

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Alaris Health at West Orange		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>07342</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure that bedroom flooring was fixed for one of 26 sample residents (Resident (R) 37) reviewed for environment. This failure had the potential to affect resident safety.</p> <p>Findings include:</p> <p>Review of R37's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact.</p> <p>During an interview after the group meeting on 12/19/24 at 11:10 AM, R37 revealed his bedroom sustained a leak on the floor from the faucet/sink within the bedroom causing the sink drain to be clogged. Water reportedly ran over the sink onto the floor below. The water remained on the floor too long causing the linoleum to buckle. R37 revealed he was concerned that his roommate could fall on the floor causing injury.</p> <p>Review of the logbook, provided by the facility, revealed a water overflow in R37's bedroom on 11/24/24 which was considered to have been repaired, however there were no records of a floor problem.</p> <p>Observation on 12/19/24 at 11:15 AM revealed a one foot wide by four-foot-long section including tile missing in one section exposing concrete flooring below for a six inch long by six inch wide area in R37's bedroom. The missing tile section had a large yellow sign noting danger in the middle of the bedroom.</p> <p>Interview with the Regional Maintenance Director (RMD) on 12/19/24 at 11:15 AM verified the condition of the floor and requested that the maintenance department repair the problem immediately. The Administrator verified the problem at this time.</p> <p>During an interview on 12/19/24 at 11:20 AM, the Maintenance Director (MD) stated he had a lot to do during the survey and was waiting for the survey to finish to begin work.</p> <p>Review of the facility's policy titled, Maintenance Repairs, dated originally on 11/12 and updated for May 2024, revealed repair concerns shall be logged in the repair or maintenance logbook.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-4.1(a)(11) NJAC 8:39-31.4(a)

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident was free from physical restraints for one of one resident (Resident (R) 64) reviewed for physical restraints out of 26 sample residents. This failure had the potential to affect all residents' rights at the facility.</p> <p>Findings include:</p> <p>Review of R64's Face Sheet, located in resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, bipolar disorder, depressive disorder, and anxiety disorder.</p> <p>Review of R64's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/29/24 and 10/23/24 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Further review revealed R64 had no wandering behaviors during either lookback period.</p> <p>Review of R64's Care Plan, dated 08/21/24 and located in the residents' EMR under the Care Plan tab, revealed The resident had the potential to go outside to get fresh air without letting staff know related to impulsive behavior and has had verbalizations of leaving the facility. Interventions in place included approach resident in a calm manner and attempt to redirect, wander guard applied to remind resident to tell staff when she wanted to go outside on the facility grounds for fresh air, social services to visit 1:1 as needed, psychiatric consult as needed, offer activities, and monitor episodes of wandering.</p> <p>Review of R64's Elopement Risk Assessment, dated July 2024 and located in the resident's EMR under the Assessments tab, revealed a low-risk score of five.</p> <p>Review of R64's Elopement Risk Assessment, dated August 2024 and located in the resident's EMR under the Assessments tab, revealed a high-risk score of 10. Further review revealed the resident was not at risk, but the rationale was a diagnosis of bipolar and depression disorder.</p> <p>Review of R64's Nurse's Note, dated 08/16/24 at 2:21 PM, located in the EMR under the Notes" tab and written by Assistant Director of Nursing (ADON), revealed .The resident was noted sitting in the patio having auditory and visual hallucination. When asked, the resident stated she was talking to her mom in Florida. Resident was re-directed to reality with some effectiveness. The resident agreed that her mother was not physically present but that she is able to speak to her through her special mind. The physician was made aware and order given to collect urine to rule out UTI [urinary tract infection] and psychiatric consult order. Resident has a diagnosis of schizoaffective no current medications in place due to resident refusal in the past. Will continue to monitor and document behaviors .