

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2026
NAME OF PROVIDER OR SUPPLIER Alliance Care Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 155 40th Street Irvington, NJ 07111	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, interview, and policy review, the facility failed to ensure an allegation involving an injury of unknown origin was reported as required for one out of one sampled resident (Resident (R)12) reviewed for reporting requirements. Specifically, R12 was discovered on 06/14/26 with an unwitnessed head injury after being observed attempting to climb back into bed. The facility's failure to report an injury of unknown origin had the potential to delay regulatory review and intervention, which could allow abuse, neglect, mistreatment, or exploitation to go unidentified and unaddressed, placing residents at risk for further harm. Findings include: Review of R12's Face Sheet located in the Electronic Medical Record (EMR) under the Profile tab revealed an initial admission date of 09/22/25 and the most admission date of 04/21/26. With the following diagnoses: included traumatic subdural hemorrhage without loss of consciousness (subsequent encounter), Parkinson's disease, Type 2 diabetes mellitus, and dementia. Review of the Quarterly Minimum Data Set (MDS) assessment located in the EMR under the MDS tab with an Assessment Reference Date of 04/27/26 revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, indicating moderate cognitive impairment. Review of previous MDS assessments did not indicate a significant decline in cognition. Review of the Progress Notes located in the EMR under the Progress Note tab revealed that on 06/14/26, R12 sustained an unwitnessed injury in his/her room. Certified Nurse Aide (CNA)12 observed the resident attempting to climb back into bed and noted dried blood on the floor and on the left side of the resident's head. The facility's fall protocol was initiated, and the resident was transferred to the local hospital for evaluation. Review of the facility's internal investigation revealed the allegation that staff negligence caused the injury was determined to be unsubstantiated. The investigation documented a hematoma measuring approximately 4 cm x 3.6 cm on the left side of the resident's head and concluded the most likely scenario was an unwitnessed, self-initiated attempt by the resident to get out of bed and subsequently re-enter the bed independently, resulting in a loss of balance and head injury. The facility's root cause analysis identified the most probable cause as an unwitnessed attempt by the resident to independently re-enter bed during an unsupervised interval. Due to the unwitnessed nature of the event and the residents' inability to provide a reliable history, the exact sequence of events could not be determined. The investigation did not identify evidence that staff failed to provide required supervision or care. Interview and observation on 06/27/26 at 12:54 PM, observation of R12 revealed the resident seated in a wheelchair during mealtime receiving assistance with lunch. The resident was observed wearing non-slip socks. No environmental hazards were identified in the room. The bed was in the lowest (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	position with a fall mat positioned beside the bed. R12 communicated primarily in Creole and required interpretation assistance from CNA12. Through interpretation, the resident indicated he had previously experienced falls, denied pain, and reported feeling safe in the facility. The residents did not demonstrate fear or hesitation toward CNA12. CNA12 was the staff who reported R12's injury and his account of the incident was consistent with facility documentation and the internal investigation findings. Interview on 06/30/26 at 03:52 PM, with Licensed Practical Nurse (LPN) 5 revealed he/she responded after being notified by CNA12. LPN5 stated that he/she did not witness the incident but observed the resident with an injury to the left side of the head while holding an ice pack. LPN5 reported the wound had already been cleaned and that the resident could not explain how the injury occurred. This surveyor inquired if the incident was considered a reportable incident LPN5 shared he/she did not feel that this incident was abused and needed to be reported. Interview on 06/30/26 at 02:45 PM with the Director of Nursing (DON) revealed the facility did not report the incident involving R12 the facility determined the unwitnessed fall, which resulted in a hematoma to the left side of the resident's head, was not related to abuse and therefore was not considered a reportable event. The DON stated the facility concluded the injury was the result of an unwitnessed fall and did not identify the incident as an injury of unknown origin requiring notification to the State Agency. Review of the facility's policy titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property Policy dated 12/01/25 read, in pertinent part, . (The facility) will ensure that allegations/violations involving abuse, neglect, exploitation or mistreatment, including injuries from an unknown source .are reported immediately but not later than 2 hours after the injury has been reported. NJAC 8:39-9.4(f)		