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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. REPEAT DEFICIENCY Based on observation, interview, and record review, it was determined that the facility failed to maintain and provide readily accessible medical documents for 1 (one) of 32 residents (Resident #4) reviewed for medical records. This deficient practice was evidenced by the following: On 9/11/25 at 11:42 AM, the surveyor observed Resident #4 in bed, awake, and able to answer the surveyor's inquiry. On 9/16/25 at 10:54 AM, the surveyor reviewed the electronic Health Record (eHR)/ hybrid medical record (paper and electronic) of Resident #4, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #4 was admitted with diagnoses that included but were not limited to diabetes mellitus (increased blood sugar level) due to underlying conditions. A review of the quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care) on 7/19/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had intact cognition. A review of medical records revealed that there was no documented evidence that the Physician Progress Notes (PPN) were done by the primary physician or by an alternating advanced practice nurse from February 2025 through July 2025. On 09/15/2025 at 11:47 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) in the pink unit, who stated that she would get the medical records from the medical record room. The RN/UM added that the PPN should be in the medical record, but cannot tell why it is not in the resident's hybrid medical records. The RN/UM did not provide the PPN record to the surveyor. On 9/16/2025 at 12:56 PM, the team of surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Regional RN regarding the concern above. But did not provide further information. On 9/17/2025 at 10:19 AM, the team of surveyors met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional RN regarding the concern above. The LNHA stated that all the PPN from February to July 2025 of Resident #4 is now available in the electronic record under the miscellaneous tab. The LNHA added that she got the PPN from the doctor's office and uploaded it to the system after the surveyor's inquiry. A review of the facility policy titled Subject: Medical Records with a reviewed date in January 2025, under Procedures: 1. The facility shall maintain medical records on each resident that are: c. Readily accessible. NJAC 8:39- 35.2(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call device was readily accessible. The deficient practice was identified for 1 (one) of the 32 residents (Resident #13) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following: On 9/10/2025 10:42 AM, the surveyor observed Resident #13 in bed, awake, unable to answer the surveyor's inquiry. The surveyor observed that the call device was located between the siderails and away from the resident's reach. On 9/11/2025 at 10:45 AM, the surveyor observed that the resident's call device was hanging on the side of the resident's bed and not within the reach of the resident. On 9/11/2025 at 11:15 AM, the surveyor reviewed the electronic Health Record (eHR)/ hybrid medical record (paper and electronic) of Resident #13, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #13 was admitted with diagnoses that included but were not limited to Alzheimer's disease (loss of memory), unspecified. A review of the significant change Minimum Data Set (SC/MDS), (an assessment tool used to facilitate the management of care) dated 8/29/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated that the resident had severe impairment in cognition. Further review of the SC/MDS, as reflected in section GG, revealed that the resident was dependent on staff for daily living activities. A review of the Care Plan (CP) report initiated on 8/16/24 focused on the resident's use of oxygen therapy related to respiratory illness. Interventions included, but were not limited to, encouraging the resident to call for assistance, but did not indicate that the call device should be within the reach of the resident. On 9/11/2025 at 10:48 AM, the surveyor interviewed the Certified Nurse Assistant (CNA), who stated that after she gives care to the resident, she will put the call device within the resident's reach, but did not provide further information on why Resident #13's call device is not within reach. On 9/11/2025 at 10:51 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that the call device must have been put there by the CNA when he was giving care to the resident. The call device should be placed within the reach of the resident. On 9/11/2025 at 11:01 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who stated that the call device should be within the resident's reach so they can call the staff if they need help. On 9/17/2025 at 1:03 PM, the team of surveyors met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional RN to discuss the above concern, but did not provide further information. A review of the facility policy titled Subject: Call Bells with the revision date in January 2025, revealed under Procedure: 9. Call bells should be within reach of resident. NJAC 8:39-31.8(c)9