</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R64's Nurse's Note, dated 08/17/24 at 8:52 AM, located in the EMR under the 'Notes' tab and written by Registered Nurse (RN) 2, revealed .Around 15:30 PM [3:30 PM], the primary nurse called the nurse supervisor about the resident noting that the resident was exhibiting signs of dissociation and detachment, reacting to the nurse as if they were hallucinating. The physician was made aware and ordered to transfer the resident to the hospital for a psych evaluation .</p> <p>Review of R64's Nurse's Note, dated 08/21/24 9:54 PM, located in the EMR under the 'Notes' tab and written by RN2, revealed .physician made aware the resident continues to have auditory hallucinations and inability to control impulses. The physician gave an order for wander guard. Order was carried out. Staff continue to monitor the resident throughout the shift. Left resident in bed resting comfortably with call bell within reach . Further review of progress notes between August 2024 to present revealed no documentation of wandering or exit seeking.</p> <p>During an interview on 12/17/24 at 4:28 PM, R64 stated staff never asked her if she was ok with wearing the wander guard and that they just kind of put it on her ankle. She stated she did not give or sign consent for it. She stated she could not remember who put the first one on her, but Unit Manager (UM) 1 placed the second one on her ankle. She said she liked to go walking outside, but that she was not allowed to go unless staff were with her. She stated she did not like wearing the wander guard because it restricted her from being able to go outside to walk. R64 stated she wanted to go outside today because it was nice, but she was unable to since there were no staff available to take her. She stated she also did not like going between the floors in the facility with the wander guard on because it caused an alarm to go off. She said she never left the facility and just liked to go outside.</p> <p>During an interview on 12/18/24 at 11:26 AM, UM1 explained the facilities wander guard criteria and stated it was placed on residents who were confused, did not follow directions, and were exit seeking. She said exit seeking was when they would try to go to the elevator, pushing the exit doors open and follow people wherever they went. She said residents who were alert and oriented were allowed to go between the floors. She said an elopement assessment was completed prior to wander guard being placed on a resident and exit seeking behaviors were documented in progress notes. She said the resident's responsible party would need to provide consent and that a cognitive resident would not need to have a wander guard. UM1 stated she placed another wander guard on R64 in October 2024. She said R64 was very alert, but she had some problems. She said R64 never complained about the wander guard, but she never asked her if she was ok wearing it or if it bothered her. UM1 stated there was an incident that occurred once when R64 thought she saw starving kids and wanted to go help them. She stated she never observed any staff asking R64 if she was agreeable to wear the wander guard and the facility did not have a document to sign, and she was not aware of R64 ever giving permission.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/18/24 at 2:44 PM, RN2 said safety was important and if a resident was confused but did not have exit seeking behaviors, a wander guard was used as a prevention. She said residents were allowed to go between floors in the facility and the wander guard would alarm but it would prevent the front door from opening. She described exit seeking when a resident said they wanted to go home, or that someone was going to come pick them up. She stated she did not consider a resident going between floors as exit seeking. She said she was unsure if there was a consent form that needed to be signed for the wander guard. RN2 stated if a responsible party or cognitive resident gave permission for the wander guard it would have been documented. She said she told R64 the wander guard was for her safety and explained to her what it was for, but she did not get consent from R64. She said there were some days she R64 was in her right mind but there were sometimes when she was not but that R64 was not exit seeking. She said the wander guard was just a prevention for R64's safety. RN2 stated staff were just concerned for her safety, but that R64 did not exit seek and that R64 just wanted to go outside and walk but she was not allowed to unless staff were present.