STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at the Chateau	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 27104 Based on record review, interview, and review of facility policy, the facility failed to ensure notification and/or timely notification was made to two resident's (Resident (R) 278 and R328) representatives (RR) when a change of condition occurred out of a total sample of 43 residents reviewed. This had the potential for the RRs to not be informed of the resident's condition and to be able to make informed decisions regarding the care of the residents. Findings include: Review of the facility's policy titled, Notification of Change last revised 12/27/22 revealed Policy: It is the policy of this facility to inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member of the following changes . Procedures: 2. Significant change in the resident's physical, mental or psychosocial status (i.e. a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications) . 4. A decision to transfer or discharge the resident from the facility. 1.Review of R278's Profile located in the electronic medical record (EMR) under the Profile tab revealed the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of chronic respiratory failure and edema. R278 discharged to the hospital on 10/19/23 and did not return to the facility. Review of R278's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an assessment reference date (ARD) of 09/10/23 revealed a Brief Interview for Mental Status (BIMS) score could not be obtained. The resident was severely cognitively impaired. Review of R278's Aculabs laboratory results, dated 10/09/23 and provided by the facility, revealed R278's hemoglobin (carries oxygen from the lungs to the body's tissues and organs, and returns carbon dioxide to the lungs) was critically low at 7.6 (normal values: 12.1 - 17.1). The resident was also noted with a critically low hematocrit (number of red blood cells) at 24 (normal values:36 - 51). (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R278's Aculabs laboratory results, dated 10/16/23 and provided by the facility, revealed a critically low hemoglobin of 6.9 and a critically low hematocrit of 21. The results further revealed the resident had a critically high lab for urea nitrogen (waste product in the blood) at 121 (normal values: 8 - 23). Review of R278's EMR revealed no evidence the family was notified of the above critically low and high lab values of 10/09/23 and 10/16/23. Review of R278's Aculabs laboratory results received by the facility on 10/17/23 at 11:07 AM, and provided by the facility, revealed a critical high lab value for potassium (for proper kidney and heart function) at 7.0 (normal values 3.5 - 5.3), a critically high urea nitrogen at 128, a critically low hemoglobin of 7.2 and hematocrit of 22. Review of R278's Progress Notes dated 10/18/23 at 4:13 PM located in the EMR under the Progress Notes tab revealed R278's RR was not notified of the critical lab values received by the facility on 10/17/23 at 11:07 AM until 10/18/23 at 4:13 PM. During an interview on 01/09/25 at 11:30 AM the Director of Nursing - South (DON-S) confirmed there was no evidence documented R278's RR was notified of critical lab values for 10/09/24 and 10/16/24. The DON-S also confirmed the RR was not notified timely of critical lab values received on 10/17/23 until 10/18/23. The DON-S confirmed resident's RR were to be notified of critical lab values in order for them to be able to make a decision on treatment decisions. 2. Review of the undated Admission Record in the EMR under the Profile tab revealed R328 was admitted to the facility on [DATE]. She was hospitalized from 02/01/24 - 02/16/24 and readmitted on [DATE]. Pertinent diagnoses included recent right above the knee amputation, end stage renal disease with dialysis, type two diabetes with neuropathy, and unstageable pressure ulcers. Family member (F)328 was R328's emergency contact. Review of the admission MDS with an ARD of 01/20/24 in the EMR under the MDS tab revealed R328 was severely impaired in cognition with a BIMS of five out 15. R328 had two unstageable pressure ulcers that were both present on admission. R328 discharged home on 04/13/24 and her closed record was reviewed. Review of the Care Plan, dated 01/11/24, found under the RAI [Resident Assessment Instrument tab revealed a problem of, [R328] was admitted with unstageable pressure ulcers . On 02/28/24, the following was added to the care plan problem statement, Facility acquired left anterior distal lower leg DTI [deep tissue injury], reclassified as unstageable 03/06/24. Review of the Wound Report record dated 02/28/24 in the EMR under the Assessment tab revealed a new pressure ulcer to the left anterior lower leg was first observed on 02/28/24. Measurements were two centimeters (cm) in length by six cm in width and the pressure ulcer was staged as a DTI. Skin Prep dressing (a transparent film forming a protective interface for intact skin) was completed by the wound care team and instructions were to apply it daily. The Wound Care record documented, Loose socks only. There was no documentation in the Wound Report showing F328 was notified of the new pressure ulcer. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent weekly Wound Report records, dated 03/06/24, 03/14/24, 03/27/24, 04/03/24, 04/10/24, documented the continued presence of the left anterior lower leg pressure ulcer through the last note on 04/10/24. R328 was discharged home on 04/13/24. There was no documentation of the family being notified of the left lower leg pressure ulcer. Review of the Wound Report, dated 04/10/24 in the EMR under the Assessment tab, revealed the pressure ulcer was unstageable and was two cm in length by 2.6 cm in width. The Wound Report read, Left anterior distal lower leg - DTI 02/28/24 secondary to tight socks per patient, reclassified as unstageable on 03/06/24. Current treatment called for application of Skin Prep daily and to leave it open to air. Review of the Nursing and Physician Progress Notes from 02/28/24 - 04/13/24 in the EMR under the Progress Notes tab revealed no mention of F328 being notified of the left anterior lower leg pressure ulcer first observed on 02/28/24. Review of the Discharge Instructions, dated 04/13/24 in the EMR under the Assessment tab revealed instructions regarding wound care were given to the patient/family. Although the presence of the unstageable pressure ulcer was not documented, under the heading of Treatments the instructions read, Left anterior distal lower leg: apply Skin Prep daily and leave open to air. Additional Notes - Loose sock only on left lower extremity. During an interview on 01/09/25 at 1:15 PM, Unit Manager 3rd Floor South (UM3S) stated she remembered R328 having a sacral pressure ulcer and something on the top of her leg. UM3S reviewed R328's EMR and stated there was a DTI from the elastic of a sock and R328 was followed weekly in wound rounds through discharge. UM3S stated R328 received Skin Prep application for the pressure ulcer through discharge on 04/13/24. During an interview on 01/09/24 at 1:37 PM, the Director of Nursing South (DON) S stated families should be notified of new pressure ulcers by the nursing staff. The DON S stated this should be documented in Nurses Notes, in Physician's Notes or on the Wound Reports. The DON S reviewed R328's EMR and stated she did not see documentation of notification in any location of the new pressure ulcer to the left anterior leg to F328. During an interview on 01/09/25 at 5:01 PM, Registered Nurse (RN)3 stated when new pressure ulcers were discovered the physician and family were both notified right away. RN3 stated the notification should be documented in Progress Notes. During an interview on 01/09/25 at 6:54 PM, the Administrator stated notification of the pressure ulcer was covered at discharge in the Discharge Instructions regarding the application of Skin Prep treatment. The Administrator stated she did not know if the family was notified prior to that. NJAC 8:39-13.1(a)(d)

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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** 27104 Based on record review, interview, and facility policy review, the facility failed to ensure pharmacy recommendations were responded to by the physician for one resident (Resident (R)160) out of five residents reviewed for unnecessary medications out of a total sample of 43 residents. This had the potential for the resident to have unmet health needs by not providing medication management. Findings include: Review of the facility policy titled, Consultant Pharmacy Reports last revised 04/2024 revealed, It is the policy of the facility that a Licensed Nurse along with the Consultant Pharmacist will review the resident drug regimen upon admission, throughout the stay depending on the resident condition and in any event of risk of adverse consequences . Any irregularities will be reported and documented to the attending physician and DON [Director of Nursing] . Procedure . 4. Any medication irregularities identified will be documented on a separate, written report and notification to the attending physician, and director of nursing, listing the resident name, relevant drug irregularity that was identified with the resolution noted by the physician . 6. If the physician chooses not to act upon the pharmacy consultant recommendations, the physician will communicate with a licensed professional. Review of R160's Profile located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of dementia and Alzheimer's disease. Review of R160's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/23/24 revealed a Brief Interview for Mental Status (BIMS) score of one out of 15 indicating the resident was severely cognitively impaired. Review of R160's Physician's Orders located in the EMR under the Orders tab revealed R160 was ordered Donepezil (Aricept) five milligrams (mg), give one table by mouth at bedtime for dementia with a start date of 08/14/24 and an order for Memantine (Namenda) five mg, by mouth two times a day for dementia with a start date of 08/15/24. Review of the Certified Consultant Pharmacist Monthly Progress Notes provided by the facility dated 08/29/24, revealed the pharmacist recommended to consider increasing the resident's Aricept after four weeks. Under the section titled Please consider implementing these recommendations and document below any changes made in response to the recommendations written, or should the recommendations be rejected, please document a rationale. There were initials in the space with no response documented. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Certified Consultant Pharmacist Monthly Progress Notes provided by the facility dated 09/26/24 and 10/25/24 revealed the pharmacist requested to consider increasing the dosage of R160's Aricept and Namenda. Under the section titled Please consider implementing these recommendations and document below any changes made in response to the recommendations written, or should the recommendations be rejected, please document a rationale. There were initials in the space with no response documented. Review of R160's Medication Administration Record (MAR) from 08/01/24 through 01/09/25 revealed the resident was still receiving the same ordered dosage of Namenda and Aricept that was originally ordered on 08/14/24 and 08/15/24. During an interview on 01/09/25 at 5:00 PM with the Director of Nursing - North (DON-N) confirmed the consulting pharmacist had made physician recommendations for R160's Namenda and Aricept to be increased three separate times and there was no documentation from the physician agreeing with the recommendations and/or any rationale as to why the recommendations were not agreed upon. During an interview on 01/09/25 at 6:00 PM with the Consulting Pharmacist (CP) revealed the reason she requested to increase the resident's Aricept on 08/29/24 after four weeks was due to the resident being on a low dose at the beginning and you want to titrate up to get the maximum effectiveness of the medication. The CP confirmed she also made follow-up recommendations to the physician to increase the Namenda and Aricept two more times and the recommendations were not responded to by the physician. She revealed the two medications are intended to slow the progression of the Dementia/Alzheimer's. NJAC 8:39-29.3

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27104 Based on observation, interview, review of the Maintenance Logbook, and facility policy review, the facility failed to ensure eight resident rooms (Rooms 225W, 213W, 209, 211D, 227P, 262, 230 and 229) on the second floor of the north building was maintained to promote a homelike environment. The facility further failed to ensure formica coverings on a half wall in the Activity room was repaired to potentially prevent injury. This affected eight rooms of 38 resident rooms occupied on the second floor of the north building and the Activity room. This had the potential for the residents not to have a home like room in good repair and had the potential to cause an injury. Findings include: Review of the facility policy titled, Maintenance Repairs last revised 05/24 revealed, Policy: To maintain a safe, clean, and functional environment for residents, staff, and visitors through timely repairs, routine maintenance, and room inspections. Procedures: 1. The Maintenance Department is responsible for conducting routine checks, repairs, and inspections throughout the facility . 3. Staff report issues (e.g., broken equipment, hazards) to the Maintenance Department. 4. Submit repair requests via the maintenance logbook on the designated floor of the issue . 6. The Maintenance Department checks the logbook for needed repairs and logs completion status/date in the logbook. 7. Maintenance performs routine checks/inspections of common areas, hallways, and safety systems (e.g., lighting, HVAC, and plumbing) on daily rounds . 12. Maintenance ensures fixtures, furniture, and systems are inspected for damage and repaired as needed. During observations on 01/08/25 at 3:10 PM with the Regional Maintenance Director (RM) and the facility Maintenance Director (MD) revealed the following concerns in residents' rooms on the second floor of the north building: -In room [ROOM NUMBER]W the closet doors would not shut, there was a missing handle/knob on one of the doors on the closet, there was paint peeling off the closet doors, there was paint peeling off the walls that surround the sink in the middle of the room. There was one ceiling tile sagging above the bed by the door; -In room [ROOM NUMBER]W there was paint peeling all around the sink in the middle of the room with cracks between the sink and the wall; -In room [ROOM NUMBER] there was paint peeling off the walls around the sink in the middle of the room; -In room [ROOM NUMBER]D there was paint peeling off the walls around sink in the middle of the room. The heating unit (radiator) had paint peeling and it was rusted; -In room [ROOM NUMBER]P there was paint peeling off walls by the window and the top of heating vent (radiator) was rusted; (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-In room [ROOM NUMBER] the closet doors had paint peeling, there was paint peeling off the walls surrounding the sink in the middle of the room; -In room [ROOM NUMBER] above the resident headboard of the bed by the window had a large section of peeling paint