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. NJ 2594265 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to thoroughly investigate an incident/accident on 6/14/25 and 6/15/25, related to an allegation of being dropped by transport for Resident #182. This deficient practice was identified for one (1) of three (3) residents reviewed for accidents and was evidenced by the following:A review of the reportable event record/report (FRE; Facility Reported Event) was called in on 6/16/25 at 11:37 AM, with an event date of 6/14/25 and 6/15/25 at 12:24 PM. The incident was reported as an allegation of being dropped by ambulance transport and involved two (2) personnel on 6/14/25 and 6/15/25. The event was described as follows: On 6/14/25 the resident reported to the nurse while reaching for their urinal, the resident heard a pop and immediately experienced pain on their elbow and shoulder. The notified physician ordered to transfer the resident to the hospital. The transport [name redacted transport #1] arrived at the facility at 8:49 PM and transported the resident to the hospital. The hospital report did not reflect inconsistent injury from their current diagnosis. The resident returned to the facility on 6/15/25 at 3:47 AM, via Transport #2. On 6/15/25 after lunch the resident informed a staff member that they were dropped by both transport on to the floor and did not inform the facility staff because they did not want to get someone in trouble. The surveyor reviewed the closed medical record for Resident #182. The admission Record (AR; or face sheet; an admission summary) reflected that the resident had been admitted with diagnoses which included multiple myeloma (a type of cancer which affects the white blood cells that produces antibodies to fight infection) , fatigue fracture of the vertebrae (small crack on the bone due to repetitive, excessive stress), pathological fracture (bone fracture due to underlying condition that weakens the bone rather than external trauma) in neoplastic disease, malignant neoplasm of the bone (cancerous tumor that originated from the bone tissue). The Significant Change Minimum Data Set (SCMDS), an assessment tool used to facilitate the management of care, dated 7/18/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had a fully intact cognition. Section E. of the MDS did not reflect behaviors related to rejection of care. Further review of the SCMDS developed by the facility to identify resident's needs and implement care interventions, revealed that Resident #182 was dependent for all activities of daily living including all surface transfers. The individualized comprehensive Plan (CP) revealed a focus that included, Resident #182 was at risk for falls related to generalized weakness initiated on 1/7/25. The interventions included to anticipate and meet the resident's needs, initiated on 1/8/25. The goals were to the resident would be free of falls through the review date, initiated on 1/8/25. A review of the investigation revealed that after reporting a fall from transport the resident received a skin assessment by a Licensed Practical Nurse. The investigation and the medical record did not reflect that a Registered Nurse assessed the resident immediately after the fall was reported. Further review of the investigation did not reflect an effort was made to contact Transport #2 to completely investigate the incident/allegation of a fall during transport. On 9/17/25 at 1:34 PM, in the presence of the survey team, the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) and the Regional Registered Nurse (R/RN), the surveyor discussed the concern regarding the resident's missing assessment from a Registered Nurse and evidence that Transport #2 was contacted as part of the investigation of the alleged fall. On 9/17/25 at 1:34 PM, in the presence of the survey team, the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) and the Regional Registered Nurse (R/RN), the surveyor discussed the concern regarding the missing assessment after the reported fall and the missing statements from Trasport #2 as part of the investigation On 9/18/25 at 10:57 AM, during a meeting with the survey team, the DON, and the LNHA, the R/RN stated that they had tried to contact the former LNHA to learn more information regarding the investigation and if an interview had occurred. The R/RN also stated that Transport #2 was contacted and confirmed of the transport that occurred on 6/15/25 and would send information (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	09/18/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding the concern. The facility team acknowledged that the information received by the survey team and the investigation conducted by the previous LNHA was in-fact incomplete. A review of the facility policy for Accident/Incident Investigation dated/revised 1/2025 included that investigation would include interviewing staff, resident, and witness statements.The witness statements would be attached to the incident report and kept on file at the DON's office. No further information was provided. NJAC-8.39-4.1(a)5

