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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 4/27/26 at 11:33 AM, in the presence of the Regional Food Service Director (RFSD), the surveyor observed the cook take the temperature of Veal [NAME] without sanitizing the food thermometer prior to use. The cook stated, I forgot to sanitize the thermometer before using. The Veal [NAME] was thrown away in the garbage by the RFSD.On 4/28/26 at 11:08 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor a facility policy titled, Temperature Monitoring During Meal Service with a reviewed date of 1/2026. The procedure section of the policy revealed, 3. How to take temperature; Sanitize the probe before and after each use.On 4/29/26 at 12:15 PM, the surveyor met with the LNHA and Director of Nursing (DON) to review concerns found during the survey. The LNHA stated the concerns in the kitchen would be addressed immediately.On 4/30/26 at 11:30 AM, the surveyor met with the LNHA and DON for the exit conference. No further pertinent information was provided. NJAC 8:39-17.2(g)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a specialty low air loss mattress (a medical-grade mattress that uses continuous airflow to keep the skin dry, cool, and pressure-free, helping prevent and treat pressure injuries) was accurately set and monitored according to the resident's weight for 6 of 8 residents (Resident #3, #4, #11, #12, #123, and #127). 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 and 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 regimens 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. On 4/23/26 at 10:54 AM, the surveyor observed Resident #3 awake in bed laying on an air mattress. Resident #3's air mattress was set at 180 pounds (lb.). Resident #3 revealed their usual body weight is between 105-115 lb but was not sure of their current body weight (CBW). On 4/23/26 at 11:55 AM, the surveyor reviewed Resident #3's electronic medical record (e-MAR) which revealed the following: A review of the Resident #3's admission Record ((AR) an admission summary) revealed that the resident was admitted to the facility with diagnoses that included: dysphagia (difficulty swallowing), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), and cerebral infarction (ischemic stroke, is the death of brain tissue caused by an interruption of blood flow to the brain). A review of the 5 Day Medicare [NAME] Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 4/14/26, revealed that the resident had a score of 13 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated intact cognitive function. The MDS further revealed under Section M, that Resident #3 was receiving a pressure reducing device for bed. A review of the April 2026 Physician Orders (PO) for Resident #3 revealed multiple POs: Pressuring Relieving Bed/Mattress, every shift check function, dated 4/13/26 and Pressure Relieving Mattress – LOW AIR LOSS, every shift check function, dated 4/13/26. A review of Resident #3's most recent weight revealed the resident weighed 102 lb on 3/11/26. A review of the Care Plan Report (CPR) revealed a Care Plan (CP) with a focus of, resident has a deep tissue injury pressure ulcer left heel and interventions including, requires pressure relieving/reducing (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	device on bed and Administer treatments as ordered and monitor for effectiveness. On 4/27/26 at 7:26 AM, the surveyor observed Resident #3 in bed with their eyes closed and the air mattress was set to 180 lb. 2. On 4/23/26 at 10:56 AM, the surveyor observed Resident #4 in bed with eyes closed and their air mattress observed set at 100 lb. A review of the Resident #4's AR documented that the resident was admitted to the facility with diagnoses that included: osteomyelitis (serious infection or inflammation of the bone), pressure ulcer of sacral region (localized injury to the skin and underlying tissue over the sacrum), and protein-calorie malnutrition (insufficient intake of protein and calories, leading to impaired growth, weakened immunity, and overall poor health). A review of the Quarterly MDS, with an ARD of 4/14/26, revealed that the resident had a score of 13 out of 15 on the BIMS, which indicated intact cognitive function. The MDS further revealed under Section M, that Resident #4 was receiving a pressure reducing device for bed. A review of the April 2026 Physician Orders (PO) for Resident #4 revealed a PO dated 4/13/26, Pressure Relieving Mattress – LOW AIR LOSS, every shift check function. A review of Resident #3's most recent weight revealed the resident weighed 228.8 lb on 4/9/26. A review of the CPR revealed a CP with a focus of, Resident has a break in skin integrity due to presence of sacral wound (stage 4 pressure ulcer) and an intervention of low air loss mattress. On 4/27/26 at 7:29 AM, the surveyor observed Resident #4 in bed with their eyes closed and the air mattress was set to 100 lb. 3. On 4/23/2026 at 11:08 AM, the surveyor observed Resident #123 in bed with their eyes open and surveyor further observed Resident #123's air mattress set at 180 lb. A review of the Resident #123's AR documented that the resident was admitted to the facility with diagnoses that included: acute respiratory failure with hypoxia (condition where the lungs fail to provide sufficient oxygen to the blood, leading to tissue hypoxia), pressure ulcer of sacral region, and protein-calorie malnutrition. A review of the Quarterly MDS, with an ARD of 3/6/26, revealed that the resident had a score of 0 on the BIMS, which indicated severe cognitive impairment. The MDS further revealed under Section M, that Resident #4 was receiving a pressure reducing device for bed. A review of the April 2026 Physician Orders (PO) for Resident #123 revealed a PO dated 4/13/26, Pressure Relieving Mattress – LOW AIR LOSS, every shift check function. A review of Resident #123's most recent weight revealed the resident weighed 78 lb on 4/27/26. A review of the CPR revealed a CP with a focus of, Resident has stage 2 pressure ulcer to right hip and an intervention of requires pressure relieving/reducing device on bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/27/26 at 7:22 AM, the surveyor had a secondary observation of Resident #123's air mattress. The air mattress setting remained at 180 lb. On 4/27/2026 at 10:25 AM, the surveyor and the Licensed Practical Nurse/Unit Manager (UM) observed Resident #3, #4, and #123's air mattresses, the UM confirmed all the residents' air mattresses were set incorrectly. The UM stated all air mattresses should be set to the resident's current body weight. On 4/27/26 at 12:00 PM, the Director of Nursing (DON) provided the surveyor with a facility policy titled, Air Mattress) with a reviewed dated 1/2026. The care and monitoring portion of the policy revealed, checking mattress function every shift. 