STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at the Chateau	96 Parkway Rochelle Park, NJ 07662

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review of facility policy, record review, and interviews, the facility failed to ensure four Residents (R) (R6, R8, R9 and R10) out of fifteen residents reviewed for assistance with Activities of Daily Living (ADLs) were not bathed according to their plans of care. The facility's failure to ensure residents were bathed routinely created the potential for the residents to experience negative effects related to poor hygiene. A total of 15 residents were reviewed in the sample. Findings include:1. Review of R6's admission Record, dated 04/16/26 and located in the Electronic Medical Record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included dementia and history of stroke. Review of R6's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/26 and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 3 out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated the resident required assistance from staff for bathing and grooming. Review of R6's ADL Care Plan, most recently dated 03/06/26 and located in the EMR under the Care Plan tab, revealed R6 required staff participation for bathing. The care plan did not indicate R6 routinely refused bathing.Review of R6's ADL Documentation, dated 03/19/26 through 04/17/26 and located in the EMR under the Point of Care (POC) tab, revealed R6 refused bathing on 04/03/26. The was no additional documentation in the resident's record to indicate he had been bathed or had refused to be bathed within the most recent 30 days. R6 was not able to be interviewed due to his poor cognition.2. Review of R8's admission Record, dated 04/16/26 and located in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included schizophrenia and depression. Review of R8's quarterly MDS, with an RD of 03/26/26 and located in the EMR under the MDS tab, revealed a BIMS assessment score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident required assistance from staff for bathing. Review of R8's ADL Care Plan, most recently dated 04/06/21 and located in the EMR under the Care Plan tab, revealed R8 required staff participation with bathing. The record did not indicate R8 had a tendency to refuse bathing.Review of R8's ADL Documentation, dated 03/19/26 through 04/17/26 and located in the EMR under the Point of Care (POC) tab, revealed nothing to show R8 had been bathed within the last 30 days. The record indicated not bathing refusals.3. Review of R9's admission Record, dated 04/16/26 and located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included type 2 diabetes and heart failure. Review of R9's quarterly MDS, with an ARD of 03/04/26 and located in the EMR under the MDS tab, revealed a BIMS assessment score of 15 out of 15, which indicated the resident was cognitively intact. Review of R9's ADL Care Plan, most recently dated 08/22/25 and located in the EMR under the Care Plan tab, revealed R9 required staff participation with bathing.Review of R9's ADL Documentation, dated 03/19/26 through 04/17/26 and located in the EMR under the Point of Care (POC) tab, revealed R9 had been bathed one time in the most recent 30 days (on 04/13/26). The record indicated no bathing refusals. 4. Review of R10's admission Record, dated 04/16/26 and located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Alaris Health at the Chateau		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Parkway Rochelle Park, NJ 07662	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included spastic hemiplegic cerebral palsy. Review of R10's quarterly MDS, with an ARD of 03/04/26 and located in the EMR under the MDS tab, revealed a BIMS assessment score of 15 out of 15, which indicated the resident was cognitively intact. Review of R10's ADL Care Plan, most recently dated 12/12/25 and located in the EMR under the Care Plan tab, revealed no bathing care plan for R10.Review of R10's ADL Documentation, dated 03/19/26 through 04/17/26 and located in the EMR under the Point of Care (POC) tab, revealed nothing to show the resident had been bathed in the most recent 30 days. The document indicated no bathing refusals.On 4/15/26 at 3:00PM, a group interview was conducted with R8, R9 and R10. All three residents stated they never received more than one bath per week and had not been bathed per their plans of care.R9 stated he/she had just been bathed on 04/13/26 but had not been bathed for three weeks prior. R9 stated a preference to be bathed twice weekly and stated he/she thought he/she stank due to not receiving regular bathing.R10 stated a preference to be bathed twice weekly and reported it had been two weeks since the last bath. R10 stated a family member had taken he/she home to bathe a few days prior to the interview. R8 stated a preference to be bathed twice weekly and reported he/she had not received a bath in a while. On 4/15/26 at 4:45PM an interview was conducted with the Administrator, Assistant Administrator, and the Director of Nursing (DON2). DON2 confirmed documentation could not be located to demonstrate R6, R8, R9 and R10 had been consistently bathed according to their preferences. DON2 stated the expectation was that residents were to be bathed consistently according to their preferences and this was to be documented in each resident's record. DON2 further stated