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive, person-centered care plan (CP) for a resident on long-term use of insulin medication. This deficient practice was identified in 1 (one) of the 32 residents (Resident#11) reviewed for CP.This deficient practice was evidenced by the following: On 9/10/2025 at 10:16 AM, the surveyor observed Resident #11 out of bed to the wheelchair, able to propel themselves, and able to answer questions appropriately. On 9/15/25 at 1:18 PM, the surveyor reviewed the electronic Health Record (eHR)/ hybrid medical record (paper and electronic) of Resident #11, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #11 was admitted with diagnoses that included but were not limited to hemiplegia (weakness of one body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (a blood vessel in the brain was blocked) affecting the right dominant side and type 2 diabetes mellitus (elevated blood sugar). A review of the quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care) on 8/18/25 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated that the resident had impaired cognition. Further review of Q/MDS reflected in Section N recorded that Resident #11 is taking insulin injection and anticoagulant medications. A review of the Order Summary Report (OSR) is as follows: 1. Insulin glargine 100 unit/ml (milliliter) inject 10 units subcutaneously (SQ, fatty layer of the skin) one time a day, with the start date of 8/8/25. 2. Heparin sodium 5000 unit/ml inject 5000 unit SQ every 8 hours with a start date of 8/7/25. A review of Resident #11's comprehensive CP report revealed no CP for the use of insulin and anticoagulant medication. On 9/15/2025 at 11:35 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the above concern. The LPN stated that there should be a CP for insulin and anti-coagulant medications. On 9/15/2025 11:52 AM, the surveyor interviewed the Registered Nurse/ Unit Manager (RN/UM) in the blue unit, who stated that the CP should include using insulin injections and anticoagulant medications. The RN/UM did not provide further information on why insulin and anticoagulants are not in the CP for Resident #11. On 9/17/2025 at 1:06 PM, the team of surveyors discussed the above concern with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional RN, but did not provide further information. A review of the facility policy titled Subject: Plan of Care and IDCP Team Meeting Policy with a reviewed date in January 2025 revealed under Procedures: The plan of care shall be individualized, based on the diagnosis, resident assessment, and personal goals of the resident and his/her family. NJAC 8:39-11.2(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	09/18/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. NJ 404793 Based on observations, interviews, records review, and review of other facility documentation, it was determined that the facility failed to ensure Resident #178's care plan was individualized, reflective of the resident's assessment, consistently provided full assistance to a resident who was dependent when eating, and the nutritional status was monitored by following the weekly weights intervention. This deficient practice was identified for one (1) of one (1) resident reviewed for nutrition (Resident #178) and was evidenced by the following: The surveyor reviewed the medical record of Resident #178 The resident's admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included dementia (decline in cognitive abilities), diabetes (high blood sugar), congestive heart failure (a condition of weakened, stiffened heart muscle causing the heart to ineffectively pump blood leading to fluid buildup in the lungs and other parts of the body) and pulmonary embolism (clot travels from one part of the body and blocks an artery in the lungs. The resident's most recent comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, dated 10/014/24, reflected that a Brief Interview for Mental Status was not conducted since the resident was rarely/never understood. The resident had no indicators of hallucination and delusion. Section GG revealed that the resident was dependent (wherein the helper is required for the resident to complete the activity) for activities of daily living that included eating. Section K reflected that the resident complained of difficulty or pain when swallowing. The resident received mechanically altered diet (a change in texture of food or liquids such as pureed food, thickened liquid). A review of the resident's comprehensive individualized Care Plan (CP) included a focus on the resident's nutritional problem related to diagnoses, impaired mobility, advanced age, textured modified diet, body mass index (measurement used to assess a person's weight status and potential health risk) and underweight (UW) status, started on 10/4/24. The interventions included to monitor, record, and report to MD signs and symptoms of malnutrition, emaciation, muscle wasting significant weight loss of three (3) pound (lbs.) a week. Further review of the CP reflected that the resident required assistance with meals as needed, which was inconsistent with the comprehensive assessment that reflected the resident was dependent when eating. A review of the electronic Medical Record (eMR) reflected one weight measurement; (wheelchair) on 10/3/2024 that equaled to 113.8. No other weights were recorded for this resident. A review of the Documentation Survey Report (the report of the electronic point-of-care system (POCS) where the Certified Nursing Assistants (CNAs) electronically document patient care activities). The POCS revealed that during the resident's stay, 24 of the 73 shifts the CNAs documented the resident was independent while eating and 3 of the 49 shifts, the resident received set-up or clean-up assistance. On 9/11/25 during an interview with the surveyor, the Speech-Language Pathologist (SLP) stated that the resident from admission was on puree and nectar thick and had not changed Resident #178's diet texture. On 9/15/25 at 12:29 PM, during an interview with the surveyor the Registered Dietician (RD) stated that all residents admitted received a nutritional assessment, medical record review to ensure a resident was on a proper diet. The RD stated the hemodialysis and CHF residents are monitored for diet, food consumption, labs, signs of fluid overload. At that time, the surveyor and the RD reviewed the formed RD's progress note that indicated the previous RD spoke with the resident's family who requested nutrition supplement for Resident #178. The record reflected the RD increased the resident's nutritional supplement from twice a day to three times a day. At that time, the RD stated that the assessment for Resident #178 was made by the former RD. The RD confirmed and acknowledged the record reflected the resident was underweight, was on puree and thickened liquid, had dementia, diagnosis of CHF and had an increase of nutrition as part of the family's request. At that time, the RD stated that the increase of supplement was reflective of the resident's status of not eating well and acknowledged that the record did not reflect how the effectiveness of the nutritional intervention was measured. On 9/16/25 at 1:22 PM, in the presence of the survey team, the DON, the (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	09/18/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Nursing Home Administrator (LNHA) and the Regional Nurse, the surveyor discussed the concern regarding the care plan that reflected the resident required assistance with meals, opposed to the assessment that reflected the resident was dependent for activities of eating and the POCs that reflected the resident did not receive full assistance 27 out of 73 shifts. Additionally, the surveyor discussed the concern that the former RD increased the resident's nutritional supplement with no method of measurement for the effectiveness of the intervention, and the care plan intervention to monitor, record and report greater that three (3) pound weight loss to the Medical Doctor (MD) was not followed. On 9/17/25 at 10:15 AM, during a meeting with the survey team, the R/RN, the DON and the LNHA, the RD stated that the care plan was generic and should have been individualized. The RD acknowledged that the CP of weekly weight monitoring was not followed and should have been. The DON stated in-services were given to staff that the care plan should follow the assessment and the POC documentation should be accurate. A review of the undated facility policy for Weights reflected that monthly, and weekly weights per the discretion of the dietician and/or physician) shall be obtained by the CAN and record on the weight sheet form. A review of the job description for the dietician included to assess the nutritional status of residents that included weight maintenance, resident's independence and overall nutritional well-being. A review of the provided facility policy