</p> <p>During an interview on 12/19/24 at 12:01 PM the Director of Nursing (DON) said the #1 reason for wander guard use was exit seeking when a resident verbalized their desire to leave and go out of the building. She said the interdisciplinary team (IDT) met to see if a wander guard would be necessary for a resident, they would call the physician and the family, but there was not a form for consent. She said they would weigh the risk versus benefits of it. She said an alert resident with a high BIMS score would not need a wander guard because they were alert and oriented and had a high BIMS. She said R64 had intermittent confusion that could come at any time of the day. She stated R64 told the facility she wanted to go out because her boyfriend was waiting outside. She said the wander guard was for R64's safety. She said the resident had the right to leave the building and could leave the facility against medical advice (AMA). She said staff were scared for her safety and that R64 could leave when staff could accompany her. She said safety was their main concern and that was why they decided to continue with the Wander guard.</p> <p>Review of the facility's policy titled, Restraints, revised 01/24, revealed Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. All residents have the right to be free from any form of physical or chemical restraint. The resident has a right to participate in care planning and the right to refuse treatment, including the right to accept or refuse restraints. The facility must ensure the use of restraint is clinically justified and guided by criteria present in current evidence-based national practice guideline's, practice parameters, pathways care or other standardized care procedures developed by appropriate professional organizations.</p> <p>NJAC 8:39-4.1(a)(6)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure that a Preadmission Screening and Resident Review (PASARR) level I assessment was completed accurately for one of three residents (Resident (R) 64) reviewed for level I PASARR screenings of 26 sample residents. This failure had the potential to prevent or delay additional services for a resident that may qualify for level II.</p> <p>Findings include:</p> <p>Review of R64's Face Sheet located in resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, bipolar disorder, depressive disorder, and anxiety disorder.</p> <p>Review of R64's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/29/24 and 10/23/24 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Further review revealed a diagnosis of schizophrenia.</p> <p>Review of R64's Care Plan, dated 01/02/24 and located in the residents' EMR under the Care Plan tab, revealed The resident had a diagnosis of Schizoaffective with delusions and paranoia. Interventions in place were to document and report any behaviors.</p> <p>Review of R64's NJ [New Jersey] Department of Human Services Pre-Admission Screening and Resident Review (PASRR) Level I screen, dated 10/24/23 and located in the resident's EMR under the Miscellaneous tab, revealed no indication of mental illness identified or history of psychiatric hospitalization s.</p> <p>Review of R64's behavioral services Psych Evaluation, dated 10/25/23 and located in the residents EMR under the Miscellaneous tab, revealed a diagnosis of schizophrenia, anxiety, and depression. Further review revealed a history of psychiatric hospitalization s.</p> <p>During an interview on 12/19/24 at 10:03 AM, the Admissions Director (AD) said the PASARR level I came from the hospital prior to the resident being admitted to the facility. She stated she would review it to see if it was completed and if it indicated it was positive or negative. The AD stated she did not review it for accuracy. She said she trusted that the hospital filled it out correctly. She said she was completely unaware that R64's was not completed accurately. She agreed it was done incorrectly and did not indicate the resident's mental illness diagnosis or psych history accurately and, but it should have been.</p> <p>During an interview on 12/19/24 at 12:01 PM, the Director of Nursing (DON) said staff reviewed the PASARR to see if it indicated if it was positive for level II. But she said it was already completed by the hospital, and she was not sure if staff reviewed it for accuracy. She stated she expected staff to ensure it was completed accurately. She stated she was unaware R64's was not completed accurately.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Pre-admission Screening and Resident Review (PASRR), revised 01/24, revealed It is the policy of this facility that all residents admitted to the facility will be screened for PASRR in accordance with Federal PASRR Regulations (42 CFR 483.106.). All resident and patients shall be screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre-screening is referred to as PASRR Level I and is completed prior to admission to the facility.