staff were expected to re-approach residents who refused bathing and document refusals and all attempts. Review of the facility's ADL Care Policy and Procedure dated last reviewed in 01/2026 indicated, Residents shall receive assistance with activities of daily living (ADLs) every shift, as appropriate; and ADLs include: bathing, grooming, dressing, eating, oral hygiene, ambulation and toilet activities.NJAC 8:39-27.2 (i)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, observations, and interviews, the facility failed to ensure significant medication errors were not made during the administration of medication for one of one resident (Resident (R) 2) observed for medication administration. The facility's failure to ensure R2 received his/her medication as ordered created the potential for this and other residents to experience significant negative physical effects related to the incorrect administration of medication. A total of 15 residents were reviewed in the sample.Findings include:Review of R2's admission Record, dated 04/16/26 and located in the Electronic Medical Record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included history of stroke, type 2 diabetes, prostate cancer, acute respiratory failure with hypoxia, gastrostomy (g-tube) status, and hemiplegia and hemiparesis affecting his right dominant side. Review of R2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 1 out of 15, which indicated the resident was severely cognitively impaired.Review of R2's Physician's Order Report, with active orders dated 04/16/26 and located in the EMR under the Orders tab, revealed the following:-Thiamine (a vitamin/mineral supplement) 100 Milligrams (MG) once daily via gastrostomy (g)-tube-Lactulose (a stool softener) 30 milliliters (ML) daily via g-tube-Chewable aspirin(non-steroid anti-inflammatory drug) 81 MG once daily via g-tube-Miralax (a stool softener) 17 grams daily via g-tube-Duoneb (an inhaled medication used open airways to treat COPD) one vial via nebulizer four times daily-Budesonide (an inhaled steroid medication used to treat COPD) one vial via nebulizer every twelve hours -Scopolamine (a medication to control oral secretions) one patch to be applied to the resident topically once every 72 hours-Glucerna 1.5 360 ML (milliliters) four times daily via his g-tube. Review of R2's Medication and Treatment Administration Records (MARs/TARS), dated 04/01/26 through 04/17/26 and located in the EMR under the Orders tab, indicated the resident received his/her medications as ordered.On 4/15/26 at 9:45am, Licensed Practical Nurse (LPN1) was observed administering R2's medications. LPN1 administered aspirin despite the expiration date being smeared and not visible. LPN1 did not administer lactulose or thiamine after determining the medications were not available in the medication cart. LPN1 stated an intention to assess R2's bowel status prior to administering Miralax; however, no assessment was performed, and Miralax was not administered. LPN1 administered Budesonide (steroid) inhaled medication before administering the resident's Duoneb. LPN1was observed administering 330 ML of Glucerna 1.5 (rather than the ordered 360 ML). LPN1 was unable to locate documentation on the MAR to indicate the application of a Scopolamine patch. Without verifying the physician's order, LPN1 removed the patch from behind the resident's left ear and did not replace it. The patch had been applied the previous day and was ordered to remain in place for 72 hours.On 04/15/26 at 10:50 AM, the surveyor interviewed LPN1. LPN1 confirmed lactulose and thiamine were not administered due to unavailability in the medication cart. LPN1 stated he/she would order the medications from the pharmacy so that they are available for the next medication pass. LPN1 also confirmed administering aspirin despite the expiration date being unreadable, stating the pharmacist had reviewed the medications the previous week and indicated they were acceptable. LPN1 confirmed that he/she gave R2 his/her aspirin in spite of the expiration date not being visible.LPN1 confirmed R2's scopolamine patch was removed because he/she did not see an order for it on the daily MAR and stated he/she did know when the patch was supposed to be applied. LPN1 stated he/she was not aware of a specific order in which to administer nebulized/inhaled medications. LPN1 stated he/she forgot to administer R2's Miralax. LPN1 confirmed he/she administered Glucerna 1.5 330ml instead of 360ml as ordered by the Physician and stated that the physician order was for 330ml. On 4/15/26 at 1:52pm, the surveyor interviewed with Director of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing (DON1) and DON2. Both confirmed that medications are expected to be available and administered as ordered. They stated medications should not be administered if the expiration date cannot be verified. They further confirmed that bronchodilator nebulized medications should be administered prior to inhaled steroids. DON1 and DON2 confirmed the scopolamine patch should not have been removed, as it was applied the previous day and ordered for a 72-hour duration.DON2 confirmed R2 was expected to receive 360 ML of Glucerna 1.5 four times daily via his/her g-tube according to physician's orders. Review of the facility's Medication Administration Policy, dated last reviewed in 01/2026, indicated, Medications shall be