STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315366	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at Belgrove	195 Belgrove Drive Kearny, NJ 07032

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** 50267 Complaint # NJ184029 Based on interview, review of the medical record, and pertinent facility documents, it was determined that the facility failed to ensure staff documented on the Treatment Administration Record (TAR) according to the physician's orders and acceptable standards of practice in accordance with the New Jersey Board of Nursing Statutes for 3 of 3 sampled residents (Resident #1, Resident #2, and Resident #3). This deficient practice was evidenced by the following: According to the Admission Record received on 3/27/25, Resident #1 was admitted to the facility on [DATE], with diagnoses that included but not limited to Acute Pyelonephritis, Depression, Hypertension, and Chronic Kidney Disease. The Quarterly Minimum Data Set (MDS), an assessment tool dated 1/4/25, indicated that the resident was cognitively intact and required assistance with activities of daily living (ADLs). A review of the Order Summary Report (OSR) received on 3/27/25 given by the Administrator for Resident #1, with a physician order date of 4/02/25 revealed the call bell within reach every shift. A review of the January 2025 Treatment Administration Record (TAR) for Resident #1 revealed that the 3:00 p.m. (1500) call bell within reach every shift on 1/4/25 was blank. A review of the March 2025 Treatment Administration Record (TAR) for Resident #1 revealed that the 11:00 p.m. (2300) call bell within reach every shift on 3/21/25 was blank. According to the Admission Record received on 3/27/25, Resident #2 was admitted to the facility on [DATE], with diagnoses that included but not limited to Restless Legs Syndrome, Type 2 Diabetes, Major Depressive Disorder, Hypertension, and Hyperglycemia. The Quarterly Minimum Data Set (MDS), an assessment tool dated 1/17/25, indicated that the resident was cognitively intact and independent with activities of daily living (ADLs). A review of the Order Summary Report (OSR) received on 3/27/25, given by the Administrator for Resident #2, with a physician order date of 4/27/21 revealed the call bell within reach every shift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Alaris Health at Belgrove	195 Belgrove Drive Kearny, NJ 07032

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the March 2025 Treatment Administration Record (TAR) for Resident #2 revealed that the 11:00 p.m. (2300) call bell within reach every shift on 3/26/25 was blank. According to the Admission Record received on 3/27/25, Resident #3 was admitted to the facility on [DATE], with diagnoses that included but not limited to Encephalopathy, Transient Ischemic Attack (TIA), Cerebral Infarction, Acute Kidney Failure, Hyperlipidemia, (COPD), and Hypertension. The Quarterly Minimum Data Set (MDS), an assessment tool dated 12/27/24, indicated that the resident was severely impaired and required assistance with activities of daily living (ADLs). The Order Summary Report (OSR) received on 3/27/25 with an order date of 6/19/24 revealed call bell within reach every shift. A review of the Order Summary Report (OSR) received on 3/27/25, given by the Administrator for Resident #3, with a physician order date of 6/19/24 revealed the call bell within reach every shift. A review of the March 2025 Treatment Administration Record (TAR) given by the Administrator for Resident #3, revealed that the 11:00 p.m. (2300) call bell within reach every shift on 3/21/25 was blank. During interview with the surveyor on 3/27/25 at 2:05 p.m., the Administrator confirmed the blanks for call bell within reach on the Medication Administration Record/Treatment Administration Record (MAR/TAR). The Administrator stated that staff failed to acknowledge and document on the MAR/TAR. The Administrator stated that the expectation was for all orders to be signed as per doctor's order. She further stated that it was important for staff to sign off and acknowledge to ensure that the doctor's orders were being followed. During interview with the surveyor on 3/27/25 at 3:09 p.m., the Director of Nursing (DON) stated that there should have been no blanks and agreed that there were blanks on the MAR/TAR. The DON stated that the nurses should have signed because it was a part of the doctor's order. During interview with the surveyor on 3/28/25 post survey at 12:31 p.m. via telephone, Registered Nurse (RN #1) who was assigned to Resident #1 on 1/4/24, stated that she worked one day and one shift at the facility as an agency nurse. RN #1 stated that she always checked to make sure resident's call bell was within reach. She further stated that she does not remember if there was a documentation that she needed to sign off on. Surveyor attempted to reach RN #2 on 3/28/25 post survey at 12:37 p.m. via telephone, who was assigned to Resident #1 on 3/21/25 and Resident #3 on 3/21/24, and was unsuccessful. During interview with the surveyor on 3/28/25 post survey at 12:40 p.m. via telephone, RN #3 who was assigned to Resident #2 on 3/26/24, stated that she checked call bells and made sure the call bell was within reach when doing rounds. RN #2 stated that she should have documented, I forgot to document. RN #2 further stated that it was important to document