STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	**96 PARKWAY , ROCHELLE PARK, New Jersey, 07662**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Survey Date: 6/10/26 Census: 191 Sample: 35 sample + 3 closed records =38 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		07/09/2026
F0908 SS = F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to maintain the kitchen exhaust hood assembly in a safe operating condition by ensuring hood panels were properly fitted without gaps. This deficient practice had the potential to affect all residents residing in the facility due to the increased risk of grease accumulation and fire associated with gaps in the kitchen exhaust hood system and was evidenced by the following: On 5/28/26 at 9:40 AM, the surveyor conducted a kitchen tour with the U. S. FOIA (b) (2) During the kitchen tour, the surveyor observed the kitchen exhaust hood system located above the stove and oven, approximately two one-inch gaps, one on each side of the hood panels. The gaps were visible between adjoining hood panel sections. At that time, the surveyor interviewed the U. S. FOIA regarding the observation. The U. S. FOIA acknowledged the presence of the gaps and acknowledged the surveyor's concern that the openings could present a fire hazard.	F0908	Corrective action for affected equipment: The kitchen exhaust hood assembly above the stove/oven was immediately removed from service for evaluation, and the U. S. FOIA (b) (2) notified Maintenance and the licensed hood service contractor. The two approximately one-inch gaps in the hood panels were inspected and repaired/re-fitted to eliminate openings and restore the hood system to safe operating condition. Documentation of repair/service was obtained and maintained on file. Identification of others potentially affected: This had the potential to effect all residents. A full inspection of all kitchen hood panels, adjoining sections, ducts, and visible hood components was conducted by U. S. FOIA (b) (2) leadership to identify any additional gaps, loose fittings, or conditions that could present a fire or grease accumulation hazard. Any identified concerns were corrected immediately or referred to the licensed vendor for repair. Systemic changes: The Kitchen Hood Cleaning Policy and preventive maintenance process were revised to include visual inspection of hood panel alignment, seams, and gaps after each professional cleaning and during routine environmental rounds. The Food Service Director, Regional Food Service Director, and Maintenance Director were re-educated by the	07/07/2026

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 reverse for further 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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F0908 SS = F	Continued from page 1 On 5/29/26 at 8:45 AM, the surveyor conducted a follow-up observation of the kitchen with the U. S. FOIA and U. S. FOIA (b) (2)). The surveyor observed that the two approximately one-inch gaps in the hood panels remained present. During interview, both the U. S. FOIA (b) (2) acknowledged the gaps remained in the hood assembly, and stated they would contact maintenance personnel or the hood cleaning contractor to evaluate and correct the condition. A review of the facility's "Kitchen Hood Cleaning Policy," dated 6/2/26, included that professional cleaning of the kitchen hood, internal ducts, fans, and racks shall be performed by a licensed, certified third-party contractor. The policy further included that management shall maintain inspection reports, service invoices, and supporting documentation related to the exhaust hood system. A review of the facility's "Kitchen Equipment Cleaning and Sanitation Policy," reviewed 1/2026, included that kitchen equipment shall be properly cleaned and maintained to ensure safe operation and to prevent hazards within the food service department. On 6/2/26 at 10:38 AM, the U. S. FOIA (b) (2) in the presence of the survey team, U. S. FOIA (b) (2), acknowledged the presence of the two approximately one-inch gaps in the kitchen hood panels, and stated the condition would require repair or evaluation to ensure the hood system was maintained in a safe operating condition. NJAC 8:39-17.2(e)	F0908	Continued from page 1 DON/ADON regarding immediate reporting and correction of any hood integrity concerns. Monitoring: The Maintenance Director or designee will conduct and document weekly kitchen hood visual inspections for 4 weeks, then monthly for 3 months. Findings will be reviewed in our quarterly Quality assurance and performance improvement meeting,and any deficiencies will be corrected promptly.	07/07/2026
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F0550	Corrective action for affected residents: The dining service concerns on NJ Ex Order 26, 4[illegible] and NJ Ex Orde[illegible] floors were immediately addressed. Staff redistributed meal service assignments to ensure residents seated in dining rooms received trays timely and respectfully. Residents identified in the citation, including UR #1 through UR #9, were reviewed to ensure NJ Exec Order 26.4b1 needs and dining preferences were addressed. Staff were counseled that residents are to be treated with dignity and that residents in dining areas are not to wait excessively while others eat. Identification of others potentially affected: All residents who receive meals in common dining areas had the potential to be affected. Meal service	07/06/2026

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F0550 SS = E	Continued from page 2 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined the facility failed to treat residents with respect and dignity during mealtime. This deficient practice was identified for 9 of 18 Unsampled Residents (UR #1, #2, #3, #4, #5, #6, #7, #8, and UR #9) and 2 of 3 dining areas ([redacted] floors) observed during dining observations. This deficient practice was evidenced by the following: 1. On 5/29/26 at 8:11 AM, the surveyor observed [redacted] floor dining area for breakfast, there were 11 residents seated at five tables, with four staff assisting residents. The surveyor observed Unsampled Resident #1 (UR #1) grabbed one used tray on the side and wanted to eat from the left over, was seen by the staff, and the staff removed the used tray away. The surveyor also observed UR #1 had asked food to eat and was told to wait while other residents were eating. On 5/29/26 at 8:21 AM, the surveyor asked	F0550	Continued from page 2 observations were conducted on all dining units for breakfast, lunch, and dinner to identify delays, workflow barriers, and unequal service patterns. Systemic changes: The Dining Policy was revised to include expectations for timely meal distribution in dining areas, prioritization of all seated residents, escalation process for delayed trays, and accountability for nursing/dietary coordination. Nursing, dietary, and supervisory staff were in-serviced By the Director of Nursing/Assistant Director of Nursing on resident dignity, mealtime rights, and timely tray delivery. Unit managers were instructed by the Director of Nursing/Assistant Director of Nursing to communicate special tray needs to dietary before meal delivery and to actively supervise meal pass. Monitoring: The Administrator, DON, FSD, or designee will perform dining observations on each unit at least 3 times weekly for 4 weeks, then weekly for 2 months, to monitor timeliness, dignity, and equitable meal distribution. Results will be trended through our quarterly Quality assurance and performance improvement meeting.	07/06/2026

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F0550 SS = E	Continued from page 3 Registered Nurse/Unit Manager #1 (RN/UM #1) who was at the dining area about UR #1's breakfast tray, and RN/UM #1 responded that they were still waiting for UR #1's tray. The surveyor observed all residents were eating except for UR #1. On 5/29/26 at 8:28 AM, the surveyor went back to [redacted] floor dining area and observed UR #1 wandering, and was looking for their food. The surveyor interviewed the Certified Nursing Aide (CNA) regarding UR #1's breakfast tray, and she responded that the tray of the resident was "not here", and waiting for the next food truck. On that same date and time, RN/UM #1 confirmed who was in the dining area at that time that they were still waiting for UR #1's tray. The surveyor observed all residents were eating except for UR #1. On 5/29/26 at 8:30 AM, the surveyor observed the 2nd (second) and 3rd food truck came and UR #1 received their breakfast tray after 19 minutes. On 5/29/26 at 8:42 AM, the surveyor interviewed RN/UM #1 regarding Resident #40's breakfast tray was late, and the [redacted] stated that the resident should not have waited that long. RN/UM #1 also acknowledged that all residents should receive their meals at the same time. She further stated but the concern was that the resident should be getting their tray in the 2nd truck, and that they only have one elevator that caused the delay. On 6/2/26 at 12:41 PM, the survey team met with the [redacted] and the surveyor notified them of the above concerns with [redacted] floor dining area that UR #1 did not have breakfast tray while other 10 residents were eating, some done eating, and UR #1 receive their tray after 19 minutes. On 6/3/26 at 11:03 AM, the survey team met with the [redacted] stated that for UR #1's tray, the [redacted] sent communication to the dietary to ensure the tray be on the 1st truck. 2. On 6/3/26 at 8:06 AM, the surveyor observed [redacted]) floor food truck was in front of the nursing station and between the dining area that was not being distributed. There were employees in the nursing station including the [redacted] and RN/UM #2. In the dining area, there were six residents who were seated in front of the tables and the 7th (seventh) resident, UR #2 was eating their breakfast, and the other six residents did	F0550		07/06/2026