administered in a safe and timely manner; and Medications must be administered in accordance with the orders, including any required times frame; and The individual administering the medication must check the label to verify the right medication, right dosage, right time and right method (route) of administration before giving the medication; and The expiration date on the medication label must be checked prior to administering. Review of the facility's Enteral Feeding Policy and Procedure, dated last reviewed in 01/2026, indicated, Enteral feeding orders will be recommended by the dietician and physician's orders will be obtained. Orders will be obtained and written by the dietician or nurse as follows: B. Bolus Feeding Order: Will include the product name, cc's for each bolus, and number of bolus feedings to be given per day.NJAC 8:39-29(d)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and interviews, the facility failed to ensure one of three residents (Resident (R) R3) three residents reviewed for dental services received timely dental services related to a decaying tooth. The facility's failure to ensure timely dental care was provided for R3 created the potential for R3 to experience pain and/or infection related to the decaying tooth. A total of 15 residents were reviewed in the sample. Findings include:Review of R3's admission Record, found in the Electronic Medical Record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included history of stroke. Review of R3's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/25/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 5 out of 15, which indicated the resident was severely cognitively impaired.Review of R3's Care Plan, most recently dated 03/20/26 and found in the EMR under the Care Plan tab, revealed R3 was to receive routine oral care daily and was to be seen by the dentist as needed. Review of R3's progress notes, dated 12/01/25 and found in the EMR under the Notes tab, revealed, [Family Member] called and informed me that resident is complaining of tooth and gum pain which [Family Member] says the dentist diagnosed last week at bedside as receding gums and a tooth with exposed root but not infected--Upon pain assessment no nonverbal cues and resident is smiling and denies pain-[Resident's Physician] ordered repeat dental consult and Orajel [a topical pain medication used to treat gum pain] prn [as needed]--Orajel to be delivered stat-[Family Member] aware. Review of R3's progress notes, dated 12/03/25 and found in the EMR under the Notes tab, revealed, [Resident] Alert and oriented, upper and lower denture. Denied discomfort when eating. Call made to [Dental Office] to schedule appointment for dental visit. No one answered the phone, message left on voice mail.Review of R3's Progress Note, dated 12/11/25 and found in the EMR under the Notes tab, revealed, Resident went out to dental appointment this morning. [Family Member] met [him/her] there, resident left facility in stable condition via wheelchair pick up time was 10:39AM. Return time 13:09 in stable condition via wheelchair. Tooth # 6 has a large cavity and needs to be extracted as per request does not want root canal. Resident needs to have medical clearance prior to tooth extraction. Resident denies having any pain or discomfort.Review of R3's Progress Note, dated 12/22/25 and found in the EMR under the Notes tab, revealed, Seen by MD (Medical Doctor) for medical clearance for dental extraction. MD spoke to [Family Member], went over medication list and diagnosis with [him/her]. Call made to (Dental Office) to know if Plavix and Asa (aspirin) have to be held prior to procedure. Message left on voice mail. Orders given for (laboratory testing).Review of R3's progress notes, dated 01/23/25 and found in the EMR under the Notes tab, revealed, Dental (Office) called to report that resident's dental appointment for Monday 01/26/26 has been cancelled due to the inclement weather. Two calls made to [Family Member] but [he/she] did not answer the phone and message cannot be left on phone.Review of R3's Progress Note, dated 01/27/26 and found in the EMR under the Notes tab, revealed, Call made to Dental Office) to reschedule dental appointment. Informed by receptionist, that the completed medical clearance forms has to be faxed to the dental office prior to appointment. Forms faxed to the office. Follow up call made to dental office to know if they got the information. Receptionist said that she will check the fax machine for the forms then will call me. Waited for 20 minutes then made call to the office, no one answered the phone, a second call was made and no one picked up the phone.Review of R3's Progress Note, dated 01/29/26 and found in the EMR under the Notes tab, revealed, This writer contacted (Dental Office) and obtained a new appointment for a tooth extraction. The appointment is scheduled for Tuesday, February 10, 2026, at 10:00 a.m. Transportation will need to be arranged. [Family Member] has been informed and is aware of the appointment. This writer spoke with [receptionist] at [Dental Office]. The appointment is for a tooth extraction. At this time, the resident reports no pain and does not exhibit any signs of (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discomfort. Although the [Family Member] is requesting that the tooth be extracted as soon as possible, this is the earliest appointment