to show the work was done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Clinical Charting and Documentation Policy and Procedure with an effective date of 11/2010, revealed that under the Policy statement that all services provided to the resident, or any changes in the resident's electronic medical record (EMR). Under Policy Interpretation and Implementation #5 revealed, Documentation of procedures and treatments shall include care-specific details and shall include at a minimum b. The name and title of the individual who provided the care The signature and title of the individual documenting. NJAC 8:39-27.1 (a) Complaint # NJ184029 Based on interview, review of the medical record, and pertinent facility documents, it was determined that the facility failed to ensure staff documented, and that prescribed treatments were completed according to the physician's orders and acceptable standards of practice in accordance with the New Jersey Board of Nursing Statutes for 3 of 3 sampled residents (Resident #1, Resident #2, and Resident #3). This deficient practice was evidenced by the following: According to the Admission Record received on 3/27/25, Resident #1 was admitted to the facility on [DATE], with diagnoses that included but not limited to Acute Pyelonephritis, Depression, Hypertension, and Chronic Kidney Disease. The Quarterly Minimum Data Set (MDS), an assessment tool dated 1/4/25, indicated that the resident was cognitively intact and required assistance with activities of daily living (ADLs). The Order Summary Report (OSR) received on 3/27/25 with an order date of 4/02/25 revealed call bell within reach every shift. The January 2025 Treatment Administration Record (TAR) revealed that the 3:00 p.m. (1500) call bell within reach every shift on 1/4/25 was blank. The March 2025 Treatment Administration Record (TAR) revealed that the 11:00 p.m. (2300) call bell within reach every shift on 3/21/25 was blank. According to the Admission Record received on 3/27/25, Resident #2 was admitted to the facility on [DATE], with diagnoses that included but not limited to Restless Legs Syndrome, Type 2 Diabetes, Major Depressive Disorder, Hypertension, and Hyperglycemia. The Quarterly Minimum Data Set (MDS), an assessment tool dated 1/17/25, indicated that the resident was cognitively intact and independent with activities of daily living (ADLs). The Order Summary Report (OSR) received on 3/27/25 with an order date of 4/27/21 revealed call bell within reach every shift. The March 2025 Treatment Administration Record (TAR) revealed that the 11:00 p.m. (2300) call bell within reach every shift was blank on 3/26/25 was blank. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. According to the Admission Record received on 3/27/25, Resident #3 was admitted to the facility on [DATE], with diagnoses that included but not limited to Encephalopathy, Transient Ischemic Attack (TIA), Cerebral Infarction, Acute Kidney Failure, Hyperlipidemia, (COPD), and Hypertension. The Quarterly Minimum Data Set (MDS), an assessment tool dated 12/27/24, indicated that the resident was severely impaired and required assistance with activities of daily living (ADLs). The Order Summary Report (OSR) received on 3/27/25 with an order date of 6/19/24 revealed call bell within reach every shift. The March 2025 Treatment Administration Record (TAR) revealed that the 11:00 p.m. (2300) call bell within reach every shift on 3/21/25 was blank. During interview with the surveyor on 3/27/25 at 2:05 p.m., the Administrator confirmed the blanks for call bell within reach on the Medication Administration Record/Treatment Administration Record (MAR/TAR). The Administrator stated that staff failed to acknowledge and document on the MAR/TAR. The Administrator stated that the expectation was for all orders to be signed as per doctor's order. She further stated that it was important for staff to sign off and acknowledge to ensure that the doctor's orders were being followed. During interview with the surveyor on 3/27/25 at 3:09 p.m., the Director of Nursing (DON) stated that there should have been no blanks and agreed that there were blanks on the MAR/TAR. The DON stated that the nurses should have signed because it was a part of the doctor's order. During interview with the surveyor on 3/28/25 post survey at 12:31 p.m. via telephone, Registered Nurse (RN #1) stated that she worked one day and one shift at the facility as an agency nurse. RN #1 stated that she always checked to make sure resident's call bell was within reach. She further stated that she does not remember if there was a documentation that she needed to sign off on. During interview with the surveyor on 3/28/25 post survey at 12:40 p.m. via telephone, RN #2 stated that she checked call bells and made sure the call bell was within reach when doing rounds. RN #2 stated that she should have documented, I forgot to document. RN #2 further stated that it was important to document to show the work was done. Review of the Clinical Charting and Documentation Policy and Procedure with an effective date of 11/2010, revealed that under the Policy statement that all services provided to the resident, or any changes in the resident's electronic medical record (EMR). Under Policy Interpretation and Implementation #5 revealed, Documentation of procedures and treatments shall include care-specific details and