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F0550 SS = E	Continued from page 4 not have breakfast in front of them. UR #3, UR #4, UR #5, UR #6, UR #7, and UR #8 were the residents who did not received their breakfast trays. The [U. S. FOIA (b) (2)] observed the surveyor checked UR #2's diet slip for resident's name. On 6/3/26 at 8:09 AM, the surveyor observed the food truck was picked up by the staff and distributed the trays to the residents in their room, while the dining area with residents still waiting for their tray. On 6/3/26 at 8:11 AM, the surveyor observed the 2nd food truck came in and staff distributed it to the residents in their room, and not with the residents in the dining area. UR #2 was the resident with breakfast tray, and the rest of the residents in [NJ Ex Order] floor dining area had no trays. On 6/3/26 at 8:14 AM, RN/UM #2 confirmed the names of seven residents who had not received their breakfast while UR #2 was eating in the dining area in [NJ Ex Order 26, 48] floor. On 6/3/26 at 8:17 AM, the surveyor observed four employees came to [NJ Ex Order 26, 48] floor dining area and served breakfast trays to the rest of the residents. The last tray was distributed to the resident at 8:25 AM [NJ Ex Order 26, 481] floor dining area, that was a total of 19 minutes when all were able to serve breakfast. A review of the facility's "Resident Rights Policy" that was provided by the [U.S. FOIA (b)] with a reviewed date of 1/2026, revealed under policy, the facility is committed to assuring the rights and protection of its residents as stipulated under federal and state laws…Resident's rights include but are not limited to the following…treated with respect, dignity, and self-determination with care… A review of the facility's "Dining Policy" that was provided by the [U.S. FOIA (b)] with a reviewed date of 1/2026, revealed under policy that the facility to provide the resident a pleasant dining experience with the level of assistance needed. Procedure…3. Meals will be served three times per day according to scheduled meal times… The above policies did not include information about residents who will be served at the same time. On 6/4/26 at 11:01 AM, the survey team met with the [U. S. FOIA (b) (2)] did not provide additional information. N.J.A.C. 8:39-4.1(a)(12), 27.1(a)	F0550		07/06/2026

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F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined	F0584	Corrective Action: The facility corrected the environmental and maintenance concerns identified during the survey. [NJ Ex Order 26, 4B] floor dining area: ceiling tile gaps were corrected, affected ceiling areas and floor molding were cleaned, floor substances were removed, and the positioning device was properly stored. [NJ Ex Order 26,] t floor main dining area: peeled wallpaper and chipped wood were repaired, ceiling vents and affected flooring were cleaned, and the water dispenser/surrounding area was cleaned. [NJ Ex Order 26, 4B] floor main dining area: chipped wood was repaired, ceiling vents were cleaned, and clean plate covers were properly protected. [NJ Ex Order 26, 4B] floor dining area: flooring and ceiling tile gaps were corrected and the two AC unit metal grills were cleaned. [NJ Ex Order 26, 4B] floor shower room: the ceiling vent was cleaned, ceiling tile gaps were corrected, and [NJ Exec Order 26.4b] were removed from the shower cubicle and properly stored. [NJ Ex Order 26, 4B] floor central bath/training restroom broken/missing tiles and uneven flooring were repaired. Room # [NJ Ex O]: the ripped privacy curtain was replaced/repaired, peeled molding and wallpaper were repaired, closet doors were adjusted, and the toilet room vent was cleaned. Room [NJ Ex Orde] the resident's clothing was removed from the empty bed and appropriately stored. Room [NJ Ex Orde]: a functioning call device was installed, connected, and placed within the resident's reach. All repairs were done by the Director of maintenance. Identification of Others Potentially Affected: All residents had the potential to be affected. Environmental rounds were conducted by the administrator and director of maintenance of resident rooms, dining areas, shower/bathrooms, common areas, vents, flooring, ceiling tiles, furnishings, and other resident-use areas to identify similar concerns. Resident call devices were checked for function and accessibility. Additional concerns identified were corrected or placed on the appropriate maintenance/housekeeping work list for prompt correction. Systemic Changes: Maintenance, Housekeeping, Nursing, and Dietary staff were educated by the U. S. FOIA (b) (2) on maintaining a safe, clean, comfortable, and homelike environment; promptly reporting environmental concerns; keeping vents and surfaces clean; properly storing equipment and clean dietary items; maintaining resident-room fixtures and furnishings; and ensuring functioning call devices are within residents' reach. Department managers will include environmental observations during routine rounds and communicate concerns to the appropriate department for timely correction. All Staff were	07/07/2026

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F0584 SS = E	Continued from page 6 that the facility failed to provide a safe, clean, and comfortable homelike setting. This deficient practice was identified for 4 of 4 dining areas ([redacted] floor, [redacted] floor, [redacted] floor, and [redacted] floor), 2 of 2 shower rooms ([redacted] floors), 3 of 35 residents' rooms (Rooms #[redacted]), and was evidenced by the following: 1. During the dining observation on 5/29/26 at 8:15 AM, of Surveyor #1 (S #1) in [redacted] floor, in the presence of the [redacted] both S #1 and the [redacted] observed six ceiling tiles with gaps, the ceiling tiles near the ceiling fan was being used at that time with accumulation of grayish substances. Both S #1 and the [redacted] also observed floor molding was blackish, red substances on the floor under the table, and there was a positioning device on the floor near the air conditioned (AC) system by the window. On 5/29/26 at 8:55 AM, S #1 observed the [redacted] floor of the [redacted] main dining area in the presence of the [redacted] the wall paper peeled off, the area near the entrance with chipped wood, and the ceiling vent with heavy accumulation of blackish substances. S #1 asked the [redacted] about the concerns, and he replied that it was better to talk to the maintenance people. At that time, the Regional [redacted] joined the [redacted] and both the [redacted] and the [redacted] stated to get Director of Maintenance #1 (DM #1) about S #1's concerns in the dining area. At that same time, S #1 asked the [redacted] about the water dispenser in [redacted] main dining area with a date of 5/28, the surrounding bottom part with brownish accumulation, and the [redacted] replied that he was about to replace the water and did not respond as to what those brown substances were. On 5/29/26 at 9:00 AM, S #1 interviewed DM #1 in [redacted] floor main dining area about S #1's concerns with environment, and he stated that he had ordered self-adhesive, and it was a challenge to put them on for those wall papers that peeled off. He also stated that the chipped wood should not be like that, the ceiling vent should have been cleaned, and he confirmed they were accumulation of dust. S #1 also showed the floor, and he also confirmed it should have been dust off. On 6/1/26 at 9:33 AM, S #1 observed [redacted] floor main dining area wall near the kitchen entrance for employee with chipped wood, there were two trucks with piled plate covers, just above was a ceiling vent with accumulation of grayish	F0584	Continued from page 6 educated by the [redacted] on these requirements for continued compliance going forward. Quality Assurance: The Maintenance Director, Housekeeping Director, Director of Nursing, Food Service Director, and/or designees will conduct weekly environmental audits for three months. Audits will include the cited locations and a sample of other resident rooms and common areas, with attention to cleanliness, vents, ceiling tiles, flooring, walls/molding, storage practices, furnishings, and call-device availability/function. Findings will be documented and corrected promptly. Results will be reviewed by the Administrator and through our quarterly Quality assurance and performance improvement meeting. . Responsible Party: [redacted] with oversight by the [redacted] Completion/Compliance Date: July 7, 2026	07/07/2026

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F0584 SS = E	Continued from page 7 substances. The trucks with plate covers were uncovered, there was another ceiling vent with light accumulation of grayish substances, and on another end which was near the patio exit two ceiling vents with heavy accumulation of gravish substances. S #1 asked the U. S. FOIA (b) (2) about the above concerns with uncovered plate covers and with ceiling vent above with grayish substances, and she acknowledged they were accumulation of dust. The U. S. FO further stated that it was better for S #1 to talk to the U. S. FO about environmental concerns. She also stated that the room was being used for dining and activities of residents. On 6/1/26 at 9:37 AM, the U. S. FOIA (b) (2) came out from the kitchen door and the surveyor asked the U. S. F about the plate covers, and he stated that they were considered clean. The U. S. F acknowledged that they were uncovered. S #1 asked about the ceiling vent just above the plate covers and he did not respond. On 6/1/26 at 9:39 AM, S #1 notified and showed DM #2 of the above concerns with NJ Ex Order 2 main dining room. On 6/3/26 at 8:06 AM, both S #1 and U. S. FOIA (b) (2) observed NJ Ex Orde floor dining area with flooring gaps, six ceiling tiles with gaps, two AC systems near the windows with accumulation of dust and dirt inside the metal grills. The U. S. FOIA (b confirmed the observation and stated that it should have been cleaned. 2. On 5/29/26 at 8:22 AM, S #1 and the AA observed NJ Ex Order 26, 4B floor shower rooms ceiling vent with accumulation of blackish substances, the ceiling tiles with gaps, the 2nd shower cubicle with two shower chairs, and at the back of the shower chair was floor mats in a plastic bag. The surveyor asked the U. S. F for the shower cubicle that was being used as a storage for floor mats, the U. S. F replied he was unsure and would ask the nurse. On 6/3/26 at 8:27 AM, S #1 with RN/Unit Manager #1 (RN/UM #1) observed the NJ Ex Order 26, 4B1 floor central bath (also known as the shower room), the middle section (Training Restroom) upon entry to the door with broken and missing tiles and the toilet area floor with uneven flooring. 3. On 5/29/26 at 8:33 AM, S #1 with Certified Nursing Aide #1 (CNA #1) entered Room NJ Ex Orde (R#360), observed the ripped privacy curtain, sink below with peeled molding, the light above sink with peeled wall paper, and the resident who was inside	F0584		07/07/2026