</p> <p>NJAC 8:39-5.1(a)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on interview and record review, the facility failed to keep Resident #103 safe from accidents/injury. Resident #103 sustained lacerations to two fingers which resulted in both fingers being amputated after a side rail fell on Resident #103's right hand while staff were providing care for the resident. This deficient practice was identified for one (1) of three (3) residents (Resident (R) #103) reviewed for accident hazards. This failure caused serious harm to R #103 and had the potential to place all residents with side rails at risk.</p> <p>Findings include:</p> <p>Review of R #103's Face Sheet located in resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility with diagnoses which included Alzheimer's.</p> <p>Review of R #103's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/22, and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 99 out of 15, which indicated the resident was severely cognitively impaired.</p> <p>Review of R #103's Incident report dated 03/26/23, and provided by the facility revealed, .7:30 PM, the aide informed writer that while taking care of resident [who] was holding onto the side rails and the side rails (missing info) off and cutting residents' fingers .</p> <p>Review of R #103's Care Plan dated 03/27/23, and located in the residents' EMR under the Care Plan tab revealed, The resident has bilateral half side rails. Interventions in place were to explain risk versus benefits, obtain informed consent and physician order and complete quarterly side rail assessment. Further review revealed no documentation of care plan interventions related to side rail use prior to incident that occurred on 03/26/23.</p> <p>Review of R #103's Nurse's Note dated 03/27/23 1:34 AM, located in the EMR under the "Notes" tab and written by Licensed Practical Nurse (LPN #1) revealed .7:30 pm, The aide informed the writer that while taking care of [Resident #103] was holding the side rail and suddenly the side rail fell off and cutting [Resident #103] fingers. Upon assessment two of [Resident #103] middle left fingers noted cut and bleeding, immediate pressure applied with rolled gauze to control and stop the bleeding. 911 called and arrived and the resident was taken [sic] to the emergency medical center. The resident was awake and alert with no signs of distress noted, nor any facial grimacing or teeth clenched noted. Physician and family made aware .</p> <p>Review of R #103's Nurse's Note dated 03/27/23 2:27 PM, located in the EMR under the "Notes" tab and written by LPN #2, revealed . Verbal consent given for side rails for resident, spoke with family .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's 5-day investigations summary dated 03/30/23, and provided by the facility revealed . The resident was a [AGE] year-old admitted to the facility on [DATE]. The resident's diagnosis is Alzheimer's disease with early onset and mood disorder, on 3/26/23 at approximately 7:30 pm, a CNA [Certified Nurse Aide] informed a nurse that a side rail had fallen off while [Resident #103] was providing care to the resident. At the time of the incident the CNA was on the opposite side of the bed providing care including washing the residents back, etc. with the resident lying on [their] left side holding onto the side rail with [their] right hand for comfort and support while receiving care. At some point the resident began to shake the side rail and as noted above the side rail fell to the floor. When that happened, somehow the side rail hit [Resident #103] right hand resulting in a laceration of the 3rd and 4th distal digits. The CNA wrapped a towel around the hand and called for the nurse. The nurse immediately responded to the resident's room after hearing the CNA call out for help. Upon assessing the injury, the nurse provided first aid, kept the hand immobile and called 911 for transport to the hospital. While at the hospital they performed a revised amputation of the 3rd and 4th distal digits of the right hand. The resident returned to the facility on the morning of 3/27/23. Upon return to the facility, the residents care plan was revised to include monitoring and treatment of the fingertip areas with physician follow-up in a week, a change of bed with a different type of siderail and siderail bumpers .</p> <p>During an interview on 12/18/24 at 11:55 AM, LPN #1 stated an aide was with R #103 providing PM [evening] care (unsure of who) to R #103 when R #103 grabbed the side rail and the resident started shaking the side rail, according to the CNA the side rail came down on the resident's hand. She stated she was unsure if it came detached or if it came down. LPN #1 stated another nurse was applying pressure to the wound, and she contacted the family, and the resident was sent to the emergency room (ER). She said she was unsure of the extent of the injury. LPN #1 stated she did provide care to [Resident # 103] after that, but did not remember if there was an injury to [Resident #103] fingers.