VPoO) the concern that Staff #5's license was not verified prior to the doh. The LNHA stated that he was the stand in BOM and that he missed it. On 7/01/24 at 10:04 AM, in the presence of the survey team, DON and VPoO, the LNHA confirmed that the license should have been verified prior to the doh. 49078 2. On 6/27/24 at 10:30 AM, the surveyor reviewed five of ten randomly selected new employee files. The review for license verification for one of the new licensed employees revealed the following: Staff #10, a Certified Nurse Aide (CNA), hired 10/23/23, had a New Jersey Division Consumer Affairs license verification printout that had no date the verification was completed visible on the printout. There was no documented evidence that Staff #10's license was verified prior to the doh. On 6/27/24 at 12:15 PM, the surveyor reviewed five of ten randomly selected new employee files. The review for license verification for one of the new licensed employees revealed the following: (continued on next page)

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	07/09/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff #8, a Registered Nurse, hired 8/25/23, had two New Jersey Division Consumer Affairs license verification printouts that were dated 10/02/23 and 11/14/23. The verification was completed after the staff member was hired. There was no documented evidence that Staff #8's license was verified prior to the doh. On 7/01/24 at 9:48 AM, the LNHA provided another copy of Staff #10's printout. The printout reflected handwriting that was highlighted printed on 6/28/24 print no date shown. The License verification printout did not reflect any other date that it was printed. There was no documented evidence that Staff #10's license was verified prior to the doh. A review of the facility provided policy titled, New Hires with a reviewed date of 01/2024, included the following: 1. All new hires shall complete the following paperwork and the paperwork will have to be reviewed by the BOM: . f. Original licenses/certification with verification by the BOM (if applicable) A review of the facility provided policy titled, Abuse Prevention Program with a revised date of 02/08/2023, included the following: .Part III-Screening . Potential hires of professional staff will have their license verified by their licensing boards prior to hire NJAC 8:39-43.15(a,b)

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	07/09/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 39885 Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to provide the resident and the resident's representative written notification of the reason for transfer to the hospital and also send a copy to a representative of the Office of the State Long-Term Care Ombudsman (LTCO) for two (2) of three (3) resident's (Resident #195 and #41) reviewed for hospitalization . This deficient practice was evidenced by the following: 1. A review of Resident #195's electronic medical record included the following: Resident #195's discharge return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, for the three DRAMDS, reflected that the resident was transferred to the hospital. A review of Resident #195's hybrid (a combination of paper, scanned, and computer-generated records) medical record did not include a written notification of the reason for transfer to the resident or resident representative (RR) and a copy to the LTCO for each transfer to the hospital. 46049 2. The surveyor reviewed the hybrid medical records of Resident #41 which revealed the following: A New Jersey Universal Transfer Form (NJUTF) and nurse progress notes documented that Resident #41 was transferred to an acute care hospital in May 2024. According to the DRAMDS in May 2024, Resident #41 was discharged (d/c) to an acute care hospital with a return anticipated to the facility. There was no documentation in the hybrid medical record of Resident #41 to indicate that the facility provided written transfer notification to the resident or RR. Additionally, there was no documentation in the hybrid medical records to indicate written transfer notification was provided to the Ombudsman's office. On 6/25/24 at 9:52 AM, the surveyor interviewed the Director of Social Services (DSS) about written emergency transfer notifications. The DSS stated social services department was not responsible for providing written emergency transfer notifications and did not provide notice to the Ombudsman's office. The DSS stated he was not sure who was responsible for providing the notifications. On 6/25/24 at 9:57 AM, the surveyor interviewed the Admissions Director and Regional Director of Case Management and Admissions (RDCMA) about written emergency transfer notification. The RDCMA stated nursing was responsible for providing the written transfer notification to the resident or RR. (continued on next page)

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	07/09/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 11:58 AM, the surveyor interviewed the Director of Nursing (DON) who stated written emergency transfer notification was not provided by nursing. The DON further stated she was not sure which department was responsible for providing and would follow up to provide further information. On 6/25/24 at 12:01 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated the medical records department was responsible for providing written emergency transfer notification to resident and/or RR and the Ombudsman's office. On 6/25/24 at 12:07 PM, the surveyor interviewed the medical records staff (MRS) who stated she was not responsible for providing any written emergency transfer notification. The MRS further explained that she would complete a monthly spreadsheet of residents that were d/c and send directly to the LNHA. The MRS stated she had no knowledge about written emergency transfer notifications and did not know who was responsible for providing. On 6/27/24 at 12:41 PM, the survey team met with the LNHA, the DON, and the [NAME] President of Operations (VPoO). The surveyors notified the facility of the concerns that there was no written emergency transfer notification provided to the resident/RR and no notification provided to the Ombudsman's office. There was no verbal response by the facility at this time. On 6/28/24 at 11:30 AM, the LNHA, the DON, and the VPoO met with the survey team. The VPoO stated in-service education was provided to staff to put the process of providing emergency written transfer notifications back into place as it was not being completed. There was no additional information provided by the facility. The surveyor reviewed the facility provided policy titled Emergency Transfer Notification with a reviewed date of 01/2024. Under Policy it read It is the policy of this facility to provide guidelines for the notification requirements when transferring residents to an acute care facility on an emergent basis. Under Procedure it read: 1. When a resident is temporarily transferred to an acute care facility a notice of the temporary transfer will be provided to the resident and/or RR as soon as practicable .2. A copy of the notice will also be sent to the Ombudsman when practicable, such as a list of residents on a monthly basis .3. The notice will contain: a. The reason for transfer; b. The effective date; c. The location to which the resident is transferred; d. Contact information . NJAC 8:39-5.3; 5.4

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	07/09/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 48423 Based on interview, record review and review of pertinent facility documentation, 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 one (1) of three (3) residents, Resident #142 reviewed for closed records. This deficient practice was evidenced by the following: On 6/26/24 at 12:58 PM, the surveyor reviewed the closed medical chart for Resident #142 whose discharge MDS was coded for discharge (dc) to an acute hospital. Review of Resident #142's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included but were not limited to unspecified atrial fibrillation (an irregular and often very rapid heart rhythm), anxiety disorder, unspecified, and essential (primary) hypertension (high blood pressure). Review of A section of the 4/27/24 Discharge MDS for Resident #142 revealed that section A2105 DC Status documented, 04. Short-Term General Hospital. The Order Summary Report (OSR) reflected a physician order dated 4/27/24 - dc home with home care services. The Progress Notes dated 4/27/24 at 9:30 AM that was electronically signed by Licensed Practical Nurse (LPN) included resident was seen this morning in their wheelchair no signs of distress or discomfort noted. Vitals taken and recorded; due medications (meds) tolerated. Resident dc, left the building at 9:30 AM, with resident representative. Resident has been educated on their meds and oxygen use; list of meds had been faxed to [name redacted] pharmacy. The dc Summary, with effective date 4/27/24 12:44 PM revealed under section 103 Social Services documented, 2. dc Status - dc home, family support. Ref (referred) to [name redacted] Home Care for home services. On 6/27/24 at 11:28 AM, the surveyor interviewed the MDS Coordinator (MDSC). MDSC explained, I do remember him/her, that Resident was dc to home. I made a mistake and entered their information transferred to hospital. The MDSC acknowledged that the MDS was coded inaccurately and Resident #142 went home and did not go to the hospital. On 6/28/24 at 11:28 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and [NAME] President of Operations (VPoO) regarding the above concerns. The VPoO stated, she [the MDSC] made an error in MDS. She further stated that the resident was dc home and did not go to the hospital. No further information provided. NJAC 8:39-33.2(d)

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	07/09/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow the physician's orders for medications with parameters for two (2) of 28 residents, Residents #44 and #134, reviewed for physician orders according to standards of clinical practice. This 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 wellbeing, 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. 1. The surveyor reviewed the hybrid (electronic and paper) medical records of Resident #44 which revealed the following: The Admission Record (AR, an admission summary) revealed that Resident #44 had diagnoses that included but were not limited to, end stage renal disease, hypotension (low blood pressure), and anemia. A Quarterly Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated 4/03/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #44 scored a 15 out of 15, which indicated the resident was cognitively intact. A physician's order (PO) dated 5/10/24 read: Midodrine HCl Oral Tablet (tab) 10 MG (milligram) (Midodrine HCl) Give 1 tab by mouth two times a day for hypotension hold for BP [blood pressure] > [greater than] 120. A review of the June 2024 electronic Medication Administration Record (eMAR) revealed the nurses signed for midodrine medication (med) being administered on 6/04/24 at 1700 [5 PM], 6/10/24 at 1700, 6/11/24 at 0900 [9 AM], 6/16/24 at 0900, 6/18/24 at 1700, 6/19/24 at 1700 and 6/24/24 at 1700. On these entries the BP was documented to be a BP greater than 120 and the midodrine med should have been held per the PO. (continued on next page)

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	07/09/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 11:12 AM, the surveyor interviewed a Licensed Practice Nurse (LPN) #1 (LPN #1) assigned to care for Resident #44 about medications (meds) with parameters. The LPN stated a PO should be followed. If the BP results were outside the parameters of the med order, the med should be held and not administered to the resident. On 6/27/24 at 12:41 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the [NAME] President of Operations (VPoO) of the concerns that the PO for the midodrine med with parameters was not being followed. The facility was to follow up and provide additional information. On 6/28/24 at 11:30 AM, the LNHA, the DON, and the VPoO met with the survey team. The DON acknowledged the nurses did not follow the parameters ordered by the physician for the midodrine med and nurse in-service education was ongoing. 38327 2. On 6/24/24 at 11:39 AM, the surveyor observed Resident #134 seated in a wheelchair in the Therapy room (also known as the dining area) with other five residents for early lunch. The surveyor reviewed the hybrid medical record for Resident #134. Resident #134's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to hypotension unspecified, traumatic subdural hemorrhage (caused by a traumatic head injury) without loss of consciousness, cerebral infarction (also known as a stroke) due to embolism of a left posterior cerebral artery, unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hemiplegia (paralysis) and hemiparesis (muscle weakness) following cerebral infarction affecting right dominant side, other secondary hypertension (elevated blood pressure), depression unspecified, and anxiety disorder. The most recent Significant Change MDS (SCMDS) dated [DATE], reflected that the resident had a BIMS score of 09 out of 15, which indicated the resident had moderately impaired cognition. A review of the OSR for May and June 2024 reflected a PO dated 3/07/24 for the following: Hydralazine HCL (hydrogen chloride) oral tab 25 mg give one tab orally every 12 hours (hrs) to treat high blood pressure hold if SBP (systolic blood pressure [the top number measures the pressure in the arteries when the heart beats]) less than 120. Toprol XL (extended-release) oral tab 50 mg give one tab by mouth one time a day for HTN (hypertension) hold for SBP less than 100 and HR (heart rate) less than 60. The above orders for Hydralazine and Toprol Xl were plotted in the eMAR for May and June 2024, were administered by nurses (checked mark), and did not follow the PO: Toprol XL hold for SBP less than 100: Date Time BP Nurse (continued on next page)