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F0584 SS = E	Continued from page 8 the room stated that it had been like that for two months. Both S #1 and CNA #1 also observed the closet doors were uneven. Both also observed inside the toilet room of R#[redacted] the vent with accumulation of blackish substances. On 5/29/26 at 8:42 AM, S #1 asked Registered Nurse/Unit Manager #2 (RN/UM #2) to accompany the surveyor inside R#[redacted] Inside the room, RN/UM #1 confirmed S #1's observation of ripped privacy curtain which she said should not be like that. She also stated that she would ask for maintenance to fix the closet doors, and that the vent should have been cleaned. On 6/1/26 at 6:30 AM, both S #1 and the [redacted]) went to Room #[redacted] (R#[redacted] observed the bed by the window with no mattress, with clothes that were unfolded on top of the empty bed. The unsampled resident inside R#[redacted] informed S #1 and the [redacted] those clothes were their clothes. On 6/2/26 at 12:41 PM, the survey team met with the[redacted], and S #1 notified them of the above findings and concerns. On 6/3/26 at 1:10 PM, S #1 asked the[redacted] for Resident Rights policy. On 6/3/26 at 11:03 AM, the survey team met with the[redacted] stated with regard to environmental concerns that S #1 pointed out with dust and gaps, "I" went with maintenance and took care of the concerns that included the chipped wood, wall papers both dining rooms, privacy curtain fixed right away, vent pulled down and cleaned thoroughly. A review of the facility's "Facility Environment Policy" that was provided by the LNHA, with a revised/reviewed date of 1/2026, revealed under policy, it is the policy of this facility to provide a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Procedure....2. Housekeeping and maintenance shall maintain a sanitary, orderly and comfortable environment. 3. This facility shall ensure clean bed and bath linens are in good condition, private closet space in each resident room, adequate and comfortable lighting in all areas, comfortable and safe temperature levels and maintenance of comfortable sound levels. On 6/4/26 at 11:01 AM, the survey team met with the[redacted] did not provide	F0584		07/07/2026

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F0584 SS = E	Continued from page 9 additional information. 4. On 5/28/26 at 11:33 AM, Surveyor #2 (S#2) observed Resident #123 lying in bed without a call device within reach of the resident. The call device cord had been removed from the wall jack. On 5/29/26 at 11:04 AM, S#2 conducted a second observation of Resident #123 and observed again that Resident #123 was lying in bed without a call device within reach of the resident. The call device was not present still. On 5/29/26 at 11:07 AM, S#2 interviewed Certified Nursing Assistant #2 (CNA #2) who stated that the call bell was broken. CNA #2 further stated that the expectation was to make sure the call bell was within reach of the resident. CNA #2 acknowledged that they did not check the resident's call bell today and should have checked the resident's call bell was within reach of the resident. On 5/29/26 at 11:19 AM, S#2 interviewed the U. S. FOIA (b) (2)), who acknowledged the call device was not present and searched for it underneath Resident #123's bed. The U.S. FOIA further stated that the resident should have had a call device that was within reach of the resident. At that time, RN/UM #3 obtained a call device, attached it to the wall jack, and clipped it to the bed within reach of the resident. A review of the Admission Record or face sheet (an admission summary) revealed that Resident #123 was admitted to the facility with diagnoses that included, but were not limited to, NJ Ex Order 26, 4B1 [redacted] A review of the care plan report, initiated NJ Exec Order 2, revealed that Resident #123 NJ Ex Order 26, 4B1 Interventions included, but were not limited to, "Be sure call light is within reach and encourage to use it for assistance as needed. Provide prompt response to all requests for assistance." On 6/3/26 at 11:04 AM, S #2, in the presence of the survey team, discussed the concern with the U. S. FOIA (b) [redacted]. On 6/4/26 at 10:28 AM, the survey team met with the U. S. FOIA (b) (2) stated they knew what needs to be corrected, in-serviced, and audited.	F0584		07/07/2026

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F0584 SS = E	Continued from page 10 A review of the facility's "Call Bell Response Policy," reviewed 1/2026, revealed, it is the policy of the facility to ensure that all residents have timely access to staff assistance through a functioning call bell system in order to promote resident safety, dignity, comfort, and quality of care...Call bells shall be placed within residents' reach. NJAC 8:39-31.2(e); 31.4(a)(c)(f); 31.8(c)9	F0584		07/07/2026
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language	F0628	Corrective action for affected residents: Residents #7, #16, and #18's transfer/discharge/bed hold records were reviewed. The bed hold notice form was revised to include the reserve bed [redacted] amount, when applicable, and the [redacted] responsibility details required by regulation. The [redacted] and The admission [redacted] were educated by the [redacted] on completing the form accurately and completely. Identification of others potentially affected: All residents transferred to the hospital or discharged had the potential to be affected. A retrospective audit of transfers/hospitalizations for the prior 30 days was completed by the [redacted] to ensure required bed hold/reserve payment information was included in notices. Systemic changes: The Transfer/Discharge and Bed Hold Policy and forms were revised to include the reserve payment amount and required notice content. Admissions, Social Services, Nursing Supervisors, and business office staff were in-serviced by the Director of Nursing/Assistant director of Nursing regarding responsibilities for emergency transfer notices, bed hold notifications, and documentation requirements. Monitoring: The Administrator or designee will audit 100% of hospital transfers/bed hold notices for 4 weeks, then 10 charts monthly for 2 months to ensure complete notice content. Findings will be reviewed in our quarterly Quality assurance and performance improvement meeting.	07/06/2026

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F0628 SS = E	Continued from page 11 and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,	F0628		07/06/2026

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F0628 SS = E	Continued from page 12 including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing	F0628		07/06/2026

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F0628 SS = E	Continued from page 13 facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on the interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to include in the written notification of emergency transfer and bed hold that was provided to the Resident or Resident Representative, the	F0628		07/06/2026

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F0628 SS = E	Continued from page 14 facility's bed hold reserve payment for 3 of 3 residents, (Residents #7, #16 and #18), reviewed for hospitalizations. This deficient practice was evidenced by the following: 1. On 5/29/26 at 9:31 AM, Surveyor #1 (S#1) observed Resident #7 asleep in bed. A review of Resident #7's Admission Record (AR) or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26, 4B1 [redacted] A review of Resident #7's most recent Discharge Return Anticipated Minimum Data Set (DRAMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of NJ Ex Order 26 [redacted], reflected that the resident's NJ Exec Order 26 [redacted] Further review reflected that the resident was transferred to a NJ Exec Order 26.4b1. A review of Resident #7's hybrid (electronic and paper) medical record included a letter to the U. S. FOIA (b) (2) [redacted] dated NJ Ex Order 26 [redacted] which included that the resident was discharged (d/c'd) to the NJ Exec Order 2 [redacted] and the bed hold policy which had one of the options listed as the Resident's accommodations could be reserved for seven days, starting on the day of discharge (d/c), with payment of charges continuing at the regular daily rate. The letter did not include the bed hold reserve payment amount. 2. On 5/29/26 at 11:30 AM, S #1 reviewed Resident #16's closed hybrid medical record. A review of Resident #16's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26, 4B1 [redacted] A review of Resident #16's most recent DRAMDS with an ARD of NJ Ex Order 26 [redacted], reflected that the resident's	F0628		07/06/2026