4. On 4/23/26 at 11:45 AM, and on 4/27/26 at 7:30 AM, the surveyor observed Resident #11 in bed and a specialty mattress in place. The resident's air mattress pump was set at 120 pounds (lbs.) on both observations. The surveyor reviewed the electronic medical record (E-mar) for Resident #11. A review of the admission Record (AR) reflected that Resident #11 was admitted to the facility on [DATE] with diagnoses that included but were not limited to; dementia (decline in cognitive function) and stage 4 (full-thickness skin loss exposing muscle, tendon, or bone) pressure ulcer of the left lower back. A review of the Quarterly MDS dated [DATE] reflected that Resident #11 had a BIMS score of 3 out of 15, indicating severe cognitive impairment. The MDS further indicated that the resident's weight was 88 lbs., was receiving hospice services, had a stage 4 ulcer, and had a low air loss pressure-reducing device for the bed. A review of the CP included a focus that the resident had the potential for skin breakdown. The CP did not include an intervention for a low-air-loss mattress. A review of the current Physician Order Summary Report (OSR) reflected a Physician's order (PO) for a low-air-loss mattress for pressure relief, check every shift for function with a start date of 9/20/25. A review of the current TAR included a low-air-loss mattress in place and to monitor every shift for pressure relief; check for function with a start date of 9/20/25 and signed by nurses, which indicated it was being monitored. A review of the resident's vital signs revealed the resident's last known weight was 88 lbs. on 12/19/25. On 4/27/26 at 10:35 AM, the surveyor showed the Registered Nurse (RN) assigned to Resident #11 the gauge setting on the specialty mattress. The RN acknowledged that the setting was at 120 lbs. and stated that the air pump was set to a specific firmness level and the pump setting had nothing to do with the resident's weight. 5. On 4/27/26 at 9:00 AM, the surveyor observed Resident #12 in bed and a specialty mattress in place. The resident's air mattress pump was set at 260 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the E-mar for Resident #12. A review of the AR reflected that Resident #12 was admitted to the facility with diagnoses that included but were not limited to; cerebral infarction (stroke). A review of the most recent MDS dated [DATE] reflected that Resident #12 had a BIMS score of 3 out of 15, indicating a severe cognitive impairment. The MDS further indicated that the resident's weight was 184 lbs. and that a pressure-reducing device was in place on the bed. A review of the CP included a focus that the resident had a potential for skin breakdown with interventions that included but were not limited to: pressure-relieving devices for bed and wheelchair, initiated 1/15/26. A review of the current OSR reflected a PO for a low-air-loss mattress every shift for pressure relief; Check for function with a start date of 3/3/26. A review of the current TAR included a low-air-loss mattress in place and to monitor every shift for function, with a start date of 3/3/26, and signed by nurses indicating it was being monitored. A review of the resident's vital signs revealed the last known weight was 179.2 lbs. on 4/9/26. On 4/27/26 at 9:40 AM, the surveyor showed the Licensed Practical Nurse/Unit Manager (LPN/UM) the gauge setting on the specialty mattress. The LPN/UM acknowledged that the setting was at 260 lbs. and further stated it should have been set to the resident's weight, which was 179.2 lbs. On 4/27/26 at 9:45 AM, the surveyor showed the LPN assigned to Resident #12's care the pump setting. The LPN confirmed that the resident's weight was 179.2 and that she should have ensured the pump was set to the correct weight, since the air mattress was ordered to prevent or heal pressure ulcers. 6. On 4/27/26 at 9:10 AM, the surveyor observed Resident #127 in bed and a specialty mattress in place. The resident's air mattress pump was set at 220 lbs. A review of the CP identified a focus area that included the potential for skin breakdown but did not include a low-air-loss mattress as an intervention. A review of the current OSR reflected that there was no PO for a low-air-loss mattress. A review of the current TAR did not indicate that the low-air-loss mattress was being monitored. A review of the resident's hospital records revealed the resident's last known weight was 124.3 lbs. on 4/21/26. On 4/27/26 at 9:40 AM, the surveyor showed the LPN/UM gauge setting on the specialty mattress. The LPN/UM acknowledged that the setting was at 220 lbs. and stated that the resident was admitted on [DATE] and that staff had not obtained the resident's weight yet. The LPN/UM further stated that the Resident's hospital weight was 124 lbs., on 4/21/26. The LPN/UM stated that the physician had not written an order for an air mattress and that she did not think the resident should have had one in place, but would check with the resident's physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/26 at 12:25 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), to discuss the above observations and concerns. The DON confirmed that the