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	07/09/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/22/24 8 PM 96/61 [SBP 96] Registered Nurse#1 (RN#1) HydrALAZINE HCl hold for SBP less than 120: Date Time BP Nurse 6/09/24 9 AM 115/73 [SBP 115] LPN#2 6/12/24 9 PM 112/68 [SBP 112] LPN#2 6/19/24 9 PM 18/67 [SBP 118] LPN#2 6/20/24 9 PM 103/64 [SBP 103] LPN#2 6/22/24 9 PM 105/70 [SBP 1050 LPN#3 5/03/24 9 AM 113/96 [SBP 113] RN#1 5/10/24 9 PM 116/72 [SBP 116] LPN#2 5/14/24 9 PM 116/68 [SBP 116] LPN#2 On 6/25/24 at 9:54 AM, the surveyor interviewed RN#1 who informed the surveyor that she was a regular full time per diem nurse for a year now in the Behavioral Unit (BHU). The RN informed the surveyor that the meds with parameters like the BP meds should follow the order of the physician if needed to hold, then it should be followed. She further stated that she checked BP first prior to administering the BP meds, and documented the BP in the eMAR. The RN also stated that the checkmark in the eMAR means it was administered. The RN further stated that it was considered a med error if BP meds were administered beyond the parameters. On that same date and time, the surveyor notified RN#1 of the above concerns and findings regarding the Toprol she administered on 6/22/24 and Hydralazine on 5/03/24 not following the parameters. The surveyor with another surveyor and RN#1 went to the BHU nursing station. RN#1 checked the eMAR and acknowledged that she was the nurse that administered the BP meds and it should not administered due to parameters. She further stated that she did not know why it was administered and did not follow the PO for parameters. On 6/25/24 at 11:22 AM, the surveyor called and left a message to an agency nurse, LPN#3. On 6/25/24 at 11:23 AM, the surveyor called and spoke to LPN#2 regarding the above concerns and findings. LPN#2 informed the surveyor that she was from an agency and had been working in the facility since June 2023 as a float nurse. On that same date and time, LPN#2 stated that meds with parameters example the BP meds should follow the PO for parameters. She further stated that she checked BP first prior to administering meds and documented the BP in the eMAR. LPN#2 admitted that she usually works the 3-11 shift. (continued on next page)

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	07/09/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, the surveyor notified LPN#2 of the above findings regarding her administered Hydralazine on 6/09/24, 6/12/24, 6/19/24, 6/20/24, 5/10/24, and 5/14/24 not following the parameters. She further stated that the above meds should not be administered due to parameters. LPN#2 had no answer as to why she did not follow the PO for parameters. On 6/25/24 at 11:38 AM, the DON provided a copy of the Med Administration Policy with a reviewed date of 01/2024. The DON stated that the policy about meds with parameters was incorporated in this policy (Medication Administration Policy with a reviewed date of 01/2024) and the DON pointed to Procedure #3: Meds must be administered in accordance with the orders, including any required time frame. The surveyor did not receive a call back from LPN#3. On 6/27/24 at 9:00 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM). The RN/UM stated that she notified the physician yesterday about the concerns with the parameters, the physician had no new order and instructed the nurse to continue the parameters. She further stated that there was no adverse effect on the resident. On 6/27/24 at 12:41 PM, the survey team met with the LNHA, the VPoO, and the DON. The surveyor notified the facility management of the above concerns and findings. On 6/28/24 at 11:29 AM, the survey team met with the LNHA, DON, and the VPoO. The DON stated that one-to-one education was provided to LPN#2 regarding following the PO for parameters. The DON acknowledged and stated that meds were given beyond the parameters and that should have been held for both meds Toprol and Hydralazine. A review of the facility provided policy titled, Medication Administration Policy, with a reviewed date of 01/2024. Under Policy it read: Meds shall be administered in a safe and timely manner, as prescribed. Under Procedure it read: .3. Meds must be administered in accordance with the orders, including any required time frame .7. The following information must be checked/verified for each resident prior to administering meds .b. Vital signs, if necessary . NJAC 8:39-11.2(b); 29.2(d)

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	07/09/2024

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 38327 Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that a discharge summary was completed for two (2) of two (2) residents, Residents #13 and #142 reviewed for discharge to home, according to the facility policy and procedure . This deficient practice was evidenced by the following: 1. On 6/26/24 at 10:10 AM, the surveyor reviewed the hybrid (combination of paper and electronic) closed record of Resident #13 and revealed the following: The Admission Record (AR, or face sheet, an admission summary) showed that the resident was admitted to the facility with a diagnosis that included but was not limited to urinary tract infection (UTI, an infection) site not specified, hypothyroidism (underactive thyroid), chronic obstructive pulmonary disease with acute exacerbation (COPD, group of lung diseases that block airflow and make it difficult to breathe), depression unspecified, anxiety disorder unspecified, and fibromyalgia (long-term condition that involves widespread body pain and tiredness). A review of the modified Comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 4/27/24 showed a brief interview for mental status (BIMS) score of 14 out of 15 which indicated that the resident was cognitively intact. The CMDS also showed that the overall goal for the resident was to be discharged (DC) to the community. Further review of the MDS revealed that the most recent DC Return Not Anticipated ARD was on 6/20/24 and was export-ready (which means it was completed but was not submitted to the Centers for Medicare and Medicaid Services or CMS). The Order Summary Report (OSR) for June 2024 showed a physician's order (PO) dated 6/20/24 for DC home with home care services. The Progress Notes (PN) dated 6/20/24 at 02:43 PM that was electronically signed by Licensed Practical Nurse #1 (LPN#1) included that patient (resident) DC to a private home, left in the company of the resident's representative (RR). Further review of the PN showed that the last note of the physician was on 6/19/24 and did not include the DC information and plan for the resident. The DC Summary in the electronic medical records (EMR), assessment tab showed that it was In Progress date 6/20/24 and the lock date was blank. The DC Summary dated 6/20/24 showed the following were left blank and no documented information found: SECTION 103. Social Services (continued on next page)

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	07/09/2024

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Admission Status=left blank SECTION 104. Rehab 1. Admission Status=left blank 2. Discharge Status=left blank SECTION 105. Dietary 1. Admission Status=left blank SECTION 106. Activities 1. Admission Status=left blank Further review of the DC Summary showed that there was no physician DC summary. On 6/27/24 at 12:20 PM, the Director of Nursing (DON) with the Registered Nurse/Unit Manager (RN/UM) met with the surveyor. The RN/UM notified the surveyor that the facility did not have a DC summary from the physician, and it was not the facility's practice. The RN/UM also stated that the only requirement from the physician was to have an order for DC and the facility to document that the physician was notified of the DC of the resident. He further stated that that was the reason why there was no DC summary from the physician in the EMR and the actual paper closed chart. On 6/27/24 at 12:41 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Operations (VPoO), and the DON. The surveyor notified the facility management of the above concerns and findings. The surveyor also notified the facility management of the RN/UM interview in the presence of the DON. On 6/28/24 at 11:29 AM, the survey team met with the LNHA, DON, and the VPoO. The VPoO stated that we have to put back the system for DC summaries, and moving forward that would be done, the DC summaries of the physician. The VPoO acknowledged that the DC summary of the physician was not something new in the requirements, and should have been done. On that same date and time, the surveyor also notified the facility management that the DC Summary that was in the Assessment tab of the EMR was still in progress and was not completed, where multiple areas were blank. On 7/01/24 at 11:09 AM, the survey team met with the LNHA, DON, and the VPoO. There was no additional information provided with regard to the above concerns. A review of the facility's DC Policy with a reviewed date of 01/2024 by the LNHA included that when a resident's DC is anticipated, a DC plan, summary, and instructions will be developed to assist the resident to adjust to his/her new living environment. The IDT (interdisciplinary team) will document the DC summary in the EMR. (continued on next page)

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	07/09/2024

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/01/24 at 11:58 AM, the survey team met with the LNHA, DON, and VPoO for an Exit Conference. No additional information was provided by the facility management, and the facility did not refute findings. 48423 2. On 6/26/24 at 12:58 PM, the surveyor reviewed the hybrid closed record of Resident #142 and revealed the following: The AR showed that the resident was admitted to the facility with diagnoses that included but were not limited to unspecified atrial fibrillation (an irregular and often very rapid heart rhythm), anxiety disorder, unspecified, and essential (primary) hypertension (high blood pressure). A review of the DC MDS reflected BIMS score of 15 out of 15 which indicated that the resident was cognitively intact. Further review of the MDS section A0310F. revealed that MDS assessment was coded 10. DC assessment- return not anticipated. A review of OSR showed a PO dated 4/27/24 for DC home with home care services. A review of PN dated 4/27/24 at 9:30 AM that was electronically signed by LPN#2 included resident was seen this morning in their wheelchair no signs of distress or discomfort noted. Vitals taken and recorded; due medications (meds) tolerated. Resident DC, left the building @ 9:30 AM, with RR. Resident has been educated on his/her meds and oxygen use; list of meds had been faxed to [name redacted] pharmacy. Further review of the PN showed that the last physician note titled as H&P was on 4/15/24 and did not include the DC information and plan for the resident. Further record review did not reveal a physician DC summary for Resident #142. NJAC 8:9-36.1(b)

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	07/09/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 39885 Based on observation, interview and review of the medical record and other facility documentation, it was determined that the facility failed to ensure that residents with decreased range of motion and mobility received consistent daily treatment of a hand splint to prevent contractures or further contraction for one (1) of two (2) residents reviewed for position and mobility (Resident #94). This deficient practice was evidenced by the following: On 6/24/24 at 10:45 AM, the surveyor observed Resident #94 seated in a wheelchair and wore a splint on their left hand. Resident #94 stated that he/she wore the splint during the day. On 6/25/24 at 11:48 AM, the surveyor reviewed Resident #94's electronic medical record. Resident #94'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 flaccid hemiplegia affecting left nondominant side (affected extremity exhibits decreased muscle tone and cannot be actively moved by the patient), type 1 diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels) and unspecified disorder of thyroid (medical condition that keeps your thyroid from making the right amount of hormones). Resident #94's electronic physician order set (POS) included the following active order: *FMP* (Functional Maintenance Program) PROM L UE (passive range of motion left upper extremity) in all planes as tolerated 3-5x/WK (week) 10-20 reps (repetitions). Donn (to put on) L (left) hand orthotic after AM care and doff (to take off) before PM care daily. Further view of the order indicated POS only and did not transfer to the TAR (Treatment Administration Record) for staff signatures. A review of Resident #94's care plan included the following focus area with an initiated date of 01/23/2023: Restorative Nursing Program: Passive ROM (range of motion) left upper extremity 3-5x/week 10-20 reps, Donn left hand orthotic device (splint) on after AM care and off before PM care daily. A review of Resident #94's January 2024 through June 2024 TAR did not have a physician's order for the splint for nurses to sign as administered. There was no documented evidence in Resident #94's hybrid (a combination of paper, scanned, and computer-generated records) medical record that the physician's order or care plan was being carried out. (continued on next page)