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F0628 SS = E	Continued from page 15 NJ Exec Order 26.4b1 Further review reflected that the resident was transferred to a NJ Exec Order 26.4b1 A review of Resident #16's hybrid medical record included a letter to the RR dated NJ Ex Order 26, which included that the resident was d/c'd to the NJ Exec Order 2 and the bed hold policy which had one of the options listed as the Resident's accommodations could be reserved for seven days, starting on the day of d/c, with payment of charges continuing at the regular daily rate. The letter did not include the bed hold reserve payment amount. On 6/3/26 at 11:46 AM, S #1 notified the U. S. FOIA (b) (2) the concerns that Resident #7's and #16's bed hold notification did not have the reserve payment amount. 3. On 5/28/26 at 11:03 AM, Surveyor #2 (S#2) observed Resident #18 lying in bed with NJ Ex Order 26 on. Resident #18 stated they came back from the hospital about NJ Exec Order 26.4B1 ago NJ Ex Order 26, 4B1 The resident further stated that they went back to the NJ Exec Order 2 at different times due to the NJ Ex Order 26, 4B1 not working and another time for NJ Ex Order 26, 4B1. S #2 asked the resident if they signed anything about a bed hold and if the facility informed them of any dollar amount for reserve payment, whenever they were transferred to the NJ Exec Order 26 Resident #18 stated that they did not sign anything, and was not informed about any payment but stated they had a bed when they came back. A review of the AR of Resident #18, revealed diagnoses that included but not limited to; NJ Ex Order 26, 4B1 A review of the DRAMDS and Progress Notes revealed that Resident #18 had NJ Ex Order 26, 4B1 On 6/1/26 at 10:01 AM, S#2 interviewed the NJ Ex Order 26.4	F0628		07/06/2026

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F0628 SS = E	Continued from page 16 U. S. FOIA (b) (2)), regarding the process for bed hold during an emergency transfer. The U. S. FO stated she would call the hospital to follow up, if the resident was admitted she would do a bed hold, and the admission department would handle that. On 6/1/26 at 10:51 AM, S#2 interviewed the U. S. FOIA (b) (2)) in the presence of the U. S. FOIA (b) (2)) regarding her role for emergency transfers. The U. S. FOIA stated that Resident #18 had a difficult time accepting being in the facility. She further stated that she was responsible for filling out the emergency transfer forms, bed hold notifications, and added that they were in the process of transferring the responsibility to the admission department for the bed hold notifications. She further stated there was a form for bed holds to give to the U. S. FO or next of kin. She also stated that most of their residents were NJ Ex Order 26, 4B and always take them back. She added that if it was a private pay resident, the Admission department handled the financial piece. On that same date and time, the U. S. FOIA stated the bed hold notification for U. S. FOIA (b) d/c was done by the admission department. S #2 was provided with the bed hold notifications for the five emergency transfers which revealed the forms did not indicate the reserve payment. S #2 asked if they were familiar with the regulations for bed hold and reserve payment, and the U. S. FOIA replied she did not know the specifics, and would need to review it. On 6/1/26 at 11:21 AM, S#2 interviewed the U. S. FOIA (b) (2) regarding bed hold reserve payments. The U. S. FO stated that he was familiar with the bed hold regulation and stated it was the facility's responsibility to tell the resident of the reserve payment and rate would be. The U. S. FO further stated, "I do not know how private pay works", and "I am" not familiar. On 6/3/26 at 11:25 AM, the survey team met with the U. S. FOIA (b) (2) and S #2 notified them of the above findings and concerns with Resident #18. A review of the facility's "Transfer/Discharge and Bed Hold Policy", with a review date of 4/19/26 revealed under policy, it is the policy of the facility to ensure that all transfer/discharges and Bed Holds	F0628		07/06/2026

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F0628 SS = E	Continued from page 17 are conducted in accordance with New Jersey Department of Health (NJDOH) regulations, resident rights, and federal requirements...Under procedure...Bed Hold Notification: In New Jersey, long term care (LTC) facilities follow specific guidelines regarding bed hold policies. These policies ensure that residents who temporarily leave the facility, for instance due to hospitalization, have their bed reserved for a certain period.... #1 Hospitalization or Therapeutic Leave: If a resident is transferred to a hospital.... the LTC must offer the resident (or their family) the option to reserve the bed." The facility policy did not include a written, dollar amount for the reserve payment for bed hold, regardless of payor source, on their bed hold transfer forms. On 6/4/26 at 10:27 AM, the survey team met with the U. S. FOIA (b) (2) for their responses to the notified concerns. They did not provide any response to the concern regarding bed hold reserve payment amount. The U. S. FOIA did not provide any additional information. NJAC 8:39-5.4(c)	F0628		07/06/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F0761	Corrective action for affected carts/items: All opened treatment items identified on the five treatment carts were immediately reviewed, labeled with opening dates if appropriate, or discarded if the opening date could not be verified. Treatment carts were cleaned and reorganized. Identification of others potentially affected: All treatment carts, medication carts, medication rooms, and treatment storage areas had the potential to be affect all residents. A house-wide audit of opened treatment products and other applicable items was completed. Systemic changes: U. S. FOIA (b) (2) were re-educated by the U. S. FOIA on proper labeling and dating of opened treatment items. Treatment cart checks were added to	07/07/2026

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F0761 SS = E	Continued from page 18 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to store medications and biologicals in accordance with facility policy by failing to ensure opened treatment items were labeled with the date opened for 5 of 5 treatment carts. The deficient practice was evidenced by: On 6/2/26 at 9:15 AM, the surveyor conducted a medication (med) storage inspection in the presence of the U. S. FOIA (b) (2) During inspection of treatment carts located in the NJ Ex Orde Building and NJ Ex Orde Building, the NJ Ex Order 26, 4B1 tified multiple opened treatment items that were not labeled with the date opened. On 6/2/26 at 9:20 AM, the surveyor observed the NJ Ex Orde Building NJ Ex O Floor Side NJ treatment cart contained three opened treatment items without an opening date, including: NJ Ex Order 26, 4B1 (an over the counter or prescription NJ Exec Order 26.4b1 med) NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 On 6/2/26 at 9:22 AM, the surveyor observed the NJ Ex Orde Building NJ Ex O Floor NJ Ex Order 2 treatment cart contained three opened tubes of NJ Ex Order 26, 4B1 that were not labeled with an opening date. On 6/2/26 at 9:35 AM, the surveyor observed the NJ Ex Orde Building NJ Ex O Floor Side NJ B treatment cart contained two opened treatment items without an opening date, including: NJ Ex Order 26, 2 NJ Ex Order 26, 4B1	F0761	Continued from page 18 change-of-shift or daily cart inspection routines. The Storage of Medications Policy was reinforced with nursing staff and supervisors. Monitoring: Unit managers/designees will audit all treatment carts weekly for 4 weeks, then monthly for 2 months for proper dating/labeling of opened items. Noncompliance will result in immediate correction and staff follow-up. Findings will be reviewed in our quarterly Quality assurance and performance improvement meeting.	07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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F0761 SS = E	Continued from page 19 On 6/2/26 at 9:37 AM, the surveyor observed the [NJ Ex Order] Building [NJ Ex O] Floor Side [NJ E] treatment cart contained two opened treatment items without an opening date, including: [NJ Ex Order 2] NJ Ex Order 26, 4B1 On 6/2/26 at 9:50 AM, the surveyor observed the [NJ Ex Order 2] Building [NJ Ex O] Floor treatment cart contained two opened treatment items without an opening date, including: [NJ Ex Order 26, 4B1] NJ Ex Order 26, 4B1 These observations were made in the presence of the [U. S. FOIA (b)] On 6/2/26 at 10:05 AM, the surveyor interviewed the [U. S. FOIA (b)] who acknowledged the opened treatment items did not contain dates indicating when they were opened. The [U. S. FOIA (b)] stated that opened treatment items should be dated when opened so staff can determine the period of use and ensure proper med storage practices. On 6/2/26 at 10:28 AM, the U. S. FOIA (b) (2) the presence of the survey team, acknowledged that the treatment items identified by the surveyor did not contain opening dates and stated that opened treatment products should be dated when opened. A review of the facility's "Storage of Medications Policy", reviewed 1/2026, included that drugs and biologicals shall be stored in a safe, secure, and orderly manner. The policy further included that drug containers with improper or incorrect labels shall be returned to the pharmacy for proper labeling before storage and that nursing staff shall be responsible for maintaining med storage and preparation areas in a clean, safe, and sanitary manner. NJAC 8:39-29.4(a)	F0761		07/07/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	Corrective action for affected practices/residents: The staff member identified was immediately re-educated on hand hygiene, NJ Exec Order 26.4b1, PPE sequencing, and gown/glove use for direct care.	07/02/2026