shall include at a minimum b. The name and title of the individual who provided the care The signature and title of the individual documenting. NJAC 8:39-27.1 (a) Surveyor: [NAME], Janese Complaint # NJ184029 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, review of the medical record, and pertinent facility documents, it was determined that the facility failed to ensure staff documented on the Treatment Administration Record (TAR) according to the physician's orders and acceptable standards of practice in accordance with the New Jersey Board of Nursing Statutes for 3 of 3 sampled residents (Resident #1, Resident #2, and Resident #3). This deficient practice was evidenced by the following: According to the Admission Record received on 3/27/25, Resident #1 was admitted to the facility on [DATE], with diagnoses that included but not limited to Acute Pyelonephritis, Depression, Hypertension, and Chronic Kidney Disease. The Quarterly Minimum Data Set (MDS), an assessment tool dated 1/4/25, indicated that the resident was cognitively intact and required assistance with activities of daily living (ADLs). A review of the Order Summary Report (OSR) received on 3/27/25 given by the Administrator for Resident #1, with a physician order date of 4/02/25 revealed the call bell within reach every shift. A review of the January 2025 Treatment Administration Record (TAR) for Resident #1 revealed that the 3:00 p.m. (1500) call bell within reach every shift on 1/4/25 was blank. A review of the March 2025 Treatment Administration Record (TAR) for Resident #1 revealed that the 11:00 p.m. (2300) call bell within reach every shift on 3/21/25 was blank. According to the Admission Record received on 3/27/25, Resident #2 was admitted to the facility on [DATE], with diagnoses that included but not limited to Restless Legs Syndrome, Type 2 Diabetes, Major Depressive Disorder, Hypertension, and Hyperglycemia. The Quarterly Minimum Data Set (MDS), an assessment tool dated 1/17/25, indicated that the resident was cognitively intact and independent with activities of daily living (ADLs). A review of the Order Summary Report (OSR) received on 3/27/25, given by the Administrator for Resident #2, with a physician order date of 4/27/21 revealed the call bell within reach every shift. A review of the March 2025 Treatment Administration Record (TAR) for Resident #2 revealed that the 11:00 p.m. (2300) call bell within reach every shift on 3/26/25 was blank. According to the Admission Record received on 3/27/25, Resident #3 was admitted to the facility on [DATE], with diagnoses that included but not limited to Encephalopathy, Transient Ischemic Attack (TIA), Cerebral Infarction, Acute Kidney Failure, Hyperlipidemia, (COPD), and Hypertension. The Quarterly Minimum Data Set (MDS), an assessment tool dated 12/27/24, indicated that the resident was severely impaired and required assistance with activities of daily living (ADLs). The Order Summary Report (OSR) received on 3/27/25 with an order date of 6/19/24 revealed call bell within reach every shift. A review of the Order Summary Report (OSR) received on 3/27/25, given by the Administrator for Resident #3, with a physician order date of 6/19/24 revealed the call bell within reach every shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the March 2025 Treatment Administration Record (TAR) given by the Administrator for Resident #3, revealed that the 11:00 p.m. (2300) call bell within reach every shift on 3/21/25 was blank. During interview with the surveyor on 3/27/25 at 2:05 p.m., the Administrator confirmed the blanks for call bell within reach on the Medication Administration Record/Treatment Administration Record (MAR/TAR). The Administrator stated that staff failed to acknowledge and document on the MAR/TAR. The Administrator stated that the expectation was for all orders to be signed as per doctor's order. She further stated that it was important for staff to sign off and acknowledge to ensure that the doctor's orders were being followed. During interview with the surveyor on 3/27/25 at 3:09 p.m., the Director of Nursing (DON) stated that there should have been no blanks and agreed that there were blanks on the MAR/TAR. The DON stated that the nurses should have signed because it was a part of the doctor's order. During interview with the surveyor on 3/28/25 post survey at 12:31 p.m. via telephone, Registered Nurse (RN #1) who was assigned to Resident #1 on 1/4/24, stated that she worked one day and one shift at the facility as an agency nurse. RN #1 stated that she always checked to make sure resident's call bell was within reach. She further stated that she does not remember if there was a documentation that she needed to sign off on. Surveyor attempted to reach RN #2 on 3/28/25 post survey at 12:37 p.m. via telephone, who was assigned to Resident #1 on 3/21/25 and Resident #3 on 3/21/24, and was unsuccessful. During interview with the surveyor on 3/28/25 post survey at 12:40 p.m. via telephone, RN #3 who was assigned to Resident #2 on 3/26/24, stated that she checked call bells and made sure the call bell was within reach when doing rounds. RN #2 stated that she should have documented, I forgot to document. RN #2 further stated that it was important to document to show the work was done. Review of the Clinical Charting and Documentation Policy and Procedure with an effective date of 