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	07/09/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 9:18 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) regarding splints. The CNA stated that everyone could do the splint and that it was documented in the computer. The CNA stated that Resident #94 was currently receiving therapy and that therapy was doing the splint now. She added that when the resident was not in therapy that nursing staff would do the splint and document it. A review of Resident #94's Documentation Survey Report (CNA documentation for interventions or tasks) for January 2024 through June 2024 did not include any documentation regarding splints. On 6/26/24 at 9:23 AM, the surveyor interviewed the Director of Rehab (DoR). The DoR stated that the Restorative Nurse Aid (RNA) documented on paper when she applied the splint. On 6/26/24 at 9:33 AM, the surveyor interviewed the RNA. The RNA stated that she had a binder that she documented in for Resident #94. On 6/26/24 at 12:09 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) of Pink unit regarding the process of splints and documentation. The RN/UM requested that the DoR be present. On 6/26/24 at 12:50 PM, in the presence of the DoR, the RN/UM stated that there was a physician order in the computer that was on the TAR and that the nurse would sign it but that it was only when resident was not on therapy. She added that when the resident was on therapy the RNA would leave the binder for the other staff to document. The surveyor requested to see the documentation. On 6/27/24 at 10:06 AM, the DoR provided the surveyor a copy of Resident #94's RNA's documentation for the splint. A review of the provided Functional Maintenance Program Flow Record for Resident #94's Splinting/Brace program included the following: June 2024 had 18 days that the RNA signed that Resident #94's splint was donned and doffed by the RNA. There were 8 days that were blank. May 2024 had 19 days that the RNA signed. There were 12 days that were blank. April 2024 had 20 days that the RNA signed. There were 10 days that were blank. March 2024 had 21 days that the RNA signed. There were 9 days that were blank. February 2024 had 19 days that the RNA signed. There were 9 days that were blank. January 2024 had 21 days that the RNA signed. There were 10 days that were blank. The surveyor asked the DoR about the blanks. The DoR stated that he did not know how nursing documented the splint. There was no documented evidence that Resident #94's splint was applied on the days that the RNA was not at the facility. (continued on next page)

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	07/09/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 10:13 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the process for splint. The LPN stated that the RNA applied the splint when she was working. She added that when the RNA was not here that the CNA or the nurse would apply the splint and that here was a section in the TAR that they signed. The surveyor asked the LPN if the CNA also documented the splint applied. The LPN stated that she believed that the CNA also documented in the computer but was not sure. She added that she did not think that the CNA documented in a binder and that the RNA only had a binder. At that same time, the surveyor then showed the LPN the forms that the DoR provided and she confirmed that there were blanks and that the CNA's were not documented on that form. The LPN then viewed the TAR and confirmed that there was a new order placed in the TAR on 6/26/24, after surveyor inquiry, for Resident #94's splint. The surveyor asked the LPN what the importance of having the order in the TAR. The LPN stated that it was to ensure that the splint was applied each day and to prevent further contractures. On 6/27/24 at 10:24 AM, the surveyor interviewed the RNA regarding the binder that she documented in. The RNA stated that she did not leave the binder for the CNA's when she was not here. There was no documented evidence that Resident #94's splint was applied on the days that the RNA was not at the facility. On 6/27/24 at 11:18 AM, the surveyor interviewed the Director of Nursing (DON) regarding the process for splinting. The DON stated that the RA documented the splint in a binder. The surveyor then asked if the RA was at the facility seven days a week. The DON stated that the RA was not at the facility seven days a week and that the nurses documented the splint in the TAR. The surveyor then asked the DON about the missing documentation of the splint for Resident #94. The DON stated that she was informed after surveyor inquiry and that they failed to have the documentation. On 6/27/24 at 01:10 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON and [NAME] President of Operations (VPoO) the concern that Resident #94 did not have any documented evidence that the splint was applied on the days that the RA was not there. On 6/28/24 at 11:41 AM, in the presence of the survey team, LNHA and DON, the VPoO stated that the staff was inserviced on documentation for splints. The facility did not provide any additional information. A review of the facility provided policy titled, Functional Maintenance Program with a revised/reviewed date of 01/2024, included the following: The facility's Functional Maintenance Program (FMP) is designed to assist residents to achieve and maintain an optimal level of function. When a resident is discharged from skilled therapy to FMP, the following steps are followed: The treating therapist will initiate recommendations for FMP and notify nursing of these recommendations with appropriate instructions and training of recommendations. (continued on next page)

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	07/09/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An FMP order will be placed in the resident's electronic chart and care planned. The care plan shall be written with nursing interventions which will give direction to the CNA's for assisting the resident in the program. CNA's shall aid the residents in performing the recommended FMP. These CNA's will be under the direction of a licensed nurse who will collaborate their activities with PT/OT (physical therapy/occupational therapy). The CNA's shall document daily in the FMP log. This log will be reviewed monthly by the nursing and rehab team and monthly nursing summary will be completed to evaluate the current program. The policy did not contain any information in regards to splints and documentation while a resident received skilled therapy. N.J.A.C. 8:39-27.1(a)

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	07/09/2024

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 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. 38327 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that the incontinence care plan was developed according to the resident's assessment to provide appropriate treatment and services for the care of the resident who had frequent urine and occasional bowel incontinence according to the facility's policy and procedure, for one (1) of one (1) resident, Resident #134, reviewed for bowel and bladder incontinence. This deficient practice was evidenced by the following: On 6/24/24 at 11:39 AM, the surveyor observed Resident #134 seated in a wheelchair in the Therapy room (also known as the dining area) with other five residents for early lunch. The surveyor reviewed the hybrid (combination of paper and electronic) medical record for Resident #134. Resident #134's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to hypotension unspecified (low blood pressure), traumatic subdural hemorrhage (caused by a traumatic head injury) without loss of consciousness, cerebral infarction (also known as a stroke) due to embolism of a left posterior cerebral artery, unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hemiplegia (paralysis) and hemiparesis (muscle weakness) following cerebral infarction affecting right dominant side, other secondary hypertension (elevated blood pressure), depression unspecified, and anxiety disorder. The most recent Significant Change Minimum Data Set (SCMDS), an assessment tool used to facilitate the management of care, dated 3/28/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 09 out of 15, which indicated the resident had moderately impaired cognition. The SCMDS also showed that the resident was coded for frequently incontinent of urine and occasionally incontinent of bowel. Also, the SCMDS revealed that the resident was not on a bladder and bowel toileting program. Further review of the SCMDS revealed that on Section V Care Area Assessment (CAA) Summary, #6 Urinary Incontinence and Indwelling Catheter that area was triggered and was checked to proceed with Care Plan (CP). The CAA included that the urinary incontinence was an actual problem, and the nature of the problem: Resident is noted more B & B (bladder and bowel) accidents. Resident is assisted with his/her toileting for safety. The CP's consideration was to address the problem to proceed with CP, with an overall objective to slow or minimize the decline. A review of the personalized CP showed that there was no focus CP, goals, and interventions for B & B incontinence. Further review of the medical records showed that the above SCMDS CAA for #6 was not followed to proceed with CP for B & B incontinence. (continued on next page)

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	07/09/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Tasks for the Certified Nursing Aide (CNA) in the electronic medical records revealed that the task description for bladder continence and bowel continence, frequency was every shift. On 6/25/24 at 9:54 AM, the surveyor interviewed the Registered Nurse (RN). The RN stated that the resident was alert with some forgetfulness with behavior of verbally abusive to staff and other residents at times. She further stated that Resident #134 with periods of B & B incontinence, staff assisted the resident in toileting. On 6/28/24 at 8:55 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM). The RN/UM informed the surveyor that Resident #134 was incontinent of B & B. The RN/UM stated that she was responsible for initiating, reviewing, and revising the CP. She added that RN Coordinator (RNC) was also responsible for the resident's CP. The RN/UM further stated that she was unsure if incontinence should be care planned for. At that time, the surveyor notified the RN/UM of the above concerns. On 6/28/24 at 9:13 AM, the surveyor interviewed the assigned CNA of Resident #134. The CNA stated that the resident was alert with periods of confusion, with periods of incontinence in both B & B. The surveyor asked the CNA how often she checked on the resident for incontinence and what kind of care and assistance was provided to the resident. The CNA responded that at least every two hours or more. The surveyor then asked again the CNA, how she knew the resident should be checked for two hours or more, the CNA responded that based on her experience as a CNA. On 6/28/24 at 9:20 AM, the surveyor interviewed the MDS Coordinator/RN (MDSC/RN). The MDSC/RN stated that she was responsible for the CAA in the MDS for the nursing side including the Continence/incontinence. At that same date and time, the surveyor notified the MDSC/RN about the above findings and concerns including the CAA for #6 that there was no CP. The MDSC/RN stated that there should be a CP for incontinence and that she will check on it and get back to the surveyor. On 6/28/24 at 10:21 AM, the MDSC/RN in the presence of the survey team informed the surveyor that she did not see a CP for incontinence and that should have been care planned. On 6/28/24 at 11:29 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the [NAME] President of Operations (VPoO). The surveyor notified the facility management of the above findings and concerns. A review of the facility's Incontinence Care Policy with a reviewed/revised date of 01/2024 that was provided by the LNHA included that the facility shall provide care for all incontinent residents. The Procedure included that the check residents at least every two hours. A review of the facility's Plan of Care and IDCP Team Meeting Policy with reviewed date of 01/2024 that was provided by the LNHA included that the facility shall provide an individualized, interdisciplinary plan of care for all residents that shall be appropriate to the resident's needs, strengths, and goals. Procedures: (continued on next page)

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	07/09/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The plan of care shall be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments and as appropriate. -the plan of care shall be documented in the facility's EMR (electronic medical record) system. Interdisciplinary Care Plan (IDCP) Team meeting: -The IDCP Team meeting shall be held after completion of the comprehensive assessment, quarterly or more frequently, as needed. On 7/01/24 at 11:58 AM, the survey team met with the LNHA, DON, and VPoO for an Exit Conference. No additional information was provided by the facility management, and the facility did not refute findings. NJAC 8:39-11.1, 11.2 (e)(1,2), 27.1(a)

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	07/09/2024

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 38327 Based on interviews, and record review, it was determined that the facility failed to ensure that the responsible physician supervising the care of residents conducted face-to-face visits and wrote progress notes at least once every sixty days from January 2024 through June 2024 according to the facility's policy and procedure. This deficient practice was identified for one (1) of 28 residents, Resident #134 was reviewed for physician visits and was evidenced by the following: On 6/24/24 at 11:39 AM, the surveyor observed Resident #134 seated in a wheelchair in the Therapy room (also known as the dining area) with other five residents for early lunch. The surveyor reviewed the hybrid (combination of paper and electronic) medical record for Resident #134. Resident #134's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to hypotension unspecified (low blood pressure), traumatic subdural hemorrhage (caused by a traumatic head injury) without loss of consciousness, cerebral infarction (also known as a stroke) due to embolism of a left posterior cerebral artery, unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hemiplegia (paralysis) and hemiparesis (muscle weakness) following cerebral infarction affecting right dominant side, other secondary hypertension (elevated blood pressure), depression unspecified, and anxiety disorder. The most recent Significant Change Minimum Data Set (SCMDS), an assessment tool used to facilitate the management of care, dated 3/28/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 09 out of 15, which indicated the resident had moderately impaired cognition. There was no documented evidence that the physician visited and examined Resident #134 at least every 60 days from January 2024 through June 2024. On 6/26/24 at 11:14 AM, the surveyor called the physician of the resident and the surveyor spoke to the receptionist of the physician's office. The receptionist informed the surveyor that the physician was not available and would let the physician know to call the surveyor for an interview. On 6/26/24 at 12:03 PM, the surveyor interviewed the Registered Nurse Coordinator (RNC) of the Peach unit (Behavioral unit). The surveyor asked the RNC what was the facility's protocol regarding the physician visit notes, and the RNC responded that he would get back to the surveyor. On that same date and time, the surveyor notified and showed to the RNC that the resident's visits notes for dates 01/25/24 (History and Physical) and 3/10/24 (Progress Notes) were both done by the Advance Practice Nurse (APN), and there were no further notes found in the resident's hybrid medical records. (continued on next page)