dated 1/2025 included that the care planning shall be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development foals for the resident that are reasonable and measurable. NJAC 8:39-27.1(a),27.2(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	09/18/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review it was determined that the facility failed ensure consistent provision of care/services in accordance with professional standards, consistently assess residents' vital signs and dialysis access site before dialysis treatments and provide ongoing communication with the dialysis center regarding a medication that was held. This deficient practice was identified for 1 of 2 residents (Resident #12) reviewed for dialysis and was evidenced by the following: Reference: According to the manufacturer's specifications for Midodrine under Mechanism of Action; Standing systolic blood pressure is elevated by approximately 15 to 30 mmHg at 1 hour after a 10-mg dose of midodrine, with some effect persisting for 2 to 3 hours. On 9/10/25 at 11:06 AM, during the initial tour of the facility the Registered Nurse/Unit Manager (RN/UM) informed the surveyor that Resident #12 was at the hemodialysis (HD) center and picked up on Monday, Wednesday and Friday at 10:15 AM. On 9/15/25 at 9:13 AM, the surveyor observed the resident in their room with their eyes closed. The surveyor reviewed the medical record of Resident #12. According to the admission Record face sheet, an admission summary, reflected that Resident #12 was admitted to the facility with diagnoses that included, end stage renal disease, dependence on renal dialysis. A review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool dated 7/3/25 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated Resident #12 was cognitively intact. Section O reflected the resident received hemodialysis during their stay at the facility. A review of the individualized comprehensive care plan reflected a focus that the resident received HD and had an access site arteriovenous fistula (AV; an irregular connection between an artery and a vein) at the left upper arm. The interventions included ensure the resident reports to HD, monitor bruit and thrill (indicator of proper functioning of an AV fistula). Monitor labs and report to the doctor as needed. A review of the electronic Treatment Administration Record (eTAR) for September 2025 included the following physician's orders:-Check left arm AV fistula for bruit and thrill, initiated on 4/26/24 reflected charting blanks.-Assess dressing site for bleeding upon return form dialysis and removal, initiated on 4/26/24, reflected charting blanks. -Remove dialysis access dressing 4 hours post dialysis treatment every evening and night shift initiated 4/26/24 reflected a charting blank. A review of the Nurse's Progress Notes from August to September 2025 reflected that on the following dates the resident was not assessed prior to attending HD treatment-9/1/25-8/29/25-8/22/25 no documented vital signs prior to leaving the facility-8/20/25-8/18/25-8/15/25 no documented vital signs prior to leaving the facility-8/13/25 no documented vital signs prior to leaving the facility-8/8/25-8/6/25-8/1/25 no documented vital signs prior to leaving the facility A review of the resident's electronic Medication Administration Record (eMAR) for September 2025 included a PO for 10 milligrams (mg) of Midodrine (a medication use to treat orthostatic hypotension, a condition wherein the blood pressure drops significantly upon standing from sitting or lying position, with effects from 1 hour up to 3 hours) with a scheduled administration time of 9:00 AM; Give 1 tablet one time a day every Monday, Wednesday and Friday prior to dialysis. Hold for systolic blood pressure higher than 140. Further review of the Midodrine reflected the following:-9/1/25 not administered; blood pressure not documented-9/3/25 not administered; blood pressure not documented-9/5/25 not administered; blood pressure not documented-9/8/25 administered; 122(systolic)/78(diastolic) millimeters of mercury (mmHg)-9/10/25 administered; 132/67 mmHg-9/12/25 not administered; blood pressure not documented -9/15/25 not administered; blood pressure not documented-9/17/25 not administered; 144/85 mmHg A review of the Dialysis Progress Notes (DPN) for August to September 2025 did not reflect documentation was made regarding the dose of the Midodrine that were held or the assessment conducted prior to HD treatment. On 9/17/25 at 9:53 AM, during an interview with the surveyor, the RN/UM stated that the facility had a communication form, DPN that was sent with the resident for the HD center to fill out. The RN/UM stated that they did not send information with the (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	