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F0880 SS = E	Continued from page 20 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880	Continued from page 20 Sharps containers identified as overfilled in Residents #6, #7, #9, and #67 rooms were replaced immediately. Identification of others potentially affected: All residents requiring direct care and all areas with sharps containers had the potential to be affected. A house-wide audit of sharps containers and precaution-sign rooms was completed to verify appropriate fill levels, PPE availability, and signage. Hand hygiene and PPE compliance observations were conducted on all shifts. Systemic changes: The Infection Preventionist re-educated licensed nurses, CNAs, supervisors, and central supply staff on hand hygiene, EBP, PPE sequencing, and timely sharps replacement. A back-up supply process was implemented to ensure sharps containers and lids are available on all units at all times. The sharps replacement responsibility chain was clarified in writing. Monitoring: The Infection Preventionist/designee will conduct 3 hand hygiene/PPE observations 3 times weekly for 4 weeks, then monthly for 2 months. All Sharps container audits will be completed weekly for 4 weeks, then monthly for 2 months. Results will be reviewed in our quarterly Quality assurance and performance improvement meeting.	07/02/2026

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F0880 SS = E	Continued from page 21 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of other pertinent facility documentation, it was determined that the facility failed to: a.) follow appropriate hand hygiene practices for 1 of 3 staff ([redacted] during [redacted] and b.) replaced sharp containers for 4 of 4 residents (Residents #6, #7, #9, and #67), and follow appropriate infection control practices to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and the facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24, it revealed... Key Times to Perform Hand Hygiene: Before having direct contact with residents. Before putting on gloves and immediately after removing gloves. Before performing invasive procedures or handling resident medication. After contact with blood, body fluids, or contaminated equipment. After moving from a contaminated body site to a clean body site on the same resident.	F0880		07/02/2026

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F0880 SS = E	Continued from page 22 After touching objects or environmental surfaces in the immediate resident vicinity… 1. On 6/1/26 at 6:26 AM, Surveyor #1 (S #1) and Registered Nurse Supervisor #1 (RNS #1) went inside Room [redacted] for [redacted]. S #1 observed RNS #1 donned (put) gloves without performing hand hygiene, checked the resident's [redacted]. On 6/1/26 at 6:30 AM, both S #1 and RNS #1 went to the next room, Room [redacted] the RNS did not perform hand hygiene prior to entering the resident's room, and prior to donning a new pair of gloves when she entered the resident's room. S #1 observed there was a PPE (personal protective equipment) sequencing and [redacted] posted signs, a PPE box outside the room, and an ABHR (alcohol base hand rub) on the wall. The RNS informed S #1 that the resident in [redacted] was [redacted]. RNS #1 did not follow the posted sign for [redacted] to perform hand hygiene prior to entering the room and to put gown when providing direct care. S #1 observed RNS #1 checked the resident inside [redacted] for [redacted] and performed hand washing after discarding used gloves. Outside [redacted] S #1 asked RNS #1 as to why she did not perform hand hygiene after doffing off used gloves in [redacted] and prior to entering [redacted] with posted sign for [redacted] with instructions to perform hand hygiene before entering the room and to put on gown when performing direct care. RNS #1 stated that because S #1 asked her to check resident's [redacted] S #1 asked RNS #1 if she should follow the posted instructions, and she did not reply. 2. On 5/28/26 at 10:53 AM, S #1 observed Resident #9 lying on their [redacted] bed with [redacted]. Outside the door was posted sign for [redacted] and PPE sequencing, and a PPE box. Upon entry to the door there was a red covered bin and on top of the wall was a sharp container which was above full line. A review of Resident #9's [redacted] and [redacted] electronic Medication Administration Record (eMAR) revealed a physician order (PO) that included but were not limited to: [redacted], [redacted] one time a	F0880		07/02/2026

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F0880 SS = E	Continued from page 23 day for NJ Ex Order 26, 4B1)-Start Date NJ Ex Order 26 NJ Ex Order 26, 4B1 Start Date NJ Ex Order 26. 3. On 5/28/26 at 11:02 AM, S #1 observed Resident #67 was lying on NJ Ex Order 26, 4B1, outside the door with posted signs for NJ Exec O PPE sequencing, and a PPE box. Upon entering the door there was a red covered bin on top of the wall was a sharp container above full line. A review of Resident #67's NJ Exec O and NJ Exec Order 26.4b1 eMAR revealed a PO that included but was not limited to: NJ Ex Order 26, 4B1 -Start Date NJ Ex Order 26, 4 NJ Ex Order 26, 4B1 -Start Date NJ Ex Orde 6. On 6/1/26 at 9:16 AM, S #1 interviewed the U. S. FOIA (b) (2) regarding the resident's sharp container that was observed on 5/28/26, that was above full line. The U. S. FO stated that she was aware that it was above full line and she notified the assigned person to replace it, the Central Supply Staff since Monday NJ Ex Order 26, 4B that the sharp containers in the unit in all rooms except for rooms NJ Ex Order 26, 4B1 needed to be replaced because they were full. She further stated that when the Central Supply Staff came back, he only had the body of the sharp container but no cover that was why it was not replaced not until the Surveyor #2 (S #2) came back on 5/29/26. On 6/2/26 at 10:45 AM, S #1 interviewed the U. S. FOIA (b) (2) regarding infection control, and she stated that she was responsible for staff education and competency for hand hygiene, PPE use, and NJ Exec O She further stated that it was expected for the staff to perform hand hygiene prior to entering the resident's room with posted sign of NJ Exec O the minimum requirement were to wear a gown and gloves when doing high contact care that included NJ Ex Order 26, 4B1 checking the NJ Exec Order 26.4b of the resident, and prior to exiting to doff (remove) PPE, and perform again hand hygiene.	F0880		07/02/2026

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F0880 SS = E	Continued from page 24 At that same time, the [U. S. FO] informed S #1 that the Central Supply Staff was responsible for [NJ Ex Orde] Pavilion sharp containers for ordering and replacing them. She further stated that it was important to replace the sharp containers when they reach the full line level to prevent needlestick infection. S #1 notified the [U. S. FO] of the above findings and concerns. On 6/2/26 at 12:41 PM, the survey team met with the [U. S. FOIA (b) (2)] and S #1 notified them of the above findings and concerns about the RNS's hand hygiene and use of PPE, and the concerns with Resident #9 and Resident #67's sharp containers. On 6/3/26 at 11:03 AM, the survey team met with the [U. S. FOIA (b) (2)] stated "we have" sharp containers available and we in service the staff that they have to replace the sharp container if they reached the dotted line. She further stated that staff was educated that if there was a question about sharp containers availability, they could reach out with the [U. S. FOIA (b) (2)] to ensure it would be replaced as soon as possible. 4. On 5/28/26 10:55 AM, S #1 observed in Resident #6's room a sharps container that was filled above the full line. On 5/29/26 at 9:26 AM, S #2 observed in Resident #6's room a sharps container that was full. A review of Resident #6's Admission Record (AR) or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [NJ Ex Order 26, 4B1] [redacted] A review of Resident #6's most recent comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [U. S. FOIA (b) (2)] reflected that the resident's cognitive skills for daily decision making was [NJ Ex Order 26, 4B1] A review of Resident #6's [NJ Exec Order 26,4B] eMAR reflected that the resident had two [NJ Ex Order 26, 4B1] orders that would require the needle to be disposed of in the sharps container.	F0880		07/02/2026