available.Review of R3's Progress Note, dated 02/12/26 and found in the EMR under the Notes tab, revealed, Returned from [Dental Office] via wheelchair/ambulette. Alert and oriented. Denied having pain. Appointment has to be rescheduled due to resident not being seen by a dentist.Review of R3's Progress Note, dated 03/09/26 and found in the EMR under the Notes tab, revealed, Resident is alert and oriented, all meds taken. [Dental Office] asked for written medical clearance for dental extraction. Call made to [Resident's Physician] for clearance. [He/She] said that [he/she] is unavailable at the moment and suggested that I call the office. Call made to the office information given to the receptionist; [he/she] said that someone will call me later. Review of R3's Progress Note, dated 04/03/26 and found in the EMR under the Notes tab, revealed, Called and left message to [Family Member] regarding dental appt. Aware that [representative] from [Dental Office] received the completed and signed medical clearance and for review of their doctor. Told [him/her] that specialist or oral surgeon only comes once a week on Tuesday only. Informed [Family Member] [Dental Representative] will call us for the date and time once MD reviewed the clearance.Review of R3's Progress Note, dated 04/13/26 1:32 PM and found in the EMR under the Notes tab, revealed, Spoke to [Family Member] regarding follow up with [his/her] dental appt (appointment).aware that I spoke to [Representative] from [Dental Office] and confirmed that medical clearance was not reviewed by their MD despite [Representative] told me [he/she] will take care of their MD to review it as soon as possible and will call us Monday but did not happen. Informed [R3] needs tooth extraction ASAP [As Soon As Possible] due to pain. [Dental Representative] said [he/she] will call MD [himself/herself] and pushed to happen today. Gave my phone to call me back.Review of R3'sProgress Note, dated 04/13/26 4:09 PM and found in the EMR under the Notes tab, revealed, Spoke to [Representative] from [Dental Office] asking for appt [appointment]. [He/She] said still waiting [sic] from their doctor to give [his/her] availability, [he/she] is fully book [sic] this week. Informed [him/her] give me the date and time at least we have something to wait for. Then [he/she] said MD replied it is ok to bring patient on Wednesday at 3P informed [him/her] as per [Family Member], specialist comes weekly every Thursday [he/she] said it is another doctor. Emphasized [he/she] need tooth extraction [Dental Representative] said [he/she] knew and [Dentist] is a surgeon. Confirmed date and time.During an interview with Family Member (FM2) on 04/14/26 at 4:15 PM, he/she confirmed he/she had been requesting to have R3 seen by a dentist for several months and stated he/she was frustrated by the repeated delays and lack of follow-up by facility staff related to R3's decaying tooth.Review of R3's Physician's Order Report, found in the EMR under the Orders tab, revealed an order, with an initial order date of 04/14/26 for the resident to be seen by her community dentist on 04/15/26 at 3:00 PM for a tooth extraction.Review of R3's Progress Note, dated 04/15/26 1:32 PM and found in the EMR under the Notes tab, revealed, [R3] returned from appt. [appointment] at the [Dentist office] post extraction [tooth] #6. Stable, no complaints. [Family Member] in to visit.During an interview with the Social Services Director (SSD) on 04/16/26 at 10:06 AM, he/she confirmed R3 had not been seen by the dentist for his/her tooth extraction timely. He/She stated the prior Unit Manager (UM4), who was no longer working at the facility had been responsible for ensuring R3 was seen by the dentist and he/she (the SSD) was not aware of the delay in care until approximately one month prior to the survey investigation. The SSD stated when he/she called the resident's dental office after becoming aware of the delay, the dental office informed him/her the resident would need to be medically cleared again for oral surgery and so that process had to be completed before R3 could be seen. The SSD stated an appointment had finally been made for R3 to see the dentist to have his/her tooth extracted on 04/14/26 and confirmed the resident had been seen on that date and his/her tooth had been extracted. During an interview with Director of Nursing (DON2) on 04/26/26 at 12:45 PM, he/she confirmed R3's dental appointment had been far too delayed and stated the resident should have been seen by the dentist more quickly than he/she had been. Review of the facility's Dental Services (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy and Procedure dated last reviewed in 01/2026 indicated, Routine and emergency dental services are available to meet the resident's oral health needs in accordance with the resident's assessment and plan of care; and In the event of need for a dental consult, the nurse will schedule a dental appointment. NJAC 8:39-15.1 (a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, observations, and interviews, the facility failed to ensure infection control procedures were followed during the administration of medication and feeding for one of one resident (Resident (R) R2) observed for medication administration. The facility's failure to ensure infection control procedures were followed for R2 created the potential for this and other residents to