09/18/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident and stated that no information meant that there were no issues with the resident. An issue would result into a phone call made to the HD center. If no information was sent that is to say, the resident is fine. At that time, the surveyor and the RN/UM reviewed the resident's electronic Medical Record (eMR) together. The eMR reflected that the resident had Midodrine that was scheduled for administration on HD treatment days prior to treatment and had parameters for when to administer based on the resident blood pressure condition. The RN/UM could not show evidence that communication with the HD center was made when the Midodrine was held or administered. The RN/UM stated that the communication form did not have an area or requirement for her or the nurses on duty to document that information for the HD center. On 9/17/25 at 1:34 PM, in the presence of the survey team, the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) and the Regional Registered Nurse (R/RN), the surveyor discussed the concern that Resident #12's pre-dialysis assessment were inconsistent and the missing proof of communication of the resident's pre-assessment and the administration or the holding of the Midodrine dose prior to HD treatment, in order to better manage and assess the changing blood pressure of the resident during and after the HD treatment. On 9/18/25 at 10:57 AM, in the presence of the survey team, the LNHA and the DON, the R/RN stated that the facility used the Dialysis Progress Notes as a communication form for the HD center to communicated with the facility and documented their assessment in the eMR [which the HD had no access to review for shared communication]. The R/RD stated the form has been updated to include the pre-assessment and ancillary information such as medication(s) initiated, administered, held or discontinued which would be available for the HD center to review. A review of the provided facility policy dated/revised did not reflect a process for shared communication between the nursing home and the HD facility. NJAC 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	09/18/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. REPEAT DEFICIENCYBased on observation, interview, and record review, it was determined that the facility failed to ensure that the resident's primary physician accurately dated their Physician Progress Notes (PPN) during their visit to ensure the resident's current medical regimen was up to date. This deficient practice was observed for 1 (one) of 32 residents (Resident #13). This deficient practice was evidenced by the following: On 9/10/2025 10:42 AM, the surveyor observed Resident #13 in bed, awake, unable to answer the surveyor's inquiry. The surveyor observed that the call device was located between the siderails and away from the resident's reach. On 9/11/2025 at 10:45 AM, the surveyor observed that the resident's call device was hanging on the side of the resident's bed and not within the reach of the resident. On 9/11/2025 at 11:15 AM, the surveyor reviewed the electronic Health Record (eHR)/ hybrid medical record (paper and electronic) of Resident #13, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #13 was admitted with diagnoses that included but were not limited to Alzheimer's disease (loss of memory), unspecified. A review of the significant change Minimum Data Set (SC/MDS), (an assessment tool used to facilitate the management of care) dated 8/29/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated that the resident had severe impairment in cognition. Further review of the SC/MDS, as reflected in section GG, revealed that the resident was dependent on staff for daily living activities. A review of the PPNs in the eHR reflected the following Effective Date, Created Date, and/or Late Entry (any documentation that is recorded in the eHR beyond 24-48 hours of the encounter is classified as a late entry) designation which indicated the PPN of medical doctor (MD) was not documented on the effective date (Date of Service): 1. PPN with an effective date of 1/5/25 and a created date of 3/5/25. 2. PPN with an effective date of 1/12/25 and a created date of 3/5/25. 3. PPN with an effective date of 1/18/25 and a created date of 3/5/25. 4. PPN with an effective date of 2/2/25 and a created date of 3/5/25. 5. PPN with an effective date of 2/9/25 and a created date of 3/5/25. 6. PPN with an effective date of 2/16/25 and a created date of 3/5/25. 7. PPN with an effective date of 2/23/25 and a created date of 3/5/25. 8. PPN with an effective date of 5/11/25 and a created date of 5/4/25. 9. PPN with an effective date of 4/30/25 and a created date of 5/4/25. 10. PPN with an effective date of 5/8/25 and a created date of 5/22/25. 11. PPN with an effective date of 3/9/25 and a created date of 5/27/25. 