nurses were responsible for monitoring the specialty mattresses and ensuring that the gauges were set according to the resident's weight. On 4/30/26 at 10:58 AM, no further information was provided. A review of the facility's Air Mattress policy and procedure, dated 1/26, reflected.The facility will provide pressure-redistribution support surfaces (including air mattresses) based on individual resident assessment, risk level, and clinical need to prevent skin breakdown and promote healing of existing pressure injuries.Air mattresses are considered a treatment and preventive medical intervention and should be ordered, monitored, and documented. NJAC 8:39-19.4(a); 27.1 (a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure that medications were stored appropriately, according to manufacturer's guidelines and standards of practice. This deficient practice was identified in 2 of 2 medication refrigerators inspected.This deficient practice was evidenced by the following: On 4/28/26 at 12:56 PM, the surveyor began inspecting the medication (med) storage room located on the facility 1st floor in the presence of the 1st floor Unit Manager (UM1). The surveyor accessed the med refrigerator located in the med room. The surveyor observed the thermometer inside the med refrigerator that reflected twenty-five (25) degrees Fahrenheit (F). The surveyor asked the UM1 to verify the temperature, and what range the temperature should be. UM1 stated that it was 25 degrees F, was too cold and should be between 36 degrees F and 46 degrees F. UM1 stated they would adjust the refrigerator control. On the same date, at 1:17 PM, the surveyor began inspecting the 2nd floor med storage room in the presence of the 2nd floor Unit Manager (UM2). of the facility. The surveyor accessed the med refrigerator located in the med room. The surveyor observed the thermometer inside the med refrigerator that reflected 32 degrees F. The surveyor asked the UM2 to verify the temperature, and what range the temperature should be. UM2 stated that it was 32 degrees F and should be between 36 degrees and 46 degrees. UM2 stated that they would put in a work order for the refrigerator. The surveyor concluded the observation. On 4/29/26 at 9:54 AM, the surveyor interviewed the regional supervisor for the facility Consultant Pharmacist (CP). The surveyor asked the CP if they check the med refrigerator temperatures. The CP stated yes, they do and they were checked on 4/27/26 and found to be in range. The surveyor informed the CP of the observed med refrigerator temperatures. On 4/29/26 at 12:49 PM, the survey team met with the facility Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss concerns with medication storage. The surveyor informed the DON of the temperature findings for the 1st and 2nd floor med refrigerators. On 4/30/26 at 9:19 AM, the survey team met with the LNHA and DON for responses to concerns. The DON stated that the 1st floor med refrigerator was adjusted, and the 2nd floor med refrigerator was replaced. The facility did not provide any further pertinent information. The surveyor reviewed the facility policy provided by the LNHA titled, Storage of Medications dated 1/26 reviewed. The policy did not reflect medication refrigerator temperatures. NJAC 8:39-29.4(h)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent residents in a timely manner for 2 of 5 residents (Resident #85 and #126) observed for incontinence care on 1 of 3 Nursing units (3rd floor).This deficient practice was evidenced by the following:On [DATE] at 7:55 AM, the surveyor conducted an incontinence tour on the 3rd floor Nursing Unit and observed the following: 1. On [DATE] at 8:00 AM, the surveyor, accompanied by the Certified Nursing Assistant (CNA #1), observed Resident #126 in bed. CNA #1 exposed Resident #126's incontinence brief and observed that the brief was saturated with urine. CNA #1 confirmed that the brief was saturated. The surveyor reviewed the medical record for Resident #126. A review of the admission Record (AR) reflected that Resident #126 was admitted to the facility with diagnoses that included but were not limited to; hemiplegia (paralysis causing loss of muscle) and hemiparesis (mild to moderate weakness on one side of the body). A review of the admission Minimum Data Set (MDS), an assessment tool, dated [DATE], reflected that the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. The MDS further assessed that Resident #126 was always incontinent with bowel and bladder and was dependent on staff for toileting hygiene. A review of Resident #126's Care Plan Report (CPR) included a Focus area that the resident was incontinent of bowel and bladder, with interventions that included but were not limited to; offer/assist with toileting during care, before/after meals, at bedtime, and when needed. 2. On [DATE] at 8:10 AM, the surveyor, accompanied by CNA #1, observed Resident #85 in bed. CNA #1 exposed Resident #85's incontinence brief and observed that the brief was saturated with urine. CNA #1 confirmed that the brief was saturated. The surveyor reviewed the medical record for Resident #85. A review of the AR reflected that Resident #85 was admitted to the facility with diagnoses that included but were not limited to; traumatic subdural hemorrhage (serious brain injury where blood collects between the dura mater and the brain surface caused by high impact). A review of the Quarterly MDS dated [DATE] reflected Resident #85 had a BIMS score of 9 out of 15, indicating a moderate cognitive impairment. A further review of the MDS indicated the resident required staff assistance for toileting hygiene and was frequently incontinent of bladder. A review of Resident #85's CP had a focus that indicated the resident was incontinent of bladder and bowel with interventions that included but were not limited to; offer/assist with toileting during care, before/after meals, and activities. On [DATE] at 8:15 AM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM) on the 3rd floor nursing unit stated that she was