</p> <p>During an interview on 12/18/24 at 3:45 PM, CNA #5 stated she was familiar with R #103. She stated on 03/26/23, [R #103] was in the day room and she took the resident back to their room to get the resident ready for bed. She said normally the side rail on the right side should be up, but on that day it was down. She stated she was giving the resident a bed bath and the resident was holding onto the side rail and shaking it. She stated she had seen the resident shaking the side rail in the past, but stated it should not be able to shake if it was tightened properly. She said on that day, she did not check to see if the side rail was locked since it was already up, but that normally she would check if it was tight since she would put the side rail up herself. She said the resident was holding onto the side rail, it was shaking. She also stated she did not stop care to check why the side rail was shaking, but she did not realize it was going to come undone. She said she heard a noise, saw the resident pull their hand, and saw blood coming from the resident's right hand. She stated she grabbed the towel she was using to clean the resident and applied pressure to the hand and screamed, a nurse came, never looked to see if the side rail came detached or if it just slid down. She said the nurse assessed the resident and she noticed the resident's fingers were cut but she was unsure which fingers because she was traumatized. She said the resident did lose two of their fingers and that there were different side rails on the resident's bed after that, but she was not sure if they assessed other side rails in the building after that happened. CNA #5 stated it was the only incident she was aware that involved side rails.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/24 at 12:38 PM, the Director of Nursing (DON) said she was not the DON at the time the incident occurred, but she said staff should be checking side rails and ensuring they are tightened properly and safe. She said when a staff member was providing care to a resident while the resident was holding onto the side rail and it started shaking, the staff should stop whatever they were doing, intervene and notify maintenance.</p> <p>Review of the facility's undated policy titled, Side Rail Policy, revealed the purpose of these guidelines is to ensure the safe use of side rails. Side rails may be appropriate when used to assist with mobility and transfer and to maintain safety related to the resident's medical condition. When side rail usage is appropriate, the facility maintenance department will ensure that side rails are secure and in proper working order.</p> <p>NJAC 8:39-33.1(d)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25490</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to accommodate one of one resident's (Resident (R) 98) dietary preferences reviewed for food choices of 26 sample residents. This failure had the potential to cause emotional distress and nutritional deficit.</p> <p>Findings include:</p> <p>Review of R98's Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE]. A review of R98's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/24 showed medical diagnoses of pain in the thoracic spine, systemic Lupus, and muscle weakness. R98's Brief Interview for Minimum Status (BIMS) score was 15 out of 15 which indicated R98 was cognitively intact.</p> <p>Review of R98's EMR Nutrition-Initial note, located under the Assessment tab, dated 11/21/24 revealed: .4. Dietary Information A. Food Preferences: No coffee, no milk, no pork Honor food preferences as able, update [prn] as needed .</p> <p>Review of the facility's weekly menu, dated 12/16/24, revealed that R98 was served the alternate meal during dinner, which was pork sausage, peppers, and noodles.</p> <p>Review of R98's undated meal tickets, provided by the facility, revealed, No Pork.</p> <p>During an interview on 12/17/24 at 10:32 AM, R98 revealed that she did not eat pork and had been served pork and not provided with an alternate protein option.</p> <p>During an interview on 12/17/24 at 3:45 PM, R98 revealed that she received eggs and biscuits for breakfast this morning, and chicken and rice for lunch, yesterday. R98 was asked when she last received pork during a meal. R98, stated, Last night the kitchen sent pork sausage and noodles. The resident further shared that she called the kitchen to request a replacement tray which never arrived.