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	07/09/2024

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/28/24 at 11:29 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), [NAME] President of Operations (VPoO), and Director of Nursing (DON). The surveyor notified the facility management of the above findings and concerns. The surveyor asked the facility management if that was the facility's policy and practice that the primary physician does not write visit notes. The LNHA stated no, and that the physician should see the resident once every 60 days, the APN can come in between months and do the alternating visits and notes. A review of the facility's Physician Visits and Services Policy with a reviewed date of 01/2024 that was provided by the LNHA included that the attending physician shall visit the resident at least once during the 30 days following admission and/or as required by the resident's needs. The attending physician shall visit the resident in accordance with the resident's needs, but at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter and as needed. On 7/01/24 at 11:58 AM, the survey team met with the LNHA, DON, and VPoO for an Exit Conference. No additional information was provided by the facility management, and the facility did not refute findings. NJAC 8:39-23.2(d)

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	07/09/2024

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 39885 Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure a.) a non-certified Nurse Aide (NA) did not continue to work as an NA after the specified 120 days for one (1) of two (2) NAs reviewed during the Sufficient and Competent Nurse Staffing task (NA #1); and b.) there was a delineated policy and/or program in place for the hiring of non-certified NAs. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health memo dated April 21, 2023 sent to Nursing Homes included the following: On February 27, 2023, the Centers for Medicare and Medicaid Services (CMS) announced that all nurse aide emergency training waivers will terminate at the end of the Federal Public Health Emergency (PHE). The PHE is expected to end on May 11, 2023. At that time, all Temporary Nurse Aides (TNAs) hired prior to the end of the PHE and who have enrolled in a NATCEP program and completed the first 16 hours of training prior to May 11, 2023, must complete the NATCEP and pass the nurse aide written exam and the clinical skills competency exam by September 10, 2023. Nurse aides hired after the end of the PHE will have four months to complete a NATCEP program and pass the exams, as required by N.J.A.C. 8:39-43.1. The New Jersey Department of Health issues this memorandum to update facilities on the interpretation of the CMS guidance, P.L. 2021, c. 326, c. 368 and Executive Directive (ED) 20-004 (Revised July 6, 2022). Facilities are advised as follows: II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. On 6/26/24 at 9:50 AM, the surveyor randomly chose ten new hire employee files to review and requested the files from the Licensed Nursing Home Administrator (LNHA). On 6/27/24 at 12:00 PM, the surveyor reviewed the facility provided file of one of the new hired employees which revealed the following: -NA #1 had a date of hire of 01/30/24. -NA #1 had a competency report skills test dated 7/27/23. -NA #1 was terminated on 6/11/24. (continued on next page)

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	07/09/2024

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The time between NA #1's date of hire and termination date was greater than 120 days. On 6/28/24 at 9:08 AM, the surveyor interviewed the Business Office Manger (BOM) regarding the process for NA employment. The BOM stated that she reviewed the skills test to see if it was within 30-60 days since they passed it. She added that they could only work at the facility for 120 days from the skills test date. On 6/28/24 at 10:06 AM, the surveyor interviewed the Director of Nursing (DON) regarding the process for NA employment. The DON stated that they would make sure that the NA's skill test was within 120 days. She added that if they do not pass the test within 120 days then the NA would be removed from the schedule. On 6/28/24 at 10:09 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) for the facility's policy process for NA employment. On 6/28/24 at 12:06 PM, in the presence of the survey team, the surveyor notified the LNHA, DON and [NAME] President of Operations (VPoO) the concern that NA#1 worked at the facility for more than 120 days after their date of hire and their skills test. On 7/01/24 at 10:18 AM, in the presence of the survey team, the LNHA stated that the only policy for NA's was the Nurse Aide Orientation policy that was provided at an earlier time. On 7/01/24 at 11:11 AM, in the presence of the survey team, DON and the VPoO, the LNHA stated that NA #1 was no longer employed at the facility. The facility did not provide any additional information. A review of the facility provided policy titled, Nurse Aide Orientation with a reviewed date of 01/2024, included the following: Purpose and Policy: This facility is committed to ensuring newly hired Nurse Aides (NA) have the knowledge, skills and abilities to have their own assignment to function effectively in this facility. This facility has established a NA orientation program to help them fully utilize their capabilities. Procedures: 1. Newly hired NA's will take part in the facility general orientation program on the first day of employment which covers the policies of the facility. 2. All newly hired NA's will shadow a C.N.A. and undergo a competency evaluation covering core competencies which include, but not limited to: a. Bed bath b. Bed making occupied/unoccupied . p. Ambulation with assistance. (continued on next page)

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	07/09/2024

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The NA will be given an assignment after they have successfully demonstrated competency in the above skills. The policy did not include information regarding the requirement of becoming certified within 120 days or the NA hiring process. N.J.A.C. 8:39-43.1

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	07/09/2024

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39885 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the 24-hour staffing report was posted and in a prominent place within the facility readily accessible to the residents and the visitors. This deficient practice was evidenced by the following: On 6/24/24 at 9:00 AM and 6/25/24 at 8:55 AM, the surveyor entered the facility and observed that there was no Nursing Home Resident Care Staffing Report (NHRCSR) posted in the entrance area. On 6/25/24 at 9:37 AM, the surveyor interviewed the Receptionist regarding the posting of the NHRCSR. The Receptionist stated that the NHRCSR was usually posted on the wall behind her. The surveyor observed three sheet protectors that did not have any documents in them hanging on the wall. The Receptionist stated that the Staffing Coordinator (SC) would post them and that the last time she saw them posted was last week. On 6/25/24 at 9:44 AM, the surveyor interviewed the SC regarding the posting of the NHRCSR. The SC stated that she posted it daily and would try to post them by 9:30 or 10 am and that the night receptionist would discard them. On that same date and time, the surveyor notified the SC that the NHRCSR was not posted for the last two days. The SC stated that she was off yesterday. She added that she was having an issue with connection to the printer but could send it to admissions to print. The surveyor asked the SC who would post the NHRCSR in her absence. The SC stated that a colleague should print them out and the Director of Nursing (DON) or Licensed Nursing Home Administrator (LNHA) would post it. On 6/27/24 at 01:08 PM, in the presence of the survey team, the surveyor notified the LNHA, DON and VP of Operations (VPoO) the concern that 24-hour staffing report was not posted and in a prominent place within the facility readily accessible to the residents and the visitors. On 6/28/24 at 11:56 AM, in the presence of the survey team, LNHA and DON, the VPoO stated that the SC was off. The LNHA stated that he would post it if it was not posted and that staff were inserviced. The facility did not provide any additional information. A review of the facility provided policy titled, Posting Nurses Staffing Information with a revised/reviewed date of [DATE] included the following: 1. The required information that needs to be posted includes: Facility name Current date (continued on next page)

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	07/09/2024

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Census Total number of staff and actual hours worked per shift for: Registered Nurses; Licensed Nurses; Certified Nurse Aides 2. The facility needs to post nurse staffing information in a prominent place where it is accessible to residents and visitors. 3. The data should be clear, readable, up to date and current. 4. When listing the total number of staff and actual hours worked, the facility is required to reflect staff absences on each shift . A review of the facility provided policy titled, Facility Staffing Policy with a revised/reviewed date of [DATE] included the following: 8. The facility is responsible for posting nurse staffing as well as have it available upon request and retain it per regulatory requirements. N.J.A.C. 8:39-41.2 (a)(b)(c)

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	07/09/2024

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 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** 49078 Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication for one (1) of 28 residents reviewed. (Resident #67). The deficient practice was evidenced by the following: On 6/24/24 at 11:17 AM, the surveyor observed Resident #67 lying in bed. The resident agreed to speak with the surveyor. During the brief interview, the surveyor asked the resident if they can toilet themselves. The resident stated, no, the nurses aides come to assist them and change if needed. The surveyor reviewed Resident #67's electronic medical record (EMR) which revealed the following. Resident #67's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to type 2 diabetes (a disease where the body does not regulate blood sugar properly, anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues) and gastritis with bleeding (inflammation and irritation of the stomach lining that may bleed). The Medicare 5-day Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/12/24, reflected that the resident had a Brief Interview for Mental Status (BIMS), a tool used to screen and identify cognitive condition, score of 8 out of 15, which indicated that Resident #67 had moderately impaired cognition. Further review of the resident's Medicare 5-day MDS dated [DATE] revealed under section H the resident was described as always incontinent. A review of the resident's MDS Care Area Assessment (CAA) (triggered responses to items coded on the MDS specific to a resident's possible problems) revealed that the resident needed assistance for toileting and was always incontinent. It also revealed the analysis of findings that the resident had a long-standing condition of bladder incontinence and was on routine incontinence care. The resident's medication orders in the EMR included the following order: Tamsulosin Capsule 0.4 MG (milligram) (Tamsulosin HCL) (used to treat [redacted] who have symptoms of an enlarged prostate gland, which is also known as benign enlargement of the prostate or BPH) give one capsule by mouth one time a day for overactive bladder, with a start date of 5/09/24. Further review of Resident #67's AR did not reveal a diagnosis of BPH but did reveal a diagnosis of overactive bladder in a Physician's progress note dated 02/16/24 that was created on 02/26/24. The surveyor reviewed the manufacturer package insert for Tamsulosin. The section labeled Indications and Usage reflected, Tamsulosin is an alpha1 adrenoceptor antagonist indicated for treatment of the signs and symptoms of benign prostatic hyperplasia. (continued on next page)

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	07/09/2024

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 10:15 AM, the Licensed Nursing Home Administrator (LNHA) provided the survey team the pharmacy consultant recommendations binder which included reports from January 2024 through May 2024. On that same date and time, the surveyor reviewed the recommendations and did not observe any mention of Tamsulosin use for Resident #67. On 6/25/24 at 01:20 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) for the unit where Resident #67 resides. The surveyor asked the LPN/UM about the change in BIMS recently. The UM stated that the recent BIMS was done by the social worker and that Resident #67 has her days and may be an 8 on one week then might be a 3 on another week and can vary how they answer questions. On 6/27/24 at 10:10 AM, The surveyor interviewed the Consultant Pharmacist (CP) by telephone. The surveyor asked the CP if they would normally comment on the use of Tamsulosin for an unapproved use. the CP stated, sometimes. The CP had nothing further to add that was pertinent to this resident's use of Tamsulosin. On 6/27/24 at 12:42 PM, the surveyor requested, from the LNHA, in the presence of the survey team, any further documentation regarding the use and effectiveness of Tamsulosin in Resident #67. On 6/28/24 at 10:20 AM, the LNHA provided several Physician progress notes (PN) for Resident #67. Two of the notes, dated 5/27/24 and 6/13/24 were observed as being late entries, created 6/24/24, after survey entrance and surveyor inquiry, one note dated 01/20/23 and one note dated 02/16/24 observed as a late entry created 02/26/24. The note dated 02/26/24 revealed documentation by the attending physician that the resident has an overactive bladder, frequent urination and it is managed with Flomax (the brand name of Tamsulosin). Further review of the above documentation by nursing in the MDS and the Physician's PN showed that there were inconsistencies with regard to resident's incontinence condition. Furthermore, there were no documentation regarding use of Tamsulosin outside the manufacturer's approved indication or the benefit versus the risk in relation to the effectiveness. On 7/01/24 at 11:59 AM, the survey team met with the Director of Nursing, the LNHA and the [NAME] President of Operations. The surveyor discussed the concern with the documentation with the facility administrative team regarding the inconsistency in the documentation. No further documentation was provided regarding Resident #67. N.J.A.C. 8:39-11.2(b)