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F0880 SS = E	Continued from page 25 5. On 5/28/26 at 10:59 AM, S #1 observed Resident #7's room with a sharps container that was filled above the full line. On 5/29/26 at 9:31 AM, S #2 observed in Resident #7's room a sharps container that was full. A review of Resident #7's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26, 4B1 [redacted]. A review of Resident #7's most recent discharge return anticipated MDS with an ARD of NJ Ex Order 26, reflected that the resident's NJ Exec Order 26, skills for NJ Exec O [redacted] was NJ Ex Order 26, 4B1. A review of Resident #7's May 2026 eMAR reflected that the resident had NJ Ex Order 26, 4B1 order that would require the needle to be disposed of in the sharps container. On 5/29/26 at 9:33 AM, S #2 interviewed the U. S. FOIA (b) (2) [redacted] who stated that it was usually the nurse that changed the sharps containers, and that they should be changed before it was half full. S #2 asked about Resident #6's and #7's NJ Ex Order 26, 4B1. The U. S. FO [redacted] stated that they definitely needed to be changed. She added that she had contacted someone to get the containers but that they did not have any in stock. On 5/29/26 at 9:51 AM, S #2 interviewed RNS #2 who stated that when the sharps in the container reached the preprinted full line that they had to be changed. She added that they were waiting for a shipment. On 6/3/26 at 11:46 AM, S #2 notified the U. S. FOIA (b) (2) [redacted] the concerns that Resident #6's and #7's room sharps containers were observed full on 5/28/26 and 5/29/26. On 6/4/26 at 10:27 AM, the survey team met with the U. S. FOIA (b) (2) for their responses to the notified concerns. They did not provide any response to the concern. The U. S. FOIA D [redacted] did not provide any additional information. A review of the facility's "Biohazard Waste Storage	F0880		07/02/2026

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F0880 SS = E	Continued from page 26 Policy" with a reviewed date of 4/19/26, included the following: Policy: The facility shall maintain all biohazardous waste, including sharps containers, in a safe, secure, sanitary, and compliant manner… Procedure:3. Sharps shall be disposed of immediately after use in approved sharps containers. Sharps containers shall be replaced when designated fill line. NJAC 8:39-19.4(a)(1)(6)	F0880		07/02/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F0582	Corrective action for affected residents: Residents #42 and #178's records were reviewed. The obsolete/incorrect [redacted] form was removed from use, and the correct documentation of the resident's choice was obtained. The Social Services Department was educated that options on the [redacted] may only reflect the resident's or resident representative's actual choice and must be supported by proper signature or documented verbal acknowledgment consistent with policy and regulation. Identification of others potentially affected: All residents receiving beneficiary notices had the potential to be affected. A retrospective audit of SNFABN/ABN notices issued in the prior 30 days was completed by the Director of social services to ensure correct forms, required signatures/acknowledgment, and accurate option selection. Systemic changes: Only current approved beneficiary notice forms will be used. The form library was updated and old forms were destroyed/removed by the director of social services. Social Services and Admissions staff were re-educated by the Director of Nursing/Assistant Director of Nursing on notice delivery, discussion of options, documentation of resident/RR choice, and signature/verbal acknowledgment requirements. Monitoring: The Administrator or designee will audit 100% of SNFABN/ABN notices for 4 weeks, then monthly for	07/07/2026

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F0582 SS = D	Continued from page 27 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide documented evidence that written notification to the beneficiary of the potential liability charges for services not covered, when the resident was discharged from Medicare Part A services with benefit days remaining were provided for them to choose which option they wanted on the Skilled Nursing Facilit [NJ Exec Order 26.4] Forms for 2 of 3 residents reviewed for [NJ Exec Order 26.4b1] notice (Resident #42 and Resident #178). This deficient practice was evidenced by the following: On 6/3/26 at 1:20PM, the surveyor reviewed the facility provided [NJ Exec Order 26.4] Forms for Resident #42 and Resident #178 which revealed the following: ABN form had the following information: Note: If [NJ Exec Order 26.4] does not pay for D. below, you may have to pay....What you need to do now: Read this notice, so you can make an informed decision about your care. Ask us any questions that you may have after you finish reading. Choose an option below about whether to receive the D. listed above. Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but [NJ Exec Order 26.4] cannot require us to do this. Resident #42's [NJ Exec Order 26.4] form, which had under additional information ending [NJ Exec Order 2], had handwritten “left message with resident	F0582	Continued from page 27 2 months to ensure correct form use and complete documentation. Findings will be reviewed in our quarterly Quality assurance and performance improvement meeting. .	07/07/2026

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F0582 SS = D	Continued from page 28 representative (RR)" on the signature line and date o[NJ Exec Order 26]. The form under section G. Options: "Check only one. We cannot choose a box for you" had Option 1 (I want the D. [service listed above] listed above. You may ask to be paid now, but I also want [NJ Exec Order 26.2] billed for an official decision on payment, which is sent to me on a [NJ Exec Order 26.2] I understand that if [NJ Exec Order 26.2] does not pay, I am responsible for payment, but I can appeal to [NJ Exec Order 26.2] by following the directions on the [NJ Exec Or] If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles) checked. There was no signature of the resident or RR. Resident #178's [NJ Exec Order 26.2] form, which had under additional information ending [NJ Exec Order 2], had handwritten emailed to [name redacted] above the signature line. The form had handwritten Resident unable to sign with date o[NJ Exec Order] on the signature line. The form under Section G. Options had Option 1 checked. There was no signature of the resident or RR. On 6/3/26 at 1:30PM, the surveyor interviewed the U. S. FOIA (b) (2) regarding the process. The [U. S. FOIA (b)] stated that admissions department let her know what resident needed the notification and that she would send them. The [U. S. FOIA (b)] stated that if the resident was [NJ Exec O] and [NJ Exec Order 25] that she would go and talk to them and have them sign the papers. The [U. S. FOIA (b)] stated that if the resident was not [NJ Exec O] and [NJ Exec Order 25] then she would call the [U. S. F] or email the forms. The [U. S. FOIA (b)] stated that the [U. S. FO] would give her verbal confirmation and that she would document it on the forms. The [U. S. FOIA (b)] stated that she would let them know what the options were and that sometimes they wanted to appeal. The surveyor asked the [U. S. FOIA (b)] to view Resident #42's and #178's [NJ Exec O] form and why the option 1 was marked and there was no signature on the forms. The [U. S. FOIA (b)] confirmed that each form had a mark on option 1 and then stated that she was not sure about the mark on the sheet and why it was there. On 6/3/26 at 1:49PM, the surveyor met with the U. S. FOIA (b) (2)) regarding the [NJ Exec Order 25.4b] The [U. S. FOIA (b)] stated that the [U.S. FOIA (b)(6)] provided them. The [U. S. FOIA] stated that there were options given. The surveyor asked the [U. S. FOIA (b) (2)] to view Resident #42 and #178's [NJ Exec O] form which had a mark on Option 1 but there was no signature of the resident or [U. S. F]. The [U. S. FOIA] stated that it must have been checked off by accident. The [U. S. FOIA (b)] stated that	F0582		07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	**96 PARKWAY , ROCHELLE PARK, New Jersey, 07662**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0582 SS = D	Continued from page 29 he would have to get a blank form and look to see about the mark. The surveyor notified the [U. S. FOIA (b) (2)] [redacted] the concern regarding the [NJ Exec(b)] [redacted] form for Resident #42 and #178. On 6/4/26 at 10:27 AM, in the presence of the [redacted] U. S. FOIA (b) (2) stated that the ABN form that was being used must have been from the previous company and should not have been filled out with the option. He added that maybe they had one form and made copies. The [U. S. FOIA (b)] [redacted] stated that they should not have been using that form and that they had a new form now. The [U. S. FOIA (b)] [redacted] did not provide any additional information. A review of the facility's "NOMNC/ABN Policy" with an effective date of 10/24/25, included the following: Policy: Medicare will only pay for services that are determined to be reasonable and necessary. Notice of Medicare Non-Coverage letter must be provided if services are determined to no longer meet skilled nursing or rehab needs. Advance Beneficiary Notice (ABN) must be provided if applicable. Procedure: The guidelines listed below outline the situations in which a Notice of Medicare Non-Coverage(NOMNC)/ABN (if applicable) is provided in accordance with Medicare requirements. 1. In the event that the Medicare beneficiary no longer qualifies for the skilled level of care, the social worker (SW)/designee will prepare the NOMNC/ABN (if applicable) informing the resident and/or responsible party that they no longer qualify for Medicare payment. 2. The SW/designee will prepare the NOMNC/ABN notice at least two calendar days before Medicare-covered services end. 3. The SW will assess the resident's cognitive status. In the event that the resident is cognitively impaired, the resident's NOK (next of kin) or designated rep will be notified. 4. The NOMNC/ABN must be provided regardless of the beneficiary's agreement on service. 5. The SW will discuss the NOMNC/ABN with the resident or their designated RR and will proceed with the option chosen by the resident or designated RR as outlined in the notices.	F0582		07/07/2026