develop infection. A total of 15 residents were reviewed in the sample. Findings include:Review of R2's admission Record, found in the Electronic Medical Record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included history of stroke, type 2 diabetes, prostate cancer, acute respiratory failure with hypoxia, gastrostomy (g-tube) status, and hemiplegia and hemiparesis affecting his/her right dominant side. Review of R2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 1 out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated R2 had an indwelling urinary catheter and a gastrostomy tube in place. Review of R2's Physician's Order Report, dated 04/16/26 and found in the EMR under the Orders tab, revealed an order, with an initial order date of 02/21/26 for the resident be on Enhanced Barrier Precautions(EBP) related to his/her indwelling urinary catheter and his/her g-tube. The orders further revealed R2 was to receive all of his/her oral medications through via g-tube and was to receive feeding and water boluses through g-tube four times per day. The orders revealed the resident was to receive inhaled medication via nebulizer, revealed orders for the resident to receive eye drops, and revealed the resident was to receive a topical nicotine patch per physician's orders. On 4/15/26 at 9:45AM, Licensed Practical Nurse (LPN1) was observed administering medications for R2. LPN1 washed his/her hands and put on gloves and then administered the resident's ordered medications through his/her g-tube followed by the resident's feeding through his/her g-tube.After administering the resident's g-tube medications, LPN1 administered the resident's first nebulizer treatment without performing hand hygiene or changing gloves after administering the g-tube medications and before administering the nebulizer treatment. While the first nebulizer treatment was in progress, LPN1 provided care to the skin surrounding the resident's g-tube and replaced the dressing without performing hand hygiene or changing gloves.After completing the dressing change to R2's g-tube site, LPN1 applied the resident's nicotine patch topically to the resident's upper chest without sanitizing his/her hands or changing his/her gloves. LPN1 then applied R2's eye drops to both eyes without sanitizing his/her hands or changing his/her gloves prior to applying the eye drops. LPN1 did not wear a gown at all while administering R2's medications or feeding per the resident's EBP orders. On 4/15/26 at 10:50AM, an interview with LPN1 was conducted. LPN1 confirmed he/she did not perform hand hygiene or change gloves as frequently as required. LPN1 stated he/she was aware that hand hygiene and glove changes should occur between administration of feedings, g-tube care, and each route of medication administration. LPN1 further stated he/she was aware that Enhanced Barrier Precautions were required for R2 but failed to follow them.On 4/15/26 at 1:52PM, an interview with Director of Nursing (DON1) and DON2 was conducted. Both confirmed their expectation was all nursing staff perform hand hygiene and change gloves before and after each route of medication administration, before and after g-tube dressing changes, and before and after administering enteral nutrition. They also confirmed Enhanced Barrier Precautions were expected to be followed as ordered.Review of the facility's Medication Administration Policy dated last reviewed in 01/2026 indicated, Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications.The facility's Respiratory Care-Nebulizer Policy and Procedure, dated last reviewed in 01/2026 indicated, (Staff) performs hand hygiene before and after contact with a resident or any (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at the Chateau	96 Parkway Rochelle Park, NJ 07662

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respiratory equipment used on the resident; and Applies gloves when in contact with respiratory secretions and changed before contact with another resident, object or environmental surface.The facility's Infection Control-Standard Precautions, Enhanced Barrier Precautions and Transmission Based Precautions Policy and Procedure dated last reviewed on 01/22/26 indicated, Enhanced Barrier Precautions (EBP) - an infection control intervention designed to reduce transmission of multi-drug resistant organisms (MDROs) that employs the use of gown and gloves during high contact resident care activities. MDROs may be indirectly transferred from resident to resident during these high contact resident care activities.Residents with indwelling medical even if the resident is not known to be infected or colonized with a NDRO (Examples include central lines, urinary catheters, feeding tubes, and tracheostomies). The facility's Hand Washing/Hand Hygiene Policy and Procedure dated last reviewed in 01/2026 indicated, Handwashing/Hand hygiene will be performed by staff as follows: When coming on duty, When hands are obviously soiled, Before and after contact with patients and between patient contacts, After contact with a source that is likely to be contaminated with microorganisms. This included but is not limited to, infected or heavily colonized patients, or objects, or devices contaminated with the patients secretions or excretions such as urinary catheters, NG tubes, urinals, etc., and Before gloving and after gloves are removed. NJAC 8:39-19.4 (a) [1,2]