11/2010, revealed that under the Policy statement that all services provided to the resident, or any changes in the resident's electronic medical record (EMR). Under Policy Interpretation and Implementation #5 revealed, Documentation of procedures and treatments shall include care-specific details and shall include at a minimum b. The name and title of the individual who provided the care The signature and title of the individual documenting. NJAC 8:39-27.1 (a) Complaint # NJ184029 Based on interview, review of the medical record, and pertinent facility documents, it was determined that the facility failed to ensure staff documented, and that prescribed treatments were completed according to the physician's orders and acceptable standards of practice in accordance with the New Jersey Board of Nursing Statutes for 3 of 3 sampled residents (Resident #1, Resident #2, and Resident #3). This deficient practice was evidenced by the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Admission Record received on 3/27/25, Resident #1 was admitted to the facility on [DATE], with diagnoses that included but not limited to Acute Pyelonephritis, Depression, Hypertension, and Chronic Kidney Disease. The Quarterly Minimum Data Set (MDS), an assessment tool dated 1/4/25, indicated that the resident was cognitively intact and required assistance with activities of daily living (ADLs). The Order Summary Report (OSR) received on 3/27/25 with an order date of 4/02/25 revealed call bell within reach every shift. The January 2025 Treatment Administration Record (TAR) revealed that the 3:00 p.m. (1500) call bell within reach every shift on 1/4/25 was blank. The March 2025 Treatment Administration Record (TAR) revealed that the 11:00 p.m. (2300) call bell within reach every shift on 3/21/25 was blank. According to the Admission Record received on 3/27/25, Resident #2 was admitted to the facility on [DATE], with diagnoses that included but not limited to Restless Legs Syndrome, Type 2 Diabetes, Major Depressive Disorder, Hypertension, and Hyperglycemia. The Quarterly Minimum Data Set (MDS), an assessment tool dated 1/17/25, indicated that the resident was cognitively intact and independent with activities of daily living (ADLs). The Order Summary Report (OSR) received on 3/27/25 with an order date of 4/27/21 revealed call bell within reach every shift. The March 2025 Treatment Administration Record (TAR) revealed that the 11:00 p.m. (2300) call bell within reach every shift was blank on 3/26/25 was blank. 3. According to the Admission Record received on 3/27/25, Resident #3 was admitted to the facility on [DATE], with diagnoses that included but not limited to Encephalopathy, Transient Ischemic Attack (TIA), Cerebral Infarction, Acute Kidney Failure, Hyperlipidemia, (COPD), and Hypertension. The Quarterly Minimum Data Set (MDS), an assessment tool dated 12/27/24, indicated that the resident was severely impaired and required assistance with activities of daily living (ADLs). The Order Summary Report (OSR) received on 3/27/25 with an order date of 6/19/24 revealed call bell within reach every shift. The March 2025 Treatment Administration Record (TAR) revealed that the 11:00 p.m. (2300) call bell within reach every shift on 3/21/25 was blank. During interview with the surveyor on 3/27/25 at 2:05 p.m., the Administrator confirmed the blanks for call bell within reach on the Medication Administration Record/Treatment Administration Record (MAR/TAR). The Administrator stated that staff failed to acknowledge and document on the MAR/TAR. The Administrator stated that the expectation was for all orders to be signed as per doctor's order. She further stated that it was important for staff to sign off and acknowledge to ensure that the doctor's orders were being followed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the surveyor on 3/27/25 at 3:09 p.m., the Director of Nursing (DON) stated that there should have been no blanks and agreed that there were blanks on the MAR/TAR. The DON stated that the nurses should have signed because it was a part of the doctor's order. During interview with the surveyor on 3/28/25 post survey at 12:31 p.m. via telephone, Registered Nurse (RN #1) stated that she worked one day and one shift at the facility as an agency nurse. RN #1 stated that she always checked to make sure resident's call bell was within reach. She further stated that she does not remember if there was a documentation that she needed to sign off on. During interview with the surveyor on 3/28/25 post survey at 12:40 p.m. via telephone, RN #2 stated that she checked call bells and made sure the call bell was within reach when doing rounds. RN #2 stated that she should have documented, I forgot to document. RN #2 further stated that it was important to document to show the work was done. Review of the Clinical Charting and Documentation Policy and Procedure with an effective date of 11/2010, revealed that under the Policy statement that all services provided to the resident, or any changes in the resident's electronic medical record (EMR). Under Policy Interpretation and Implementation #5 revealed, Documentation of procedures and treatments shall include care-specific details and shall include at a minimum b. The name and title of the individual who provided the care The signature and title of the individual documenting. NJAC 8:39-27.1 (a)