12. PPN with an effective date of 3/10/25 and a created date of 5/27/25. 13. PPN with an effective date of 3/14/25 and a created date of 5/27/25. 14. PPN with an effective date of 3/15/25 and a created date of 5/27/25. 15. PPN with an effective date of 3/17/25 and a created date of 5/27/25.16. PPN with an effective date of 3/19/25 and a created date of 5/27/25. 17. PPN with an effective date of 3/20/25 and a created date of 5/27/25. 18. PPN with an effective date of 3/31/25 and a created date of 5/27/25. 19. PPN with an effective date of 4/6/25 and a created date of 5/27/25. 20. PPN with an effective date of 4/13/25 and a created date of 5/27/25. 21. PPN with an effective date of 4/19/25 and a created date of 5/27/25. 22. PPN with an effective date of 4/27/25 and a created date of 7/19/25. 23. PPN with an effective date of 5/9/25 and a created date of 7/19/25. 24. PPN with an effective date of 5/11/25 and a created date of 7/19/25. 25. PPN with an effective date of 5/13/25 and a created date of 7/20/25. 26. PPN with an effective date of 5/15/25 and a created date of 7/20/25. 27. PPN with an effective date of 5/19/25 and a created date of 7/20/25. 28. PPN with an effective date of 5/20/25 and a created date of 7/20/25. 29. PPN with an effective date of 5/22/25 and a created date of 7/22/25. 30. PPN with an effective date of 5/26/25 and a created date of 7/22/25. 31. PPN with an effective date of 5/29/25 and a created date of 7/22/25. 32. PPN with an effective date of 6/1/25 and a created date of 7/22/25. 33. PPN with an effective date of 6/2/25 and a created date of 7/22/25. 34. PPN with an effective date of 6/4/25 and a created date of 7/22/25. 35. PPN with an effective date of 6/8/25 and a created date of 7/22/25. 36. PPN with an effective date of 6/10/25 and a created date of 7/22/25. (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	09/18/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37. PPN with an effective date of 6/15/25 and a created date of 7/22/25. 38. PPN with an effective date of 6/20/25 and a created date of 7/22/25. 39. PPN with an effective date of 7/8/25 and a created date of 7/22/25. 40. PPN with an effective date of 6/25/25 and a created date of 8/24/25. 41. PPN with an effective date of 7/9/25 and a created date of 8/24/25. 42. PPN with an effective date of 7/10/25 and a created date of 8/24/25. 43. PPN with an effective date of 7/21/25 and a created date of 8/25/25. 44. PPN with an effective date of 7/23/25 and a created date of 8/25/25. 45. PPN with an effective date of 7/24/25 and a created date of 8/25/25. 46. PPN with an effective date of 7/28/25 and a created date of 8/25/25. 47. PPN with an effective date of 7/30/25 and a created date of 8/25/25. 48. PPN with an effective date of 8/4/25 and a created date of 8/25/25. 49. PPN with an effective date of 8/7/25 and a created date of 8/25/25. 50. PPN with an effective date of 8/12/25 and a created date of 8/25/25. 51. PPN with an effective date of 8/19/25 and a created date of 8/25/25. On 9/15/2025 at 11:00 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that the physician comes into the facility regularly and writes their notes in the eHR. On 9/15/2025 11:33 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) from the pink unit, who stated that the physician visits their residents regularly and documents the progress notes in the computer. The RN/UM did not provide further information on why the PPN has a late entry. On 9/17/2025 at 11:30 AM, the surveyor called the primary physician and left a message to call back for an interview, but the primary physician did not return the call. A review of the facility policy titled Subject: Physician Visits and Services, with a reviewed date in January 2025, under Procedure: 5. Progress notes and orders must be written, signed, and dated at each physician visit, which may be done in a physical or electronic chart. NJAC 8:39-23.2(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	09/18/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards and ensure consistent accountability and reconciliation of narcotic medication for Resident #95's and 151's narcotic medications. These deficient practices were identified for one (1) of five (5) medication carts inspected and was evidenced was as follows:On 9/16/25 at 11:57 AM, in the presence of the Licensed Practical Nurse (LPN) the surveyor began the narcotic medication inspection, stored in a mounted, double locked portion of the medication cart (narcotic box) located on the high side of the pink unit. A review of the facility's Controlled Medication Accountability Sheet (a shift-to-shift count/sign in sheet, used to account for the narcotics and syringes within the medication cart) for September 2025, reflected that the inventory counts were performed on three shifts (7:00 AM, 3:00 PM and 11:00 PM), daily from 9/1/25 at 7:00 AM, to at 9/15/25 at 7:00 AM by the two nurses, the outgoing shift and the incoming shift. At that time, the surveyor and the LPN observed Resident #95's Clonazepam 0.5 milligram, tablets (a narcotic psychotropic indicated for anxiety, seizure and panic disorder; mg) bingo cards (a multidose card containing individually packaged medications) contained a total of 47 tablets. At that time, the surveyor compared the count of the bingo card against the Individual Patient Controlled Substance Administration Record (declining inventory log) for Resident #95's Clonazepam 0.5 mg tablet which reflected a balance of 48 tablets and was last signed by the administering nurse on 9/15/25 at 21:00 PM (9:00 PM). At that time, the surveyor questioned the one (1) tablet discrepancy of the Clonazepam count. The LPN stated she administered the Clonazepam that morning to Resident #95 and forgot to sign that she removed the medication from the inventory against the facility's policy. At that time, the surveyor and the LPN reviewed the declining inventory log for Resident #95's Morphine 20 mg/ml which reflected a balance of balance of 26 milliliters and was last signed by the administering nurse on 9/15/25 at 9:00 PM. At that time, the surveyor and the LPN reviewed the electronic Medication Administration Record (eMAR) for Resident #95's Morphine which reflected an administration on 9/16/25 for the 9:00 AM dose. This administration was not reflected on the declining inventory log. At that time, during an interview with the surveyor, the LPN stated that she also administered the Morphine that morning to Resident #95 and forgot to sign that she removed the medication from the inventory because she was distracted. On 9/16/2025 at 12:10 PM, in the presence of the LPN, the surveyor observed Resident #'151's Alprazolam 0.5 mg, tablets (a narcotic psychotropic indicated for anxiety) bingo cards contained a total of 69 tablets. At that time, the surveyor compared the count of the bingo card against the declining inventory log for Resident #151's Alprazolam 0.5 mg tablet which reflected a balance of 70 tablets and was last signed by the administering nurse on 9/16/25 at 8:00 AM. At that time, during an interview with the surveyor, the LPN could not explain why the discrepancy was not identified during the shift-to-shift count earlier that day. At that time, during a meeting with the Registered Nurse/Unit Manager (RN/UM) the surveyor discussed the concerns regarding the discrepancy for the accountability of Resident #95's narcotic medications (Clonazepam and Morphine) and the failed reconciliation of Resident #151 Alprazolam that resulted in a discrepancy of one (1) pill. At that time the RN/UM stated an in-service would be provided to the nurses, an investigation for the shortage would be initiated and the Director of Nursing (DON) along with the Assistant Director of Nursing (ADON) would be informed. On 9/16/25 at 1:22 PM, in the presence of the survey team, the DON, the Licensed Nursing Home Administrator (LNHA) and the Regional Nurse, the surveyor discussed the concern regarding the failure to ensure that the declining logs were signed upon removal from active inventory and implement reconciliation of the narcotic inventory during the shift-to-shift counts. On 9/17/25 at 10:15 AM, during a meeting with the survey team, the LNHA, and the Regional Nurse, the DON stated that in-services were provided regarding signing the declining (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	09/18/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sheet upon removal and ensuring that the counts were conducted during the shift-to shift counts. An investigation was conducted regarding the shortage of Resident #151's Alprazolam and found that the outgoing nurse from the 11 to 7 shift destroyed a loose pill in the medication cart and destroyed the pill in the drug buster without a witness since he did not realize it was a controlled substance. The DON stated that the nurse should have tried to identify the loose pill prior to destroying the narcotic medication and should have been done in the presence of another nurse as a witness of the destruction/disposal. A review of the provided policy for Inventory of Controlled Substances dated/revised on 1/2025 included that the controlled substances are counted by the oncoming nurse and outgoing nurse at the change of each shift and documented.a documentation of any discrepancy must be reported to the Director of Nursing. Further review of the policy reflected that all medication destructions in the facility must be witnessed by at least two persons, each of whom shall be the registered professional nurse, licensed practical nurse or pharmacist consultant. NJAC 8:39-11.2(b), 29.2(d), 29.4(g)(i) .