</p> <p>During an interview on 12/17/24 at 4:03 PM, Certified Nurse's Aide (CNA) 1 confirmed that R98 received pork and noodles on her dinner tray last evening. CNA1 continued to share that R98 asked her to remove the tray and was informed by the resident that she had contacted the kitchen for an alternative meal.</p> <p>During an interview on 12/17/24 at 4:07 PM, the Registered Dietician (RD) and Dietary Manager (DM) revealed that pork and noodles were served on the alternate menu. The DM further shared that he recalled receiving a call around during the dinner hour from R98 and a meal that consisted of baked chicken was sent to the resident's room. Both the DM and RD confirmed that they expected residents to be served what they preferred.</p> <p>During an interview on 12/19/24 at 12:40 PM, the Director of Nursing (DON) revealed that residents' preferences should always be respected, and preferences honored.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Alaris Health at West Orange		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Resident Food Preferences, revised 02/24, revealed Policy Statement Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team .Policy Interpretation and Implementation 1. Upon admission, the dietitian or nursing staff will identify a resident's food preferences .10. The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night .</p> <p>NJAC 8:39-17.4(c)(e)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>29015</p> <p>Based on interviews, record review, and facility policy review, the facility failed to ensure for one of one resident (Resident (R) 22) reviewed for activities of daily living (ADL) care had complete and accurate medical records of 26 sample residents. This continued practice did not ensure the medical record accurately reflected the care of the residents.</p> <p>Findings include:</p> <p>Review of R22's Documentation Survey Report located in the electronic medical record (EMR) under the Tasks tab, dated 10/01/24 through 10/31/24, 11/01/24 through 11/30/24; and 12/07/24 through 12/11/24, revealed no documentation for bladder continence, movements, personal hygiene, toilet transfer, toileting hygiene, turn and reposition every two hours, shower/bath, tub, and shower transfers, for the following shifts and dates:</p> <p>-From 7:00 AM-3:00 PM on 10/03/24-10/12/24, 10/14/24, 10/16/24, 10/26/24-10/28/24, 11/02/24, 11/06/24, 11/09/24, 11/11/24, 11/15/24-11/19/24, 11/22/24, 11/24/24, and 12/07/24.</p> <p>-From 3:00 PM-11:00 PM on 10/01/24-10/04/24, 10/11/24-10/16/24, 10/25/24-10/29/24, 10/31/24, 11/01/24-11/04/24, 11/07/24, 11/09/24-11/12/24, 11/14/24, 11/16/24-11/21/24, 11/23/24-11/25/24, and 12/07/24-12/09/24.</p> <p>-From 11:00 PM-7:00 AM on 10/04/24-10/08/24, 10/12/24; 10/25/24-10/27/24, 11/01/24, 11/03/24-11/05/24, 11/07/24, 11/12/24; 11/13/24, 11/18/24; 11/23/24-11/24/24, 12/07/24, and 12/10/24.</p> <p>During an interview on 12/19/24 at 10:16 AM, Certified Nurse Aide (CNA) 4, was asked to demonstrate how the staff were to document the residents' ADLs. CNA4 stated the staff documented the ADLs on a kiosk located in the halls of the nursing units. CNA4 was questioned on what would cause the ADLs to not be documented. CNA4 stated once they selected the task, they had to save it, or they would lose the documentation.</p> <p>During an interview on 12/19/24 at 10:51 AM, the Medical Records (MR) staff were questioned about who conducted the EMR audits, and how often they were completed. MR staff responded that the audits were conducted monthly by an interdisciplinary team. MR staff confirmed that R22's documentation was incomplete.</p> <p>During an interview on 12/19/24 at 11:05 AM, the Unit Manager (UM) 1 confirmed R22's ADLs were not documented. UM1 stated it was probably due to the CNAs who did not know how to use the kiosk to document them.</p> <p>During an interview on 12/19/24 at 12:24 PM, the Director of Nursing (DON) confirmed the lack of documentation of the ADLs in R22's EMR.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Alaris Health at West Orange		STREET ADDRESS, CITY, STATE, ZIP CODE 5 Brook End Drive West Orange, NJ 07052	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Medical Records, dated 01/24, revealed This facility shall maintain medical records on each resident that are: a. Complete; b. Accurately documented .3. The medical record shall reflect a resident's progress toward achieving their person-centered plan of care objectives and goals and the improvement and maintenance of their clinical, functional, mental, and psychosocial status. 4. It must also reflect the resident's condition, and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team.</p> <p>NJAC 8:39-35.2</p>		