STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315449	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at West Orange	5 Brook End Drive West Orange, NJ 07052

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 2688530Based on interviews, review of medical records, and review of other pertinent facility documents on 12/22/2025, it was determined that the facility failed to ensure that residents received care and services necessary to attain or maintain the highest practicable physical well-being, in accordance with professional standards of practice, by failing to timely assess, monitor and implement appropriate interventions for identified skin integrity concerns.This deficient practice was identified for 2 of 3 residents reviewed (Resident #1 and Resident #2), as evidenced by the following:Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist.According to the admission Record (AR), Resident #1 was admitted with diagnoses that included but were not limited to: adult failure to thrive.According to the Minimum Data Set (MDS), an assessment tool dated 10/10/25, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 indicating that Resident #1 was cognitively intact.A review of Resident #1's Admit/Readmit Screener - V5 dated 11/13/25 at 09:59 P.M., reveals under 10. Integrity that Resident #1 has four sites of integrity areas noted; a stage 2 pressure injury to the coccyx, a stage 2 pressure injury to the right buttock, a stage 2 pressure injury to the left buttock, and bruising to the right toe.A review of Resident #1's Progress Note (PN) dated 11/13/25 at 10:00 P.M., revealed Resident #1 was admitted to the facility with a stage 2 sacral pressure ulcer.A review of Resident #1's Nurse Practitioner's (NP) PN dated 11/14/25 at 3:00 P.M., revealed Skin: Denies skin breakdown and rashes and no notes of pressure injury or stage 2 sacral pressure ulcer throughout the note.A review of Resident #1's Order Summary Report (OSR) with a print date of 12/22/25, revealed an order for Silver Sulfadiazine Cream 1% to be applied to right and left buttocks with a start date of 11/21/2025 at 9:00 A.M.A review of Resident #1's Care Plans (CP) with a print date of 12/23/25, revealed Resident #1 has Stage 2 Pressure ulcer upon re-admitting related to their disease process with an initiation date of 12/23/2025 and an intervention to administer treatments as ordered with an initiation date of 12/23/2025.According to the AR, Resident #2 was admitted with diagnoses that included but were not limited to: Cerebral infarction and type 2 Diabetes Mellitus.According to the MDS, an assessment tool dated 10/1/25, Resident #2 had a BIMS score of 13 indicating that Resident #2 was cognitively intact.A review of Resident #2's CP with a print date of 12/22/25 revealed, on 11/28/2025 a CNA reported an area of redness to Resident #2's left thigh with open area measuring 1.0 cm X 1.0 cm slightly swollen and warm to touch with redness around the site with an initiation date of 12/02/2025. The CP interventions included, Complete treatment to wound using clean technique as per physicians order with an initiation date of 12/2/2025.A review of a document provided by the facility as the incident report, titled #2957 Other dated 11/28/2025 at 11:30 A.M., for Resident #2 reveals under Immediate Action Taken Description: NP made aware of findings with order to apply warm compress every shift X3 days, monitor the site and keep her informed. DON aware. wound consult next Wednesday. Resident [Resident #2] is alert, was educated to stay on [their] right side, report pain to site.A review of Resident #2's Progress Note (PN) dated 12/1/25 at 3:45 P.M., revealed Resident #2 was noted to have an abscess with drainage and a wound culture was ordered.A review of Resident #2's PN by the NP dated 12/2/25 at 10:20 A.M. revealed infectious disease consultation requested today for cutaneous abscess noted with swelling, redness and induration since Friday with purulent drainage.A review of Resident #2's PN dated 12/3/25 at 10:00 A.M., revealed the resident was seen on wound care rounds and it was recommended to transfer to the hospital for a surgical evaluation due to worsening of the wound. Provider was notified and the daughter also made aware. Resident #2 was sent to the hospital on [DATE].A review of Resident #2's PN dated 12/18/25 at 10:05 P.M., revealed Resident #2 was readmitted to the facility with a left hip abscess wound and a stage one sacral wound pressure ulcer.A review of Resident #2's Admit/Readmit Screener - V5 dated 12/18/25 at 10:04 P.M., revealed under 10. Integrity that Resident #2 had three sites of integrity areas noted; a stage 1 pressure injury to the coccyx, an other/specify injury to left trochanter (hip), and a stage 1 pressure injury to the sacrum.A review of Resident #2's Administration Record: TREATMENT ADMINISTRATION RECORD dated 12/1/2025 thru 12/31/2025 reveals the treatment Boudreauxs Butt Paste