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	07/09/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49078 Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication administration observation on 6/26/24, the surveyor observed four (4) nurses administer medications to six (6) residents. There were 25 opportunities for error, and three (3) errors were observed which calculated to a medication administration error rate of 12%. This deficient practice was identified for two (2) of six (6) residents, (Resident #34 and Resident #132), that were administered medications by two (2) of four (4) nurses that were observed. The deficient practice was evidenced by the following: 1. On 6/26/24 at 8:31 AM, during the medication (med) administration observation, the surveyor observed the Licensed Practical Nurse #1 (LPN #1) preparing to administer medications (meds) to Resident #34. The surveyor observed the resident's Electronic Medication Administration Record (eMAR) which reflected an order for Colace oral capsule (a medication used to soften the stool), give one (1) capsule by mouth two (2) times a day for constipation. The order did not reflect a strength or dosage. The surveyor observed LPN #1 prepare one (1) tablet of Docusate (the generic equivalent to Colace) 100 mg (milligram). The surveyor asked LPN #1 how they knew that was the correct dose. LPN #1 stated that those were the only ones they use there. The Surveyor continued to observe LPN #1 administer meds to Resident #34. LPN #1 returned to the med cart to electronically sign the eMAR for the meds that were administered. The surveyor observed LPN #1 electronically sign by checking the box for Enoxaparin (an injectable medication used to prevent blood clots). The surveyor did not observe LPN #1 prepare or administer this med to resident #34. The surveyor asked LPN #1 why they were signing for that med. LPN #1 stated that they gave the Enoxaparin earlier, prior to the surveyor observation. The surveyor asked LPN #1 if they always sign for meds at times other than when they were administered. LPN #1 stated, no they do not. The surveyor asked LPN #1 if this was the only med that they administered earlier and signed after administering meds to another resident. LPN #1 responded, yes. 2. On 6/26/24 at 8:56 AM, during the med administration observation, the surveyor observed LPN #2 preparing to administer meds to Resident #132. The surveyor observed LPN #2 place the resident's oral meds in a plastic dose cup on top of the med cart and prepare a container of Glucerna (a nutritional supplement), Prostat (a protein supplement) and a cup of water. The surveyor then observed LPN #2 take the Glucerna, Prostat and water to the resident who was in the day room (a common area often used for recreation) while leaving the dose cup of other oral meds on top of the med cart unattended in the hallway. The surveyor asked LPN #2 if meds should be left on the med cart unattended. The LPN responded, no, but I wanted the resident to finish the Glucerna first. (continued on next page)

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	07/09/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 and 10:58 AM, the Licensed Nursing Home Administrator (LNHA)provided the facility's Policy and Procedure for Med Administration. The surveyor reviewed the policy. The policy reflected an effective date of 11/2010 and a reviewed date of 01/2024. The policy reflected on page 1 item 6, The individual administering meds must check the label to verify the right med, right dosage, right time and right method (route) of administration before giving the med. The policy reflected on page 2 item 12, The nurse administering the med must electronically sign, date and time the resident's eMAR by selecting 'Y' (yes) after giving each med. The nurse will then select the 'Save' button to finalize the administration of given meds before moving on to the next resident. The policy reflected on page 2 item 11, .No meds are kept on top of the cart. The surveyor reviewed the med information sheet for Colace capsules (docusate sodium). The information reflected that Colace capsules are available in multiple strengths, including 50 mg, 100 mg and 250 mg. The information also reflected that the daily dose can be from 50 mg to 300 mg per day. On 6/27/24 at 10:10 AM, the surveyor interviewed the consultant pharmacist (CP) by phone and asked if they perform Med Pass observations. The CP responded yes. The CP stated that she was aware of the med pass observation results and was usually aware of what was happening in the facility. The surveyor asked the CP if the order for Colace was appropriate and if LPN #1 signed meds appropriately. The CP responded that the provider pharmacy should have addressed the incorrect Colace order. The CP offered no further information pertinent to the med pass observation. On 6/27/24 at 12:42 PM, the surveyor, in the presence of the survey team, discussed the Med Pass Observation concerns with the Director of Nursing, the LNHA, and the [NAME] President of Operations. No further information was provided to the surveyor. N.J.A.C 8:39-29.2 (d)

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	07/09/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49078 Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure that medications were stored and labeled appropriately. This deficient practice was identified in one (1) of five (5) medication carts inspected and two (2) of two (2) medication storage rooms inspected on three (3) of four (4) units. This deficient practice was evidenced by the following: On [DATE] at 10:35 AM, the surveyor inspected the Pink Unit Medication (med) Room. The surveyor accessed the med refrigerator located in the med room. The surveyor observed an unlabeled amber plastic vial in the refrigerator. Upon inspection of the amber vial, the surveyor observed an unlabeled vial of Retacrit (a med used to increase red blood cell production) located inside. The surveyor opened an under counter drawer in the med room and observed a Novolin R Flex Pen (a self-contained device used to administer insulin, a med used to treat high blood sugar) with a pharmacy label and dispensed date of [DATE]. At that same time, the surveyor interviewed the Assistant Director of Nursing (ADON) who was present on the unit if they thought the medications (meds) were stored properly. The ADON stated that the insulin pen should have been in the refrigerator and the Retacrit should have had a label identifying who it was prescribed to. The surveyor then inspected a room labeled Pharmacy Room on the Pink Unit. The surveyor observed the med refrigerator which contained vaccines. The surveyor also observed a temperature log on the outside of the refrigerator that reflected documentation of the refrigerator temperature once per day. The surveyor observed a bag of medical supplies that contained individually wrapped tubes labeled BD Viral transport tubes. The wrapper reflected an expiration date of [DATE]. The surveyor asked the ADON to check the expiration date. The ADON agreed that the tubes were expired. The surveyor inspected the High Side med cart on the Blue Unit. The surveyor observed one (1) foil package of Ipratropium/Albuterol nebulizer solution (an inhaled med used to treat asthma) that contained 1 vial and was not dated when it was opened. The surveyor asked the med nurse assigned to the med cart if there was a date on the opened package or box and what were there any manufacturer instructions after opening. The med nurse stated there was no date and the package reflected instructions to dispose one (1) week after opening. On [DATE] at 12:42 PM the surveyor, in the presence of the survey team, discussed the Med Storage and Labeling concerns with the Director of Nursing, the Licensed Nursing Home Administrator (LNHA), and the [NAME] President of Operations. The facility did not provide requested policy for Med Storage. The facility did not provide any further pertinent information regarding med storage and labeling. A review of the facility's Medication Administration Policy that was provided by the LNHA reflected on page 2 item 8, The expiration date on the med label must be checked prior to administering. When opening a multi-dose container, the date shall be recorded on the container. On page 2 item 9, Med and Treatment carts are checked by ,d+[DATE] nurse for any discontinued or expired meds. (continued on next page)

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	07/09/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the CDC (Centers for Disease Control and Prevention) guidelines for vaccine storage which reflected for Monitoring Vaccine Temperatures, To ensure the safety of vaccines, the storage unit minimum and maximum temperatures should be checked and recorded at the start of each workday. If using that does not display minimum and maximum temperatures, then the current temperature should be checked and recorded a minimum of two times (at the start and end of the workday). The surveyor reviewed the manufacturer packaging and labeling for Ipratropium/Albuterol nebulizer solution. The product packaging and labeling reflected under Storage Conditions: Once removed from the foil pouch, the individual vials should be used within one week. The surveyor reviewed the manufacturer information sheet for Novolin R Flex Pen. The manufacturer information sheet reflected under 16.2 Table 2: Storage Conditions and Expiration Dates for Novolin R. Single patient use Flex Pen, storage at room temperature either in use (opened) or not in use (unopened) is 28 days. NJAC 8:,d+[DATE].4(d)(g)

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	07/09/2024

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 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** 45449 COMPLAINT: NJ#172727 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete, available, and readily accessible medical records. This deficient practice was identified for three (3) of the 31 residents reviewed (Residents #86, #134, and #196). This deficient practice was evidenced by the following: 1. On 6/24/24 at 9:15 AM, during an interview with the surveyor, regarding the process for reportable, the Licensed Nursing Home Administrator stated that when an incident occurred, he was supposed to be notified with the Director of Nursing (DON) immediately. We also notify the physician, family, state agency and the ombudsman's office for a reportable. The LNHA also stated that determining the cognitive level such as the BIMS (Brief Interview for Mental Status) score, when a resident was not able to explain, that needs to be investigated and depending on what was learned will depend on if it should be a reportable or not. All staff that sees an abuse, incident or accident must report to the nurse, or supervisor. Multiple parties investigate such as the Unit Manager (UM), the Social Services, the DON and LNHA we are all in the process for the investigation. Sometimes the UM and Social Worker (SW) will gather information and we review those. Any questions remained unanswered, we follow up and seek, we have the initial investigation and follow-up with the aid, family member etc. At that time, the LNHA stated that the initial investigation consisted of resident statements, witnesses, assessments, skin checks, neuro checks, pain assessment, range of motion, review of the CCTV (closed circuit television; video surveillance) of the common areas, courtyard outside, nursing station and day room. I don't know how far back it [CCTV] goes. At that time, the LNHA stated that the Summary and conclusion were done within five days of the incident/accident/ abuse. At that time the surveyor submitted the requests for the Investigative File for Resident #196 and #86. A review of the reportable event record/report (FRE; Facility Reported Event) reflected that it was called in on 4/04/24 at 9:47 PM, with an event date of 4/04/24 at 9:15 PM. The incident was reported as an allegation of resident-to-resident altercation. The event was description included but was not limited to the following: Resident #196 was walking down the hallway by Resident # 86, then was hit by Resident #196 on the right side the head without provocation. Staff in the area immediately intervened separating both residents preventing further harm to Resident #86, who sustained no injury or falls from the incident. (continued on next page)

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	07/09/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #196's diagnoses included schizoaffective disorder, mood disorder, bipolar disorder with psychotic features, anxiety (mental disorders) The resident had a BIMS score of 15, which indicated the resident was cognitively intact. Resident #86 diagnoses included mood disorder, psychotic disorder, and anxiety (mental disorders). Review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care dated 5/18/24, reflected BIMS score of five (5) out of 15 which indicated the resident had severe cognitive impairment. A review of the facility's investigative folder included the following under Summary and Conclusion: The investigation summary included review of staff statements, CCTV. The CCTV feedback showed Resident #86 walking towards the nurses' station speaking with an aide, then Resident #86 began to walk away from the nurses' station at around 9:15 PM, Resident #196 was walking in the same direction. Resident #86 did not address Resident #196, nor was anything spoken in between both residents. Resident #196 stepped toward Resident #86 and struck him/her one (1) time at on the left side of the head. Resident #196 provided no warning to staff or residents about his intent to hit someone and was unprovoked. The staff that were actively monitoring the hallway, acted immediately to ensure separation of resident and no additional aggression was witnessed by either resident. Resident #86 did not fall, nor did he suffer injury from this accident; signed by the LNHA. A review of the nursing progress notes (PN) for Resident #196 included the following: Incident #1 On 4/04/24 at 18:27 [6:27 PM], the nurse documented that Resident #186 had a verbal argument with another patient. Resident #186 became anxious after being told that he/she had to wait until 7:30 PM which was the next scheduled of the smoke break. The resident went to the hallway and pulled the smoke alarm and then went to his/her room and threw furniture around. Incident #2 On 4/04/24 at 21:10 [9:10 PM], the nurse documented that Resident #196 asked the aid for a diaper change. The aid stated that she would in a few minutes when she completed her tasks. Resident #196 did not want to wait, and pulled the fire alarm, and threw a cart that had food and drinks on it and made a mess in the day room. Incident #3 (associated with the FRE) (continued on next page)