aware that the staffing regulation was 1:14 on the night shift and that the 11-7 CNAs each had 20 and 21 residents on their assignments. The LPN/UM stated that the facility policy was for CNAs to provide incontinence care every 2 hours.A review of the CNA assignment sheet for the 3rd floor indicated that CNA #2 had 21 residents on their assignment, and CNA #3 had 20.On [DATE] at 8:20 AM, the surveyor conducted a telephone interview with CNA #2 assigned to Resident #85 for the 11:00 PM-7:00 AM shift. CNA #2 stated that she was responsible for 21 residents during that shift and was unable to provide incontinence care every two hours as required. CNA #2 further stated that she was doing her very best. On [DATE] at 8:35 AM, the surveyor conducted a telephone interview with CNA #3 assigned to Resident #126 for the 11:00 PM-7:00 AM. CNA #3 stated that she was responsible for 20 residents during that shift and was unable to provide incontinence care every two hours as required. CNA #3 further stated that she was doing her very best. On [DATE] at 12:25 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations and concerns. The DON confirmed that incontinence care should be provided every 2 hours. On [DATE] at 10:58 AM, no further information was provided. A review of the facility's Incontinence Care policy and procedure dated as reviewed 1/2026 reflected.The facility shall provide (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care for all incontinent residents.Check residents at least every two to four hours. NJAC 8:39-27.1 (a), (e), 27.2 (h)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that a resident received proper assistance in using hearing assistive devices for one (1) of twenty-two (22) residents reviewed, (Resident #6).The 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 and 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 regimens 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. On 4/23/26 at 11:05 AM, the surveyor observed Resident #23 in their room seated in a wheelchair (WC). The surveyor interviewed the resident and observed that the resident had some difficulty hearing. The surveyor did not observe any hearing aids or other hearing assistance devices applied to the resident.On 4/27/26 at 11:44 AM, the surveyor observed Resident #23 seated in a chair in the hallway outside their room. The surveyor did not observe any hearing aids applied to the resident.On 4/28/26 at 10:37 AM, the surveyor observed Resident #23 seated in a WC in their room. The surveyor asked the resident if they have hearing aids and who put them in. The resident gestured toward a bedside table and stated, the nurse helps. The surveyor asked the resident why they didn't have them in now. The resident responded by shrugging their shoulders and stated broken.On 4/28/2026 at 1:26 PM, the surveyor interviewed the 2nd Floor Unit Manager (UM2). The surveyor asked UM2 about Resident #23's hearing aid use. UM2 stated that they believe the resident puts them in themselves and charting was just accountability, but they need to check the Care Plan. On 4/28/26 at 1:33 PM, UM2 informed the surveyor that the staff probably does help Resident #23 with hearing aids and that they should be in. The surveyor informed UM2 that the surveyor had not observed the resident with them in at all.The surveyor reviewed the electronic medical record (EMR) for Resident #23 which revealed the following: An admission Record (AR) reflected that Resident #6 was admitted to the facility with medical diagnoses that included but were not limited to essential hypertension, overactive bladder and dysphagia (difficulty swallowing). A Quarterly Minimum Data Set (qMDS) an assessment tool, with an assessment reference date (ARD) of 2/11/26, reflected, in Section C, that the resident had a brief interview for mental status (BIMS) score of 13 out of 15 indicating the resident was cognitively intact. A Comprehensive Care Plan (CCP), a summary of a person's health conditions, specific care goals, and current interventions, which revealed an Intervention dated revised 6/26/23, CNA to check that resident has their hearing aids. An electronic treatment administration record (eTAR), which reflected a physician's order to check hearing aid to both ears every shift. The eTAR also reflected that the hearing aids were documented as applied on the day and evening shifts from 4/2/26 through 4/26/26. On 4/29/26 at 12:49 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) for concerns regarding Resident #23 and the documentation for hearing aid use. The surveyor notified the DON that the surveyor did not observe Resident #23 with hearing aids, there was documentation by the staff that they were being used, and the hearing aids were observed in a case on a table. On 4/30/26 at 9:19 AM, the surveyor met with the LNHA and DON for responses to concerns for Resident #23. The LNHA stated that the facility obtained new hearing aids for the resident and staff was educated. The surveyor reviewed the policy titled Hearing Impaired Resident, (continued on next page)

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	315366	A. Building B. Wing	05/07/2026