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F0582 SS = D	Continued from page 30 6. The SW will ensure that the beneficiary or the responsible party signs and dates the NOMNC/ABN, confirming that they have received the notice and understand their rights to appeal. 7. In the case that a resident is cognitively impaired and unable to sign the required notices, the SW will reach out to the designated RR of the resident via telephone or email to inform them of the NOMNC/ABN notice. The SW will also discuss the preferred options and the appeal process with the RR. A verbal acknowledgement will be obtained. 8. The SW department will keep a binder containing copies of all NONMC/ABN notices given to residents for record-keeping purposes. NJAC 8:39-4.1(a)(8), 5.1	F0582		07/07/2026
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure that a Significant Change in Status Assessment (SCSA) was completed for 1 of 38 residents, (Resident #17), reviewed for Minimum Data Set (MDS). This deficient practice was evidenced by the following: According to the CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, updated October 2025, reflected, a SCSA must be completed within 14 days of determining a significant change from baseline. The resident's condition is not expected to return to baseline within two weeks. Comparison	F0637	Corrective action for affected resident: Resident #17's clinical status was reviewed by the interdisciplinary team. A Significant Change in Status Assessment was completed/corrected to reflect the resident's [NJ Exec Order] and the care plan was reviewed and updated accordingly. Identification of others potentially affected: All residents with notable decline or improvement had the potential to be affected. A review of MDS assessments completed in the prior 60 days was performed to identify residents meeting significant change criteria who may require SCSA review. Systemic changes: The MDS Coordinator and IDT were re-educated by the Director of Nursing and Assistant director of Nursing on CMS RAI criteria for significant change, required timelines, interdisciplinary review, and documentation of decision-making when a SCSA is or is not initiated. A tracking tool was implemented for major declines, fractures, new dependency, and return-from-hospital changes. This tool will be overseen by the MDS coordinator along with the regional MDS consultant. Monitoring: The Regional MDS Consultant or designee will audit all significant clinical changes and corresponding	07/07/2026

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F0637 SS = D	Continued from page 31 with the most recent comprehensive and quarterly assessments is crucial. Criteria for SCSA include two areas of decline or improvement, or IDT (Interdisciplinary team) recommendation. Documentation of criteria met is essential in the resident's medical record… On 5/28/26 at 11:46 AM, Surveyor #1 (S #1) observed Resident #17 in activity room with other residents. The U. S. FOIA (b) (2)) stated that for the past NJ Exec Order 26.4b1 , the resident had incident in their room, the roommate stated that Resident #17 wanted to use the bathroom, , and complained of . The further stated that the showed NJ EX Order 26, 4B1 and no other after that. Surveyor #2 (S #2) reviewed the medical records of Resident #17, and revealed: A review of the Admission Record or face sheet (an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to:NJ Ex Order 26, 4B1 A review of the comprehensive MDS (cMDS) with an assessment reference date (ARD) of , and quarterly MDS (qMDS) with an ARD of revealed in NJ Exec Order 26.4b1 Patterns, a brief interview for mental status (BIMS) score of which reflectedNJ Ex Order 26, 4B1 . Section NJ Exec Order 26.4b1 (it measures a resident's and functional status in performing basic daily tasks, specifically tracking their baseline (usual performance) upon admission, their progress during a stay, and their discharge goals) was coded for theirNJ Exec Order 26.4b1 as follows: =was coded for =was coded for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 =was NJ Exec Order 26.4b1	F0637	Continued from page 31 MDS decisions weekly for 4 weeks, then monthly for 2 months. Results will be presented in our quarterly Quality assurance and performance improvement meeting.	07/07/2026

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F0637 SS = D	Continued from page 32 [redacted]=was [redacted] The above cMDS and qMDS were also coded for no wheelchair (w/c), [redacted] both upper and [redacted], and [redacted] in use. A review of the qMDS with an ARD of [redacted] revealed that the resident had BIMS score of [redacted], which reflected [redacted]. Section [redacted] revealed that the resident had [redacted], no w/c and [redacted] in use, was coded set up for [redacted], and [redacted] for both [redacted] and [redacted] A review of the qMDS with an ARD of [redacted] revealed that the resident had BIMS score of [redacted] Section [redacted] revealed that the resident had [redacted], w/c in use, [redacted] Further review of the MDS revealed that Resident #17 had [redacted]. A review of the medical records revealed there was no documentation that the team met and discussed the above decline in [redacted] and as to why a SCSA should or should not be made. On 5/29/26 at 10:36 AM, S #2 interviewed the [redacted]), and the [redacted] stated that if the [redacted] was identified and will not return to [redacted] a SCSA would be done. The [redacted] further stated that would be considered a [redacted] or [redacted] depends on type of [redacted] most of the time with [redacted] the resident who came back from the [redacted] and [redacted] examined, did their eval (evaluation), and team decided that the resident was [redacted] before, would not return to previous adls, "we usually give it 14 days somewhat to wait and see if there was an improvement". She also stated that the interdisciplinary team (IDT) meet to discuss the [redacted] and then documented the decision to proceed or not with SCSA and document it in the progress notes. On that same date and time, S #2 asked the [redacted] if the qMDS with an ARD [redacted], be a SCSA since the resident had a [redacted] [redacted]s were all coded that showed a [redacted] The [redacted] responded, "I say" it should have been a SCSA for Quarterly [redacted] #2 asked the	F0637		07/07/2026

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F0637 SS = D	Continued from page 33 U. S. FOIA (b) (2) for any documentation that the IDT decided not to do a SCSA, and she stated that she would get back to S #2. On 5/29/26 at 11:40 AM, the U. S. FOIA (b) (2) informed S #2 that the NJ Exec Order 26 qMDS should have been a SCSA "but we cannot back date," and that they would open an MDS for SCSA. She also stated that she notified the IDT about the SCSA. She further stated that there was no documentation that the IDT decided not to initiate a SCSA for ARD NJ Ex Order 26. S #2 asked for facility's policy about MDS with regard to SCSA, and she stated that she would get back to S #2. On 5/29/26 at 11:47 AM, the U. S. FOIA (b) (2) informed S #2 that the facility had no policy about MDS with regard to SCSA, and they followed the RAI manual. On 6/2/26 at 12:41 PM, the survey team met with the U. S. FOIA (b) (2) and S #2 notified them of the above findings and concerns about Resident #17's MDS. On 6/3/26 at 11:03 AM, the survey team met with the U. S. FOIA (b) (2) stated that the SCSA was not done for Resident #17, and in service was provided to the U. S. FOIA (b) (2) by U. S. FOIA (b) (2). NJAC 8:39-11.2(i)	F0637		07/07/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F0641	Corrective action for affected residents: Resident #17's MDS assessments were reviewed and corrected to accurately reflect NJ Ex history and related data. Resident #23's MDS was reviewed and corrected to reflect the documented NJ Exec Order 26.4b1 as applicable. Identification of others potentially affected: All residents with recent MDS submissions had the potential to be affected. A targeted audit done by the U. S. FOIA (b) (2) of the previous quarter comprehensive, quarterly, and discharge-return MDS assessments was conducted with focus on NJ Ex Order 26, 4B1. Systemic changes: The U. S. FOIA (b) (2) were re-educated by the U. S. FOIA (b) (2)	07/07/2026

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F0641 SS = D	Continued from page 34 §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 2 of 38 residents, (Residents #17 and #23), reviewed for MDS accuracy. This deficient practice was evidenced by the following: 1. On 5/28/26 at 11:46 AM, Surveyor #1 (S #1) observed Resident #17 in activity room with other residents. Licensed Practical Nurse #1 (LPN #1) stated that for the [redacted], the resident had [redacted] incident in their room, the roommate stated that Resident #17 [redacted] LPN #1 further stated that the [redacted] showed [redacted], and no other [redacted] after that. Surveyor #2 (S #2) reviewed the medical records of Resident #17, and revealed: A review of the Admission Record (AR) or face sheet (an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; unspecified [redacted].	F0641	Continued from page 34 on accurate source documentation review, coding of [redacted] and assessment validation prior to submission. Monitoring: The Regional MDS Consultant/designee will audit 5 MDS assessments weekly for 4 weeks, then 5 monthly for 2 months with emphasis on falls, wounds, cognition, and functional status. Results will be reported to our quarterly Quality assurance and performance improvement meeting.	07/07/2026