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	07/09/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/04/24 at 21:41 [9:41] the nurse documented that after the resident pulled the fire alarm the nursing supervisors were called in to the unit. In front of both supervisors and this nurse, the patient ripped multiple picture frames off the walls, punched the nurses station Plexiglas, and punched another patient completely unprovoked. The Physician was made aware of the situation and ordered to have the resident sent out for psychiatric evaluation. 911 was called and EMS arrived but refused to transport the resident because the resident would not cooperate in the ambulance, and they felt it would be a risk to their safety. Crisis intervention was contacted and at this time we are waiting for another ambulance to arrive. Patient refused to have his vital signs taken at this time. The surveyor reviewed the facility provided investigative folder, the hybrid (combination of paper and electronic) medical records and staff statements. The medical records did not show evidence that the resident was de-escalated, redirected, or monitored for safety. On 6/25/24 at 12:18 PM, during an interview with the surveyor, the Registered Nurse/Unit Coordinator (RN/UC) stated that the nurse on duty for incident #1 was a good nurse. At that time, the surveyor and the RN/UC reviewed Resident #186's electronic Medical Record together. The RN/UC confirmed that the record did not show how the abuse on 4/04/21 at 9:15 PM was prevented when there were two incidents on the same day that began at 6:27 PM followed by 9:41 PM. At that time the surveyor discussed the concern and the RN/UM stated that he would investigate the matter and inform his supervisors. On 6/26/24 at 9:43 PM, during a meeting with the DON, RN/UM, the LNHA provided three new signed statements that addressed what was done in between incidents. At that time, the LNHA and the RN/UM acknowledged that the statements were collected yesterday (6/25/24) and was not part of the original investigative summary folder. At that time, the surveyor asked the LNHA, how long should the statements be gathered, for the root cause analysis that was required to arrive at the result of the resident to resident abuse investigation. At that time, the LNHA stated no excuse why it was not immediately done. On 6/26/24 at 12:03 PM, in the presence of the surveyors, the UM and the LNHA confirmed the statements were obtained yesterday (6/25/24) only to show that there was a de-escalation of what the nurses described as anxious behavior. A review of the provided policy and procedure for the Abuse Prevention Program, dated/revised on 02/08/23, under Part VII Investigation, subsection Procedure included the following: The results of the investigation are reported within five days of the incident. Reference (continued on next page)

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	07/09/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	S483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken 38327 2. On 6/24/24 at 11:39 AM, the surveyor observed Resident #134 seated in a wheelchair in the Therapy room (also known as the dining area) with other five residents for early lunch. The surveyor reviewed the hybrid medical record for Resident #134. Resident #134's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to hypotension unspecified (low blood pressure), traumatic subdural hemorrhage (caused by a traumatic head injury) without loss of consciousness, cerebral infarction (also known as a stroke) due to embolism of a left posterior cerebral artery, unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hemiplegia (paralysis) and hemiparesis (muscle weakness) following cerebral infarction affecting right dominant side, other secondary hypertension (elevated blood pressure), depression unspecified, and anxiety disorder. The most recent Significant Change Minimum Data Set (SCMDS) dated [DATE], reflected a BIMS score of 09 out of 15, which indicated the resident had moderately impaired cognition. A review of the hybrid medical records reflected there was no documented evidence that the physician visited and examined Resident #134 at least every 60 days from January 2024 through June 2024. The Advance Practice Nurse (APN) had a printed documented History and Physical (H & P) dated 01/25/24 and a Progress Note (PN) dated 3/10/24 that was in the paper chart of the resident. Further review of the resident's hybrid medical records showed that there were no other PN from the physician and the APN except for the 01/25/24 and 3/10/24 of the APN. On 6/26/24 at 12:03 PM, the surveyor interviewed the Registered Nurse Coordinator (RNC) of the Peach unit (Behavioral unit). The surveyor asked the RNC what was the facility's protocol regarding the physician visit notes, and the RN responded that he would get back to the surveyor. On that same date and time, the surveyor notified and showed to the RNC that the resident's visits noted for dates 01/25/24 and 3/10/24 were both done by the APN, and there were no further notes found in the resident's hybrid medical records. At that same time, the surveyor asked the RNC if physician and APN notes should be available and easily accessible as part of the resident's medical records, and the RNC responded yes. On 6/27/24 at 12:41 PM, the survey team met with the LNHA, [NAME] President of Operations (VPoO), and DON. The surveyor notified the facility management of the above findings and concerns. (continued on next page)

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	07/09/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 at 8:59 AM, the surveyor reviewed the paper chart of Resident #134 in the Peach unit nursing station. There were a total of 12 PN (not previously seen in the chart) and revealed the following: Service Date Created and Provider Electronically signed 6/19/24 6/20/24 at 01:20 PM APN 5/14/24 6/24/24 at 04:31 PM APN 4/11/24 6/24/24 at 01:29 PM APN 3/07/24 3/14/24 at 07:29 AM APN 3/06/24 3/14/24 at 05:34 AM APN 3/04/24 3/14/24 at 07:27 AM APN 2/29/24 3/14/24 at 05:40 AM APN 2/28/24 3/14/24 at 05:39 AM APN 2/25/24 3/14/24 at 05:32 AM APN 2/24/24 3/14/24 at 05:34 AM APN 2/16/24 3/04/24 at 01:53 PM APN 1/26/24 2/04/24 at 01:39 AM APN On 6/28/24 at 11:29 AM, the survey team met with the LNHA, VPoO, and DON. The DON stated and acknowledged that the above PN was not on the physical chart of the resident not until the surveyor's inquiry. She further stated that the facility management spoke to the APN about the visit notes and that was why all PNs were in the chart now. The facility management acknowledged that the visit notes of the APN should have been completed on time and readily accessible to the resident's medical records. On 7/01/24 at 11:58 AM, the survey team met with the LNHA, DON, and VPoO for an Exit Conference. No additional information was provided by the facility management, and the facility did not refute findings. NJAC 8:39-35.2 (d)(6)

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	07/09/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46049 REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices to prevent and control the spread of infection: a) improper storage of a urinary drainage bag for one (1) of two (2) residents (Resident #103), reviewed for urinary catheter care, b) performing hand hygiene during a wound treatment observation by one (1) of one (1) nurse (Licensed Practical Nurse), and c) doffing (taking off) of Personal Protective Equipment (PPE) when exiting an Enhanced Barrier Precaution (EBP) room during a wound treatment by one (1) of one (1) nurse. This deficient practice was evidence by the following: 1. On 6/24/24 at 10:49 AM, the surveyor observed Resident #103 with their face only visible from behind the privacy curtain drawn. Resident #103 greeted the surveyor and for the surveyor to approach their bedside. Resident #103 was observed lying in bed, alert and verbally responsive. The surveyor observed the resident's incontinent brief was open, their pants were below their knees, and the resident had a urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag). The resident's urinary catheter was connected to a large urinary drainage bag, which was resting on top of the resident's mattress at the foot of their bed. The large drainage bag was not full and cloudy, yellow colored urine was draining from the catheter into the large urinary drainage bag. Resident #103 stated staff was helping them, were to return and could not say how much time had passed. The resident was agreeable for the surveyor to follow up with nursing staff. The surveyor did not observe any staff or cart near the resident's room. On 6/24/24 at 10:50 AM, the surveyor approached the Licensed Practical Nurse (LPN) who was seated at the nurses' station. The LPN accompanied the surveyor to Resident #103's room. Resident #103's incontinent brief remained open, and their urinary drainage bag on the foot of the resident's mattress. The LPN stated that Certified Nurse Aide (CNA) provided hygiene care to the resident and was to let her know when she was done, to provide wound treatment to the resident's sacral wound. The LPN stated she would do the resident's wound dressing and assist resident. On 6/24/24 at 10:58 AM, the surveyor interviewed the CNA who was assigned to Resident #103. The CNA had been in another room assisting a resident. The surveyor discussed with the CNA the observation of Resident #103 in bed. The CNA stated she pulled the privacy curtain prior to exiting room and stated that she informed the LPN that the resident was ready for their wound dressing to be changed. The CNA stated she did not realize she left the resident's urinary drainage bag on the foot of the mattress and acknowledged it should not have been left there. The CNA stated the drainage bag should be in a privacy bag hanging on the side of the resident's bedframe. (continued on next page)

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	07/09/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/24 at 11:15 AM, the surveyor interviewed the LPN about the observation of the resident's urinary drainage bag. The LPN stated the resident's urinary drainage bag was supposed to be hanging by gravity below the resident's bladder level. The LPN further explained that the drainage bag was placed on the mattress at the foot of the bed because the resident was going to be transferred out of the bed with a hoyerlift (an electric patient lift to safely transfer patients). She acknowledged that the urinary drainage bag should not have been placed on the mattress and it should have been moved at the time of the resident being transferred out of bed. On 6/24/24 at 11:20 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) about the observation of Resident #103's drainage bag. The RN/UM stated the urinary catheter drainage bag should be hanging by gravity. She further explained that while a resident was in bed, the drainage bag should be hanging by gravity from the bed frame positioned below the resident's bladder level as to allow the urine to drain freely. The RN/UM stated the urinary drainage bag should not have been on the foot of the resident's mattress even if the resident was being transferred out of bed. On 6/27/24 at 12:41 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the [NAME] President of Operations (VPoO) of the above concerns. There was no verbal response from the facility at this time. On 6/28/24 at 11:30 AM, the LNHA, the DON, and the VPoO met with the survey team. The VPoO acknowledged the drainage bag should not have been on the resident's mattress and provided staff with in-service education for catheter care. The surveyor reviewed the facility policy titled, Catheter Care, Urinary with a reviewed date of 01/2024. Under catheter care it read, .3. The urinary drainage bag must always be positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder . 2. On 6/27/24 at 10:15 AM, the surveyor observed the LPN perform a sacral wound treatment for Resident #103. The LPN informed the surveyor that Resident #103 was on EBP, which required providers and staff to don (put on) gown and gloves when performing high-contact resident care activities, such as wound care. The surveyor observed signage at door which indicated the resident was on EBP precaution. The LPN and CNA, who was to assist the LPN with the positioning of the resident during the wound treatment, donned gown, and gloves prior to entering the resident's room. The LPN took germicidal disposable wipes and cleaned the bedside table by the resident's bed. The LPN disposed the used wipe in the garbage bin, removed her gloves, and disposed it in the garbage bin. The LPN went to the bathroom sink to wash her hands. She turned on the faucet, applied soap to her hands first, then wet her hands with the running water, lathered her hands for 22 seconds, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. On 6/27/24 at 10:27 AM, after the LPN set up a field with the wound treatment supplies on the resident's bedside table, the surveyor observed the LPN wash her hands at the sink. She turned on the faucet, applied soap to her hands first, then wet her hands with water from the sink, lathered her hands for 21 seconds, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. (continued on next page)