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 1/30/26, provided by the LNHA. The policy reflected: Staff will assist residents with care and maintenance of hearing devices. The facility did not provide any further pertinent information. N.J.A.C. 8:39-27.5(a)(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy it was determined that the facility failed to ensure the Registered Dietitian (RD#1) completed a nutritional reassessment for a resident who was readmitted to the facility in a timely fashion. This deficient practice was identified for 1 of 4 residents reviewed for Nutrition (Resident #123), and was evidenced by the following: On 4/23/26 at 11:08 AM, the surveyor observed Resident #123 in bed with their eyes open, resident noted with confusion.On 4/23/26 at 11:13 AM, the surveyor interviewed Resident #123's Licensed Practical Nurse (LPN#1), who stated the resident had recently been readmitted to the facility.A review of the Resident #123's admission Record ((AR) an admission summary) indicated that the resident was admitted to the facility with diagnoses that included: acute respiratory failure with hypoxia (condition where the lungs fail to provide sufficient oxygen to the blood, leading to tissue hypoxia), pressure ulcer of sacral region (localized injury to the skin and underlying tissue over the sacrum), and protein-calorie malnutrition (insufficient intake of protein and calories, leading to impaired growth, weakened immunity, and overall poor health).A review of the Entry Medicare Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 4/18/26, revealed that the resident had been readmitted from a short-term general hospital. A review of the nursing progress notes revealed, Resident #123 was readmitted to the facility on [DATE] from the hospital with a diagnosis of respiratory failure. Further review of the progress note revealed a nutrition reassessment note dated 4/27/26 at 2:30 PM, 9 days after the resident was readmitted to the facility.On 4/29/26 at 11:39 AM, the surveyor interviewed RD#1, who stated she would try to conduct initial and readmission assessments within 24 hours of a resident entering the facility but has 72 hours to complete the assessments. Surveyor reviewed Resident #123's readmission and nutrition reassessment dates with RD#1, who confirmed the nutrition reassessment note was not completed until ninth day after readmission. RD#1 acknowledged the nutrition note was late. On 4/29/26 at 11:55 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LHNA) and the Director of Nursing (DON) who stated initial and readmission nutrition assessment should be completed within five days of admission and/or readmission into the facility. Both the LNHA and DON acknowledged Resident #123's readmission assessment was late.On 4/29/26 at 12:10 PM, the DON provided the surveyor with a facility policy titled, Medical Nutrition Therapy (MNT) Documentation, reviewed on 1/2026. The procedure section of the policy revealed, the initial comprehensive MNT assessment for a new or readmitted individual is generally initiated and/or completed with 5 days of admission.On 4/29/26 at 12:15 PM, the surveyor met with the LNHA and DON to review concerns found during the survey. The DON stated nutrition notes would be reviewed for any irregularities.On 4/30/26 at 11:30 AM, the surveyor met with the LNHA and DON for the exit conference. No further pertinent information was provided. NJAC 8:39 - 11.2(e)(1)(f), 17.1(c), 17.2(c)(d), 27.1(a)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on observation, interview, and record review, it was determined that the facility failed to assure that the physician responsible for supervising the care of residents completed monthly progress notes. This deficient practice continued over several months for 1 of 22 residents, Resident #6, reviewed for physician progress notes and current physician orders.This deficient practice was evidenced by the following: On 4/28/26 at 12:20 PM, the surveyor observed Resident #6 in bed in their room. The resident was alert, oriented and conversed with the surveyor. The surveyor reviewed the electronic medical record (EMR) of Resident #6 which revealed the following: An admission Record (AR) reflected that Resident #6 was admitted to the facility with medical diagnoses that included but were not limited to; bullous pemphigoid (a chronic autoimmune skin disorder), anemia, and essential hypertension. A Quarterly Minimum Data Set (qMDS), an assessment tool, with an assessment reference date (ARD) of 3/29/26, reflected that the resident had a brief interview for mental status (BIMS) score of 15 out of 15 indicating the resident was cognitively intact. A review of Resident # 6's EMR revealed that from 8/3/25 to 4/1/26 the Primary Physician (Physician #1) had not written any monthly Medical Progress Notes (PN) in the electrotonic or paper chart. On 4/29/26 at 12:49 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) for concerns regarding physician documentation. The surveyor notified the LNHA that Resident #6's primary physician, who was also the facility's medical director, did not have any completed progress notes in the medical record for the period of 8/3/25 through 4/1/26 inclusive. On 4/30/26 at 10:35 AM, the survey team met with the LNHA and DON for responses to concerns. For the concern regarding physician documentation, the LNHA stated that the physician is not satisfying the regulation requirements for documentation. The facility did not provide any further pertinent information. The surveyor reviewed the policy provided by the LNHA titled, Physician Visits and Services with a reviewed date of 1/26. Under Procedure: 4. The attending physician shall visit the resident in accordance with the resident's needs. 5. Progress notes and orders must be written, signed and dated at each physician visit. NJAC 8:39-23.2(b)(d)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to a.) maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey, and b.) failed to ensure that sufficient and competent staff were available to provide appropriate incontinence care to dependent residents for 2 of 5 residents (Resident #85 and #126) on 1 of 3 units (3rd floor) Nursing unit.This deficient practice was evidenced by the following:Refer to F677 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. Direct care staff member means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) One certified nurse aide to every eight residents for the day shift. (2) One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties. 1.A review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the two weeks of staffing from 4/5/26 through 4/18/26 prior to the Standard survey of 5/7/26, revealed the facility was deficient in staffing hours as evidenced by the following: a. For the 2 weeks of staffing prior to survey from 04/05/2026 to 04/18/2026, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -04/05/26 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs.-04/06/26 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.-04/07/26 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs.-04/08/26 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs.-04/09/26 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs.-04/10/26 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs.-04/11/26 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -04/12/26 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs.-04/13/26 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.-04/14/26 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.-04/17/26 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.-04/18/26 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. b For the 2 weeks of Complaint staffing from 10/19/2025 to 11/01/2025, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -10/19/25 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs.-10/20/25 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs.-10/21/25 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs.-10/23/25 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs.-10/25/25 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -10/26/25 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.-10/27/25 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.-10/28/25 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs.-10/29/25 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs.-10/30/25 had 12 CNAs for 101 residents on the day shift, required at least 13 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNAs.-10/31/25 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.-11/01/25 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. c. For the 2 weeks of Complaint staffing from 12/28/2025 to 01/10/2026, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -12/28/25 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs.-12/29/25 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs.-12/30/25 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs.-12/31/25 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs.-01/01/26 had 8 CNAs for 109 residents on the day shift, required at least 14 CNAs.-01/02/26 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs.-01/03/26 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -01/04/26 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs.-01/05/26 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs.-01/06/26 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs.-01/07/26 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs.-01/08/26 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs.-01/09/26 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs.-01/10/26 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. 2. On 4/27/26 at 7:20 AM, the surveyor conducted an incontinence tour on the 3rd floor Nursing Unit and observed the following: a.On 4/27/26 at 8:00 AM, the surveyor, accompanied by the Certified Nursing Assistant (CNA #1), observed Resident #126 in bed. CNA #1 exposed Resident #126's incontinence brief and observed that the brief was saturated with urine. CNA #1 confirmed that the brief was saturated. b. On 4/27/26 at 8:10 AM, the surveyor, accompanied by CNA #1, observed Resident #85 in bed. CNA #1 exposed Resident #85's incontinence brief and observed that the brief was saturated with urine. CNA #1 confirmed that the brief was saturated. Review of the 11:00 PM-7:00 AM CNA assignment sheet revealed that the 3rd floor nursing unit had a census of 41 residents with 2 assigned aides. CNA #2 and CNA #3 had assignments of 20 and 21 residents, respectively, on that 11 PM -7 AM shift. On 04/27/2026 at 12:05 PM, the surveyor interviewed the staffing coordinator (SC), who stated that they were aware of the staffing ratios for CNAs. The SC also stated that staffing for the night shift was more difficult than the other shifts and that the facility did not use agency staff. The SC further stated that she was unaware that the 3rd-floor Nursing Unit had a Census of 41 and that there were only 2 CNAs scheduled for the 11-7 shift. On 4/27/26 at 8:15 AM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that she was aware that the staffing regulation was 1:14 on the night shift and that her expectation was that the CNAs provide incontinence care every 2 hours. On 4/27/26 at 8:20 AM, the surveyor conducted a telephone interview with the 11:00 PM-7:00 AM CNA (CNA #2) assigned to Resident #85. CNA #2 stated that she was responsible for 21 Residents during that shift and was unable to provide incontinence care every two hours as required. CNA #2 stated that she was doing her very best. 4/27/26 at 8:35 AM, the surveyor conducted a telephone interview with the 11:00 PM-7:00 AM CNA (CNA #3) assigned to Resident #126. CNA #3 stated that she was responsible for 20 Residents during that shift and was unable to provide incontinence care every two hours as required. CNA #3 further stated that she was doing her very best. On 4/29/26 at 12:25 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations and concerns. The DON confirmed that the minimum CNA-to-staff ratio on the 11:00 PM-7:00 AM shift was 1:14 and the facility had not met that requirement. On 4/30/26 at 10:58 AM, no further information was provided. A review of the facility's policy, Staffing, dated 01/2026, revealed. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met.Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. A review of the facility's Incontinence Care policy and procedure, dated as reviewed 1/2026, reflected.The facility shall provide care for all incontinent residents.Check residents at least every two to four hours. NJAC 8:39-27.1 (a), (e), 27.2 (h)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policies it was determined that the Consultant Pharmacist (CP) failed to clarify medication route for a resident during the monthly medication reviews for 1 of 6 Residents, (Resident #3). On 4/23/26 at 10:54 AM, the surveyor observed Resident #3 awake in bed, the resident stated they were currently on a tube feeding ((TF), also known as enteral feeding, delivers liquid nutrition through a flexible tube directly into your stomach or small intestine) and does not consume anything by mouth.On 4/23/26 at 11:55 AM the surveyor reviewed Resident #3's electronic medical record (e-MAR) which revealed the following: A review of the Resident #3's admission Record (an admission summary) documented that the resident was admitted to the facility with diagnoses that included: dysphagia (difficulty swallowing), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), and cerebral infarction (ischemic stroke, is the death of brain tissue caused by an interruption of blood flow to the brain). A review of the 5 Day Medicare [NAME] Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 4/14/26, revealed that the resident had a score of 13 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated intact cognitive function. The MDS further revealed under Section K, that Resident #3 was receiving a TF.A review of the April 2026 Physician Orders (PO) for Resident #3 revealed multiple POs: NPO (nothing by mouth), every shift. Dated 4/13/2026, Mylanta Suspension 200-200-20 milligram/milliliter (MG/5ML) (Alum & Mag Hydroxide-Simeth) Give 30 ml orally every 4 hours as needed for heartburn & indigestion AND Give 30 ml orally every 4 hours as needed for dyspepsia SHAKE WELL. TAKE AFTER MEALS.' Dated 4/14/2026, and Milk of Magnesia Suspension 400 MG/5ML (Magnesium Hydroxide) - Give 30 ml by mouth as needed for no BM after 2 days Give at bedtime. If ineffective after 24 hours, call MD. Dated 4/14/2026.A review of Resident #3's progress notes revealed a note from the Pharmacy consultant dated 4/16/2026, Medication Regimen Reviewed. No recommendations made.On 4/28/26 at 9:17 AM, the surveyor interviewed the 2nd Floor Unit Manager (UM) and Director of Nursing (DON) who both confirmed that Resident #3 is NPO and had two POs for milk of magnesia by mouth. The DON further stated that this discrepancy should have been caught by the CP as well as facility staff.On 4/28/26 at 9:18 AM, the DON provided the surveyor with a copy of the CP's report for 4/302026-4/30/2026. The report does not mention Resident #3's medication discrepancy.On 4/29/26 at 9:29 AM, the surveyor conducted a phone interview with the Regional Pharmacy Consultant (RPC) who stated the CP conducts medication reviews a for all residents monthly and two times per week for new and re-admitted residents. The RPC revealed Resident #3's medication discrepancy should have been caught and noted by the CP.On 4/29/26 at 12:00 PM, the DON provided the surveyor with a facility policy titled, Consultant Pharmacy Reports revised on 1/2026. The procedure section of the policy revealed, 2. The Consultant Pharmacy will perform a drug regiment review (DRR) of all new admission/readmission orders.4. Any medication irregularities identified will be documented on a separate, written report and notification to attending physician, and director of nursing, listing the resident name, relevant drug and irregularity that was identified with resolution noted by the physician.On 4/29/26 at 12:15 PM, the surveyor met with the LNHA and Director of Nursing (DON) to review concerns found during the survey. The DON stated the medication irregularity for Resident #3 has been fixed, and the facility willing be conducting an addition medication audit.On 4/30/26 at 11:30 AM, the surveyor met with the LNHA and DON for the exit conference. No further pertinent information was provided. NJAC 8:39- 29.3 (a)

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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. Based on 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, by diagnosis, indication and effectiveness, for one (1) of twenty-two (22) residents reviewed, (Resident #6).The deficient practice was evidenced by the following: The surveyor reviewed Resident #6's electronic medical record (EMR) which revealed the following: An admission Record (AR) reflected that Resident #6 was admitted to the facility with medical diagnoses that included but were not limited to bullous pemphigoid (a chronic autoimmune skin disorder), anemia, and essential hypertension. A Quarterly Minimum Data Set (qMDS) an assessment tool, with an assessment reference date (ARD) of 3/29/26, reflected that the resident had a brief interview for mental status (BIMS) score of 15 out of 15 indicating the resident was cognitively intact.Section H of the MDS reflected that the resident was always incontinent of urine. A review of Resident #6's Order Summary Report (OSR), a listing of the resident's physician orders, revealed that the resident was being administered Tamsulosin .4mg, (Flomax), a medication used to relax muscles in the bladder and prostate in men to facilitate the flow of urine.The order reflected the instructions: Give 1 capsule by mouth one time a day for BPH (an enlargement of the prostate gland). A review of the resident's electronic medication administration record (eMAR) revealed the order dated 10/24/25, Tamsulosin HCL oral capsule .4mg Give 1 capsule one time a day for BPH. A review of Resident # 6's EMR revealed that from 8/3/25 to 4/1/26 the Primary Physician (Physician #1) had not written any monthly Medical Progress Notes (PN) in the electrotonic or paper chart that reflected a diagnosis, indication, or other comment relating to the unapproved or off-label use, or benefit vs risk for the use of tamsulosin. Further review of the EMR revealed PN from the Nurse Practitioner (NP). A note dated as a Late Entry 3/13/26, reflected a diagnosis of urinary retention. There were no NP notes that reflected the use of Tamsulosin that included the benefit vs risk for use, the effectiveness or that the resident was incontinent. Further review of the EMR revealed Consultant Pharmacist (CP) notes. The CP notes did not reflect any mention of off-label use of tamsulosin, or requests for physician supportive documentation. On 4/29/26 at 9:54 AM, the