approximately 12 inches by 12 inches. A ceiling tile above the entrance to the door was sagging; -In room [ROOM NUMBER] the walls surrounding the sink in the middle of the room was peeling. -In the Activity room there was a half side wall surrounding the activity room with formica (laminated composite) covering the top ledge. A piece was broken off the top of the ledge leaving a sharp pointed piece of formica sticking up. The wall was approximately three feet in height, making it the same height for a resident in a wheelchair and if they would use the wall to help propel themselves it had the potential to stick the resident in the hand or arm and cause an injury. Review of the Daily Maintenance Logbook provided by the facility dated 2024 and 2025 revealed there were no requests completed by staff to complete any painting, repair any closet doors, repair any sagging ceiling tiles, or to fix the wall surrounding the Activity room. Further review of the logbook was an entry dated 01/09/25 revealed there were no maintenance issues reported by staff or found on maintenance rounds. During an interview with the RM and MD at the time of the above observations, they confirmed the rooms needed to be painted and the closet doors needed to be repaired. NJAC 8:39-31.4(a)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27104 Based on observation, interview, review of Maintenance Logbooks, and facility policy review, the facility failed to ensure handrails located in the corridors throughout the second floor of the north building on all four hallways had handrails in good repair and/or were not missing. This had the potential for the residents to potentially injure themselves when using the handrails during ambulation. This affected all four hallways of the second floor in the north building out of three floors in the building. Findings include: Review of the facility policy titled, Maintenance Repairs last revised 05/24 revealed, Policy: To maintain a safe, clean, and functional environment for residents, staff, and visitors through timely repairs, routine maintenance, and room inspections. Procedures: 1. The Maintenance Department is responsible for conducting routine checks, repairs, and inspections throughout the facility . 3. Staff report issues (e.g., broken equipment, hazards) to the Maintenance Department. 4. Submit repair requests via the maintenance logbook on the designated floor of the issue . 6. The Maintenance Department checks the logbook for needed repairs and logs completion status/date in the logbook. 7. Maintenance performs routine checks/inspections of common areas, hallways, and safety systems (e.g., lighting, HVAC, and plumbing) on daily rounds . 12. Maintenance ensures fixtures, furniture, and systems are inspected for damage and repaired as needed. During observations on 01/08/25 at 3:10 PM with the Regional Maintenance Director (RM) and the facility Maintenance Director (MD) revealed the following concerns with handrails in the corridors on the second floor of the north building: -Handrail between rooms [ROOM NUMBERS] had duct tape with foam around the ends of the handrails; -Handrail on the left side of the hall starting right before room [ROOM NUMBER] had duct tape on the ends securing the handrail to the wall; -Handrail on the left side of the hallway between the soiled utility room and MDS office door had duct tape on both ends of the handrail; -Missing handrail in front of the women's shower on the north hall; -Missing handrail in between the elevators; -Handrail to the right of the elevator had duct tape on both ends; -Handrail in front of the TV room was loose and pulled away from the wall. Review of the Daily Maintenance Logbook provided by the facility dated 2024 and 2025 revealed there were no requests to fix handrails on the corridors of the second floor. Review of the entry in the logbook dated 01/09/25 revealed there were no maintenance issues reported by staff or found on maintenance rounds related to handrails. (continued on next page)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at the time of the above observations the MD said they were waiting on caps to come into place on the ends of the handrails so they could be replaced. A request was made for a copy of the invoice showing handrails and caps were ordered so the handrails could be fixed. The RM said they would not be able to produce any invoices for copies of any orders to show replacement parts for the handrails had been ordered. During an interview on 01/09/25 at 9:25 AM Interview with the Unit Manager 2nd floor - North (UM2N) revealed she was not sure how long the handrails were in need of repair and confirmed there was no record in the logbooks of the needed repairs for the handrails. During an interview on 01/09/25 at 9:30 AM Licensed Practical Nurse (LPN)2 she was unsure how long the duct tape and foam had been on several of the handrails. She said she knew they were working on the handrails last night. During an interview with the Assistant Administrator on 01/09/25 at 1:30 PM revealed she had heard there was a plan to remodel the second floor but did not know when that would be started. NJAC 8:39-31.2(e)