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	07/09/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LPN applied new gloves, removed the wound dressing covering the resident's sacral wound and removed the packing dressing from the wound bed with a tongue depressor. She disposed of the old dressing in the plastic garbage bag attached to the bedside table. She did not remove her gloves, opened two normal saline solution (NSS) vials removing the tops and placed the vials back on the supply field of the bedside table. The LPN removed her gloves, did not wash her hands, and applied new gloves. She then picked up the two NSS vials, applied the NSS to 4x4 gauzes, and cleansed the wound. On 6/27/24 at 10:31 AM, the LPN removed her gloves, did not wash her hands, opened the door of the room, and retrieved gloves from the top of the treatment cart outside doorway of the room. She returned to the room, placed the gloves on the supply field on the bedside table and then closed the room door. The LPN washed her hands at the sink. She turned on the faucet, applied soap to her hands first, then wet her hands with water from the sink, lathered her hands for 24 seconds, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. The LPN applied new gloves, then applied the ointment medication and calcium aliginate (an absorptive dressing) to the wound bed. The LPN with gloves retrieved a marker, wrote the date and time on the bordered dressing on the bedside table. She lifted her PPE gown with one hand and with the other hand placed the marker into her jacket pocket. She removed her gloves, did not wash her hands, and applied new gloves. On 6/27/24 at 10:37 AM, the LPN cleaned the supply field and disposed items in the plastic garbage bag. She tied off plastic garbage bag, removed gloves, and stated to the surveyor I'm going to throw this out in the soiled utility room. The surveyor observed the LPN wearing a PPE gown and holding the plastic garbage bag walk out of the room and down the hallway of the unit. On 6/27/24 at 10:39 AM, the surveyor observed from the doorway of the resident's room, the LPN walking back toward the room with the PPE gown balled up in her right hand. She stated to the surveyor I'm not supposed to walk in the hallway with this [showing PPE gown in hand] and explained that there was a red bin in the room to throw the gown away before exiting room. She threw the gown away in the red bin of the room. On 6/27/24 at 10:50 AM, the surveyor interviewed the LPN after the wound treatment about hand hygiene. She stated the steps for hand hygiene were to open the faucet, apply soap to hands, then wet hands, scrub hands, dry hands with paper towel, and then when hand are dried use another paper towel to turn off the faucet. The LPN replied to surveyor when asked about the sequence of applying soap prior to wetting hands, that it was the appropriate sequence and to not get the soap dispenser wet with water. The surveyor asked the LPN about hand hygiene when changing gloves. The LPN stated when changing or removing gloves hand hygiene should be performed. The surveyor discussed observations during the wound treatment when hand hygiene was not performed. She replied she was trying to save time and get the wound treatment done. The surveyor discussed observation of wearing PPE gown in the hallway. The LPN stated she should not have been in the hallway wearing the used PPE gown and it should have been thrown out in the red bin of the room prior to exiting room. (continued on next page)

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	07/09/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 11:03 AM, the surveyor interviewed the RN/UM about the wound treatment observation. The RN/UM demonstrated hand hygiene and stated hands should be wet first prior to applying soap. RN/UM stated that when changing gloves hand hygiene should be performed and PPE gowns should not be worn in the hallway. On 6/27/24 at 11:40 AM, the surveyor interviewed the Infection Preventionist (IP) about the wound treatment observation. The IP stated the steps of hand hygiene were to turn on the water faucet, wet hands, apply soap, scrub hands at least 20-30 seconds, rinse, dry hands with paper towel, and use another paper towel to turn off faucet. IP stated when changing gloves hand hygiene was to be performed. IP stated applying soap then wetting hands was not the appropriate sequence and hand hygiene should have been performed when the nurse changed her gloves. The IP continued that PPE should be disposed of prior to exiting the room and not worn in the hallway. The IP stated she would provide in-service education to the LPN. On 6/27/24 at 12:41 PM, the surveyor informed the LNHA, the DON, and the VPoO, of the above concerns observed during the wound treatment. There was no verbal response by the facility at this time. On 6/28/24 at 11:30 AM, the LNHA, the DON, and the VPoO met with the survey team. The VPoO stated wound care and hand hygiene competency was completed with the LPN and in-service education was being provided to all nursing staff. There was no additional information provided by the facility. A review of the facility's policy titled Handwashing/Hand Hygiene with a reviewed date of 6/28/2024, under Guidelines: Hand hygiene will be performed by staff as follows it read: .On entering and leaving an isolation room .Before and after contact with wounds .Before gloving and after gloves are removed . Under Hand Washing Procedure it read, Turn on water and adjust temperature .wet hands and wrist thoroughly .apply soap to hands .Rub hands briskly, pay attention to areas between the fingers, for at least 20 seconds . A review of the facility's policy titled Infection Control- Standard Precautions, EBP and Transmissions Based Precautions with last reviewed/revised date of 3/22/24, documented that CDC (Centers for Disease Control and Prevention) guidelines were the primary resource for determining the type of precaution and duration of isolation. The policy did not further address doffing of PPE when exiting EBP rooms. N.J.A.C. 8:39-19.4

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	07/09/2024

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 46049 Based on the interview and review of pertinent facility documents, it was determined that the facility failed to ensure have an Infection Preventionist (IP) dedicated solely to the infection prevention and control program (IPCP) who worked at least part-time and had completed specialized training in infection control and prevention for one (1) of two (2) staff. According to the NJ Executive Directive 21-012 (revised 12/22/22) included The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPCP by establishing or revising the infection control plan, annual infection prevention and control program risk assessment, and conducting internal quality improvement audits. According to the CMS QSO-22-19-NH Memo dated 6/29/22 and Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety dated 6/29/22, effective date on October 24, 2022 Overview of New and Updated Guidance, Summary of Significant Changes, included that in Infection Control, requires the facilities to have a part-time IP. While the requirement is to have at least a part-time IP, the IP must meet the needs of the facility. The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. IP's role is critical to mitigating infectious diseases through an effective infection prevention and control program. IP specialized training is required and available. On 6/24/24 at 10:04 AM, during entrance conference, the Licensed Nursing Home Administrator (LNHA) informed the Team Coordinator (TC) the current IP was full-time and started working in the facility at the beginning of this year. The TC requested the LNHA for the IP timeline since the last recertification survey. On 6/28/24 at 10:05 AM, the surveyor interviewed the LNHA about the IP timeline. The LNHA stated he started working in the facility in May 2023 and at the time there was no IP. The LNHA stated there were ongoing attempts to recruit and hire without success. The LNHA acknowledged they did not have an IP in the facility from May 2023 until the current IP started working in January 2024. The surveyor asked the LNHA who was responsible for overseeing the IPCP in the facility during the time there was no IP. The LNHA replied that the Director of Nursing (DON) was responsible for the IPCP and that he assisted with the reporting of data to outside agencies such as the New Jersey Department of Health. A review of the timeline provided by the LNHA revealed the previous IP, last day of employment at the facility was 4/22/2023. The current IP began working on 01/25/2024 at the facility. On 6/28/24 at 11:30 AM, the surveyor informed the LNHA, DON and [NAME] President of Operations (VPoO) of the concern that there was no IP working at the facility from May 2023 until when the current IP was hired in January 2024. Additionally, the full-time DON, was responsible for the IP role which was to be at least a part-time position. (continued on next page)

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	07/09/2024

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/01/24 at 9:46 AM, the TC interviewed the LNHA regarding the facility's Quality Assurance and Performance Improvement (QAPI) plan. The TC asked about two (2) of three (3) QAPI meeting quarters there was no IP present. The LNHA stated there was no on-site IP at the time. The TC asked how infection reports were being communicated for QAPI meetings. The LNHA replied that statistics data for COVID-19 were reviewed and he could not further explain what other infection control reports were reviewed. On 7/01/24 at 11:09 AM, the LNHA, DON, and VPoO met with the survey team. There was no additional information provided by the facility. The surveyor reviewed the facility's policy titled Infection Prevention and Control Program with an effective date of 9/12/2017. Under Policy it read, .7. The Infection Prevention and Control Program shall be conducted in accordance with all applicable federal and state rules and regulations, accrediting body standards, as well as nationally recognized infection prevention and control practices and guidelines .9. There shall be a collaboration between the Infection Preventionist and all departments to identify any HAI (Hospital Acquired Infection) trends or patterns that may occur, as well as identification of opportunities to improve outcomes in the reduction and control of infections . The surveyor reviewed the facility's policy titled Surveillance Plan with an effective date of 9/15/2017 read under Procedure, 1. The Infection Preventionist(s) shall have overall responsibility for the Surveillance Plan . The qualifications and job responsibilities of the Infection Preventionist were outlined in the Infection Preventionist Job Description. The position summary read The Infection Disease Preventionist is an RN (Registered Nurse), with a BSN (Bachelor of Science in Nursing) preferred, that performs all nursing functions related to Infectious Disease prevention. These include but are not limited to surveillance, data collection, assessment, teaching, and policy development. NJAC 8:39-19.1(b)

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	07/09/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on interviews, record review, and review of other pertinent provided facility documents, it was determined that the facility failed to ensure that a.) each resident was offered influenza and pneumococcal immunizations, b.) education was provided regarding the benefits and potential side effects of the immunizations, c.) resident or representative has the opportunity to refuse immunizations unless the immunization was medically contraindicated or the resident had been immunized. This deficient practice was identified for one (1) of five (5) residents, Resident #134, reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 6/24/24 at 11:39 AM, the surveyor observed Resident #134 seated in a wheelchair in the Therapy room (also known as the dining area) with other five residents for early lunch. The surveyor reviewed the hybrid (combination of paper and electronic) medical record for Resident #134. Resident #134's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to hypotension unspecified (low blood pressure), traumatic subdural hemorrhage (caused by a traumatic head injury) without loss of consciousness, cerebral infarction (also known as a stroke) due to embolism of a left posterior cerebral artery, unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hemiplegia (paralysis) and hemiparesis (muscle weakness) following cerebral infarction affecting right dominant side, other secondary hypertension (elevated blood pressure), chronic systolic (congestive) heart failure, depression unspecified, and anxiety disorder. The most recent Significant Change Minimum Data Set (SCMDS), an assessment tool used to facilitate the management of care, dated 3/28/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 09 out of 15, which indicated the resident had moderately impaired cognition. The SCMDS revealed that the resident did not receive the influenza and pneumococcal vaccines because it was offered and declined. A review of the Immunization tab in the electronic medical record (EMR) showed that there was no documentation about the influenza and pneumococcal vaccines. There was no documented evidence that the immunizations were offered and declined. The Miscellaneous tab in the EMR revealed a hospital records with a printed date of 02/06/24 that showed: Influenza vaccine this season?-refused Pneumococcal vaccine ever?-unsure A review of the personalized care plan (CP) showed that there was no focus CP, goals, or interventions about the immunizations or vaccines status of the resident. (continued on next page)