surveyor interviewed the Regional CP. The surveyor asked the CP if it is an expectation of the CP to request documentation for tamsulosin use in females from the MD. The CP stated yes, it is an expectation to request supportive documentation. The surveyor reviewed the Manufacturer Package Insert for Flomax (PI) which reveal the approved use of Flomax under INDICATIONS AND USAGE FLOMAX (tamsulosin hydrochloride, USP) capsules are indicated for the treatment of the signs and symptoms of benign prostatic hyperplasia (BPH).The (PI) also reflected the statement FLOMAX is not indicated for use in women. On 4/29/26 at 12:49 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) for concerns regarding the Resident #6 and the documentation for tamsulosin use. The surveyor notified the LNHA that Resident #6's primary physician did not have any documentation regarding the use of tamsulosin for Resident #6. Additionally, the NP had not documented anything about the use of tamsulosin in the resident at all. The surveyor also notified the DON of the indication reflected on the order and asked if BPH would be appropriate for Resident #6. The DON stated, no, it is not. On 4/30/26 at 9:19 AM, the surveyor met with the LNHA and DON for responses to concerns for Resident #6. The DON stated that the resident saw urology in the hospital and got a diagnosis of urinary retention. The DON also stated that the indication of BPH was missed at several levels, admission nurses, 24 chart checks, pharmacists. The facility did not provide any further pertinent information. 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
	315366	A. Building B. Wing	05/07/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications (meds) were administered without error of 5% or more during medication administration, four (4) nurses administered meds to six (6) residents. There were twenty-eight (28) opportunities for error, two (2) errors were observed which calculated to a medication administration error rate of 7.1%. This deficient practice was identified for 2 of 6 residents, (Resident #125, Resident #129), that were administered meds by 2 of 4 nurses observed.The 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 and 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 regimens 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. On 4/27/26 at 9:00 AM, the surveyor observed the Registered Nurse (RN) assigned to Resident #125 (RN#1) prepare meds for the resident. The meds included an active physician's order (PO) for the following:Multivitamin-Minerals Tablet Give 1 tablet by mouth one time a day for supplement. (MVI).The surveyor observed the RN prepare and administer Resident #125's medications which included one (1) MULTIVITAMIN TABLET (MV).The surveyor then observed RN#1 administer the multivitamin, along with other due medications to the resident. Upon return to the medication cart (med-cart), the surveyor asked RN#1 to identify the bottle she took the MVI from. RN#1 showed the surveyor the bottle labeled Multivitamin tablets. The surveyor asked RN#1 to compare the bottle label to the order on the resident's electronic medication administration record (eMAR). RN#1 stated that it should have been with minerals. On 4/27/26 at 10:08 AM the surveyor interviewed RN#1. The surveyor asked RN#1 if they should follow physician orders as written. RN#1 stated yes, they should. On 4/28/26 at 8:50 AM, the surveyor observed the RN assigned to Resident #129 (RN#2) prepare meds for administration to the resident. The meds included an active PO for the following: Midodrine HCl 5 MG Tablet (Midodrine) 1 TABLET BY MOUTH TWICE DAILY FOR HYPOTENSION HOLD FOR SBP GREATER THAN 120 (a medication given for low blood pressure), scheduled for administration at 7:30 AM. The surveyor observed RN#2 document the resident's blood pressure (BP) in the electronic medication administration record (eMAR). The surveyor did not observe RN#2 obtain a BP from the resident, the surveyor asked RN#2 when the BP reading was taken. RN#2 stated that they took the BP around 7:30 AM. RN#2 stated that they were holding (not administering) the med per the instructions if the BP was over 120 and the BP was 148. The surveyor asked RN#2 if they normally use the BP reading from the morning to give meds later. RN#2 stated that if the BP was not taken earlier, they would have taken it right before giving the med.The surveyor concluded the medication pass observation with RN#2. On 4/28/26 at 9:16 AM, the surveyor interviewed the Director of Nursing (DON). The surveyor asked what the expectations are for the staff taking BP for meds that require it. The DON stated that the BP should be taken just before administration. The surveyor reviewed the electronic medical record (EMR) for Resident #129 which revealed the following:An eMAR entry for Midodrine on 4/28/26 with a code of 5 that indicated hold/see nurse notes.An eMAR - Medication Administration Note dated 4/28/26 at 8:53 AM that reflected, Midodrine HCl Oral Tablet 5 MG Give 1 tablet by mouth two times a day for Hypotension Hold for SBP greater than 120 med held B/P 148/75. On 04/29/26 at 12:49 PM, the survey team met (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the DON and Licensed Nursing Home Administrator (LNHA) to discuss concerns with the medication pass. The surveyor informed the DON and LNHA of the errors observed during the observation.On 4/30/26 at 9:19 AM, the survey team met with the LNHA and DON for responses to concerns. The DON stated that the staff was educated about following physician orders and proper recording of BP.The facility did not provide any further pertinent information. The surveyor reviewed the policy provided by the LNHA titled Medication Administration Policy dated 1/26 Reviewed. The policy reflected, under Procedure: 3. Medications must be administered in accordance with the orders, including any required time frame. Line 10. Medications. must be administered within one (1) hour of their prescribed time, unless otherwise specified. N.J.A.C 8:39-29.2 (d)