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	07/09/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the hybrid medical records showed that there was no documentation from the facility that the influenza and pneumococcal vaccines were offered and declined. There was no documentation that the education was provided to the representative about the benefits and potential side effects of the vaccines. Also, there was no documentation that the representative was provided an opportunity to refuse the vaccines and no documentation that the vaccines were contraindicated and previously received. On 6/26/24 at 10:46 AM, the surveyor interviewed the Registered Nurse Coordinator (RNC) of the Peach unit (Behavioral unit). The surveyor asked the RNC regarding the immunization and where it was documented that the resident received or declined influenza and pneumococcal vaccines. The RNC stated that it should be documented in the EMR in the Immunization tab. At that same time, the surveyor showed the RNC the Immunization tab of the resident wherein there were no influenza and pneumococcal vaccines documented except for TB (tuberculin) test results and COVID vaccinations. The RNC then stated that he would get back to the surveyor and he would ask the Infection Preventionist Nurse (IPN). On 6/26/24 at 12:03 PM, the RNC informed the surveyor in the presence of the survey team that the resident's representative (RR) told him (RNC) that the resident was probably vaccinated at the previous facility. The RNC stated that he called the RR today to verify the resident's immunization status. On that same date and time, the surveyor then asked the RNC what was the facility's protocol and policy with regard to offering vaccines to the resident. The RNC stated that it was the facility's policy and protocol to offer vaccines including influenza and pneumococcal to all residents upon admission, and quarterly. The RNC was not able to provide and show documentation that the vaccines were offered from admission and the most recent quarterly MDS. At that same time, the RNC further stated that he was still waiting for RN/Unit Manager #1 (RN/UM#1) from the Pink unit if the vaccines were offered prior to transferring the resident to the Peach unit. On 6/27/24 at 8:14 AM, the surveyor interviewed the IPN in the Peach unit. The IPN informed the surveyor that she started working in the facility end of January 2024 and there was no IP at that time she started as an IPN, and unsure when the last IP worked in the facility. The IPN stated that she was responsible for tracking the immunization records of staff and residents. She further stated that she gathered information from the records of the resident. The IPN also stated that when the resident comes in for admission, the receptionist will page or notify the IPN of the admission Monday through Friday when I'm here, the IPN check the records for immunization of new admit and document it in the Immunization tab of EMR. On that same date and time, the IPN informed the surveyor that as per facility policy and protocol, influenza vaccine was being offered during flu season. The IPN acknowledged that flu season was from October through March. She further stated that the facility offers pneumococcal vaccine if the resident has not received the vaccine. The IPN also stated that the consent should be gathered from the resident or RR, and documented in the Immunization tab and IDT (Interdisciplinary) notes in the EMR. (continued on next page)

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	07/09/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, the surveyor asked the IPN if there was a form the facility used to offer, consent, and decline the vaccines, and the IPN responded that there was no form. The surveyor then notified the IPN of the above findings and concerns. The IPN stated that the information regarding the resident's immunization for influenza and pneumococcal should have been documented and it should have been offered. Furthermore, the surveyor asked the IPN if she was responsible for tracking influenza and pneumococcal immunization records. The IPN said yes, but the immunization tracking was for COVID-19 and influenza, and there were none for pneumococcal. The surveyor asked the IPN why the pneumococcal was not being tracked, and the IPN did not respond. The surveyor then asked for the tracking log for the vaccinations of the residents in the facility and she stated that she would get back to the surveyor. On 6/27/24 at 8:25 AM, the surveyor observed Resident #134 seated in a wheelchair in the Therapy room with other residents, and RN/UM#2. RN/UM#2 was the UM in the Peach Unit. At that time, the surveyor interviewed RN/UM#2 when she left the Therapy room when another nurse stepped in to watch the room. RN/UM#2 informed the surveyor that it was the responsibility of the admitting nurse to check, verify, and document in the Immunization tab in the EMR the immunizations of the resident including influenza and pneumococcal. She stated that the admitting nurse would check the hospital records for immunization if there was none in the record, the nurse would have to ask the resident or RR for the history of vaccinations. She further stated that if the resident or RR did not have or was unsure, the facility's responsibility was to offer the vaccines and document the information and the refusal in the Immunization tab and IDT notes in the EMR. The surveyor asked if there was a consent form for the immunization, and RN/UM#2 stated yes, there's a form on paper. The surveyor then asked RN/UM#2 to provide a copy of the consent form and she stated that she would get back to the surveyor. At that same time, the surveyor notified RN/UM#2 of the above findings and concerns. RN/UM#2 stated that she was unaware that the RR was called by RNC yesterday, to verify the vaccination status of the resident. She further stated that she thought this was done before and was documented in the IDT notes, she also stated that she would verify it with the RNC. On 6/27/24 at 8:32 AM, RN/UM#2 informed the surveyor that there was no consent form for the refusal of vaccinations. On 6/27/24 at 9:01 AM, the IPN in the presence of the survey team informed and showed to the surveyor the copy of Transmission Based Precautions (TBP) log dated 6/25/24, and IPN stated the TBP forms was where the immunization status of their residents was being tracked. The IPN showed that influenza and COVID were being tracked but not the pneumococcal vaccination. At that same time, the surveyor asked the IPN if she should track the pneumococcal vaccination status of their residents, and the IPN responded that she should track them as well. She further stated that if she needed the list of residents with their pneumococcal vaccine she could just print it from EMR. The surveyor then asked how she would know who needed to offer and who was due for pneumococcal vaccines, the IPN did not respond. The IPN also stated that she would get back to the surveyor to provide a copy of the IDT notes that the influenza and pneumococcal vaccines were offered and declined for Resident #134. (continued on next page)

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	07/09/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the provided TBP log revealed that Resident #134 was on the list, but the influenza log was blank (no information if it was offered and declined). On 6/27/24 at 12:25 PM, the MDS Coordinator (MDSC) in the presence of the RNC provided a copy of the hospital records when the resident was admitted to the facility that included the following the influenza vaccine for the season was refused and the pneumococcal vaccine was unsure. The surveyor then asked the facility management if that was from the hospital, should the facility offer the influenza vaccine because it was flu season when the resident was admitted to the facility, and also offer the pneumococcal vaccine since the hospital records showed it was unsure if the resident received the vaccine. At that same time, the RNC stated that the facility was waiting for the RR to respond regarding the vaccination status of the resident at this time. The surveyor then asked, if should there be documentation that vaccines were offered and declined on admission. The RNC stated that he was aware that there was no documentation that the vaccines were offered in the medical records which was why the facility was trying to get the email correspondences from the RR. On 6/27/24 at 12:41 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), [NAME] President of Operations (VPoO), and Director of Nursing (DON). The surveyor notified the facility management of the above findings and concerns. A review of the facility's Influenza Vaccine Policy and Procedure with a reviewed/revised date of 01/2024 that was provided by the LNHA included that influenza vaccination is the primary method for preventing influenza and its severe complications. Therefore, vaccination against influenza will be offered to residents of this facility. Procedure: -All persons, upon admission to long-term care programs, shall be assessed for recent and past flu vaccinations. -The influenza vaccine shall be offered to all residents annually during flu season. Education shall be provided regarding the risks vs benefits of the vaccine. The resident or resident's representative may refuse immunization. -Those residents who are admitted during the winter months after completion of the program's vaccination program, will be offered the vaccine at the time of their admission. -The facility shall document the provision or did not receive the vaccine due to medical contraindications, previous vaccination, or refusal of the flu vaccine for each resident. (continued on next page)

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	07/09/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Pneumococcal Vaccination Policy and Procedure with a reviewed date of 01/2024 that was provided by the LNHA, included that in order to prevent the spread of infectious diseases and decrease the morbidity and mortality associated with pneumococcal pneumonia, the facility will offer pneumococcal vaccinations to residents as per the following procedures. Administration of pneumococcal vaccines will be made in accordance with current CDC (Centers for Disease Control and Prevention) recommendations. CDC recommends pneumococcal vaccination for [AGE] years old and older, adults 19 through [AGE] years old with certain underlying medical conditions or other risk factors which include but were not limited to chronic heart disease (including congestive heart failure and cardiomyopathies). On 7/01/24 at 11:58 AM, the survey team met with the LNHA, DON, and VPoO for an Exit Conference. No additional information was provided by the facility management, and the facility did not refute findings. NJAC 8:39-19.4 (a,4)(d)(h)(i)

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	07/09/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48423 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain a safe and sanitary environment. This deficient practice was identified in behavioral unit for four (4) of six (6) residents rooms, one (1) of one (1) shower room, and one (1) of two (2) unit rooms. This deficient practice was evidenced by the following: On 6/25/24 at 10:08 AM through 10:49 AM, the surveyor conducted a Behavioral Unit (BU) tour with the Licensed Nursing Home Administrator (LNHA) and Registered Nurse/Unit Coordinator (RN/UC) in the presence of a second surveyor. The following was observed during the tour: 1. At 10:08 AM, the surveyor entered into room [ROOM NUMBER] and observed a gray-black colored substance on the air vent cover on the ceiling of the room. The LNHA stated, the gray/black substance was an accumulation of dust. The LNHA was unable to state when the air vent was last cleaned. The surveyor observed one ceiling tile near the window area with a large circular, brownish colored stain in the middle of the tile. The LNHA responded that it was probably due to condensation, and he was unsure when that had happened. The RN/UC stated, the tile should not be there. The surveyor entered the bathroom and observed a laundry bin with one piece of black colored clothing inside of it. The RN/UC stated, the clothing was probably from other resident who was transferred to another room last Friday. The RN/UC acknowledged that the room and the dirty clothing should have been cleaned immediately after the resident was moved to another room. 2. At 10:15 AM, the surveyor entered into room [ROOM NUMBER] and observed dry debris hanging from the upper area of the window. The RN/UC confirmed that it was dust. The LNHA and RN/UC acknowledged that the window should have been cleaned. 3. At 10:21 AM, the surveyor entered into the bathroom of room [ROOM NUMBER] and observed two toilet paper holders with brownish discoloration. The RN/UC acknowledged it was rust and stated it should not be like that. The surveyor observed a white hat [a plastic container for urine collection] on the floor. The RN/UC stated, it was a urine collection container, and it should not be on the floor for infection control. It was used to measure the resident's urine output. The RN/UC further explained that there was currently no resident in the room and the resident was transferred to the hospital yesterday. 4. At 10:27 AM, the LNHA opened the unlocked door of the Motor Access Room and informed the surveyors that it was an electrical room. The surveyor observed a brown colored, dried-up substance on the floor. There was a blanket on the floor with brownish discoloration. The LNHA acknowledged that the room door should have been locked. 5. At 10:30 AM, the surveyor entered into room [ROOM NUMBER] and observed that the smoke detector on the ceiling. The smoke detector was detached and hanging from the ceiling. The LNHA stated, it should have been fixed and attached to the ceiling. (continued on next page)

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	07/09/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. At 10:43 AM, the surveyor entered the room labeled the Eyewash Station. Inside the room there were three shower stalls on the right side. The surveyor observed in the second shower stall, a square shaped opening on the right wall of the shower where there was a knob to control the water. The RN/UC acknowledged that the part to close the opening was missing. The surveyor observed an air vent on the ceiling which had no cover. The RN/UC stated that it should have been covered and acknowledged that there was an accumulation of dust, and it should have been cleaned. On 6/27/24 at 8:53 AM, the surveyor interviewed the Director of Housekeeping (DoH) who stated that the housekeeping staff were supposed to clean the resident rooms and hallway daily. The DoH stated he was responsible to make daily rounds on the units to ensure that housekeeping staff were completing their responsibilities. He further stated that he did not have any logs or documentation to account for the cleaning of vents and windows, or for his daily rounds. On 6/27/24 at 12:41 PM, the survey team met with the LNHA, Director of Nursing (DON), and [NAME] President of Operations (VPoO). The surveyors notified the facility management of the above concerns and findings regarding the resident rooms, bathrooms, shower room, and motor access room. On 6/28/24 at 11:29 AM, the LNHA, DON, and VPoO met with the survey team. The VPoO stated in-service was provided to housekeeping staff regarding environmental concerns and high dusting issues. The LNHA stated that the valve in the middle shower stall was temporarily covered and closed until a new cover was received. The LNHA further explained the air vent cover in the shower room was replaced and the smoke detector was properly mounted to ceiling. A review of the facility provided Facility Environment policy with a revised date January 2024, included: Policy: It is the policy of this facility to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Procedure: 1. The facility shall provide a safe, clean, comfortable and homelike environment, allowing the resident to use their personal belongings to the extent possible. 2. Housekeeping and maintenance shall maintain a sanitary, orderly and comfortable environment. NJAC 8:39-31.4 (a)(b)(f)