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F0641 SS = D	Continued from page 35 A review of the [NJ Ex O] investigations provided by the U. S. FOIA (b) (2) for Resident #17 for the last [NJ Exec Order 26.4b1] revealed: On [NJ Exec Orde], a [NJ Ex] incident was reported by LPN #1, reflected that the [NJ Ex O] happened in resident's room, at approximately 11:55 AM, assessment was done and NJ Ex Order 26, 4B1 On [NJ Ex Order 26, 4B] , a [NJ Ex] incident was reported by LPN #1, reflected that the [NJ Ex Order 26, 4B1] in resident's room, at approximately 1:00 PM, assessment was done and NJ Ex Order 26, 4B1. On [NJ Ex Order 26] , a [NJ Ex Order 26, 4B1] was reported by Registered Nurse #1 (RN #1), reflected that the [NJ Ex] happened in resident's bathroom area, at 5:35 AM, assessment was done and noted [NJ Ex Order 26, 4B1] , and the resident NJ Ex Order 26, 4B1. On [NJ Ex Order 26, 4] , a [NJ Ex O] incident was reported by RN #2, reflected that the [NJ Ex] happened in resident's room, at 5:30 PM, assessment was done and [NJ Ex Order 26, 4B1] noted. On [NJ Ex Order 26] , a [NJ Ex O] incident was reported by LPN #2, reflected that the [NJ Ex O] happened in resident's room, at 7:30 PM, assessment was done and [NJ Ex Order 26, 4B1] On [NJ Ex Order 26] , a [NJ Ex O] incident was reported by LPN #1, reflected that the [NJ Ex O] happened in resident's room, at approximately 8:00 AM, assessment was done and the NJ Ex Order 26, 4B1 A review of the comprehensive MDS (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [NJ Ex Order 26, 4] and quarterly MDS (qMDS) with an ARD of [NJ Ex Order 26, 4] , revealed in [NJ Exec Order 26.4b1] Patterns, a brief interview for mental status (BIMS) score of [NJ] which reflected NJ Ex Order 26, 4B1. Section [NJ Exec Order 26.4b1] were [NJ Ex Order 26, 4B1] A review of the qMDS with an ARD of [NJ Ex Order 26,] revealed that the resident had BIMS score of [NJ Ex Order 26, 4] which reflected NJ Ex Order 26, 4B1. Section [NJ] was coded with [NJ Ex Order 26] . A review of the discharge return anticipated (DRA) MDS with an ARD of [NJ Ex Order 26] revealed in Section [NJ]	F0641		07/07/2026

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F0641 SS = D	Continued from page 36 that the resident NJ Ex Order 26, 4B1 and a NJ Ex Order 26, 4B1. A review of the qMDS with an ARD of [redacted], revealed that the resident had BIMS score of [redacted] Section [redacted] was coded with NJ Ex Order 26, 4B1. Further review of the above NJ Ex Order 26, 4B1 and MDSs revealed: The cMDS with an ARD [redacted] the [redacted] was not captured for [redacted] that happened on [redacted] The qMDS with an of ARD [redacted], the [redacted] was not captured for [redacted] that happened on [redacted] The DRA MDS with an ARD of [redacted], the [redacted] were not captured for [redacted] incidents that happened on [redacted], and NJ Ex Order 26, 4B1 On 5/29/26 at 10:36 AM, S #2 interviewed the U. S. FOIA (b) (2) and the [redacted] stated that if a resident [redacted] and there was a [redacted] it should be coded in MDS as [redacted]. She also stated that if a resident had complained of NJ Ex Order 26, 4B1 and had a NJ Ex Order 26, 4B1 it should be coded in MDS as injury not major. She agreed that for those NJ Ex Order 26, 4B1 there were NJ Ex Order 26, 4B1, NJ Ex Order 26, 4B1, and NJ Ex Order 26, 4B1. The [redacted] stated that she would get back to S #2 as to why there were discrepancies in the MDS for captured [redacted] On 5/29/26 at 11:40 AM, the [redacted] informed S #2 that she corrected the MDS with an ARD of [redacted] to NJ Ex Order 26, 4B1. She also stated that the MDS with an ARD of [redacted] was also corrected to NJ Ex Order 26, 4B1 with [redacted], NJ Ex Order 26, 4B1, and NJ Ex Order 26, 4B1. S #2 asked for facility's policy about MDS with regard to MDS accuracy, and she stated that she would get back to S #2. On 5/29/26 at 11:47 AM, the [redacted] informed S #2 that the facility had no policy about MDS with regard MDS accuracy, and they followed the RAI (Resident Assessment Instrument) manual. On 6/2/26 at 12:41 PM, the survey team met with the U. S. FOIA (b) (2)	F0641		07/07/2026

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F0641 SS = D	Continued from page 37 U. S. FOIA (b) and S #2 notified them of the above findings and concerns about Resident #17's inaccurate MDS. On 6/3/26 at 11:03 AM, the survey team met with the U. S. FOIA (b) (2) stated that the in-service was provided to the U. S. FOIA (b) (2) by U. S. FOIA (b) (2) 2. On 5/28/26 at 10:35 AM, Surveyor #3 (S #3) observed Resident #23 lying in bed with NJ Exec Order 26.4B1 . An NJ Ex Order 26, 4B1 was in place and observed to be set at pounds. On 5/29/26 at 10:55 AM, S #3 observed Resident #23 lying on bed inside their room and stated that all of their NJ Exec Order 26.4b1 . A review of the AR revealed the resident had diagnoses which included, but were not limited to; NJ Ex Order 26, 4B1 A review of the resident's qMDS, with an ARD of NJ Ex Order 26, 4 included a BIMS score of NJ Ex Order 26, 4B1 , which indicated the resident's NJ Ex Order 26, 4B1 . The qMDS was coded "No" for the presence of NJ Ex Order 26, 4B1 . A review of the Order Summary Report, dated as of NJ Ex Order 2 , included physician orders dated NJ Ex Order 26 , for treatment of a NJ Ex Order 26, 4B1 A review of a NJ Ex Order 26 care consultation note dated NJ Ex Order 26, 4 revealed the resident was evaluated at bedside and was identified as having a NJ Ex Order 26 equiring ongoing assessment and treatment. On 6/2/26 at 10:50 AM, S #3 interviewed the U. S. FOIA (b) (2) . The U. S. FOIA (b) (2) reviewed the resident's NJ Exec Orde care consultation note dated NJ Ex Order 26, 4 and the qMDS with an ARD of NJ Ex Order 26, . The U. S. FOIA (b) (2) stated, "Looks like the NJ Ex Order 26, 4B1 NJ Exec Order 26 should have been captured on the MDS. I will have to correct that." On 6/2/26 at 1:15 PM, S #3 interviewed the U. S. FOIA who stated that the MDS assessment should accurately reflect the resident's clinical condition and documented NJ Ex Order 26, 4 during the assessment reference period. On 6/2/26 at 3:00 PM, the U. S. FOIA (b) , in the presence of	F0641		07/07/2026

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Alaris Health at The Chateau	**96 PARKWAY , ROCHELLE PARK, New Jersey, 07662**

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F0641 SS = D	Continued from page 38 the [U.S. FOIA] and the survey team, acknowledged that Resident #23's NJ Ex Order 26, 4B1 documented on [NJ Ex Order 26] was not accurately coded on the qMDS assessment dated [NJ Ex Order 26, 4] NJAC 8:39-11.2(g); 33.2 (d)	F0641		07/07/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to ensure that; a.) the physician orders (PO) were clarified with regard to duplicate orders for 2 of 38 residents (Residents #9 and #17), b.) the PO was followed for 1 of 5 residents (Resident #4) reviewed for unnecessary medications, c.) the PO was obtained for NJ Ex Order 26, 4B1 and set according to the resident's assessed needs for Resident # 3, and d.) the PO was clarified with regard to NJ Ex Order 26, 4B1 for Resident #8, in accordance with standards of clinical practice and facility's policies and procedures. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "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 wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case-finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of	F0658	Corrective action for affected residents: Resident #3's [NJ Ex Order 26, 4B1] was evaluated, physician order obtained/clarified, and the [NJ Exec Order 26] setting adjusted to the resident's assessed/current [NJ Exec Orde] and clinical needs. Resident #4's medication monitoring order was corrected to ensure documentation follows the physician's specific instructions. Resident #8's NJ Ex Order 26, 4B1 were clarified with the physician/dietitian to eliminate conflicting [NJ Exec Order 26,] Residents #9 and #17's duplicate/conflicting medication orders were reviewed and clarified/discontinued as appropriate. Identification of others potentially affected: All residents with specialty mattresses, enteral feeding orders, PRN monitoring parameters, and duplicate/conflicting medication orders had the potential to be affected. Audits were completed of these categories. Systemic changes: Licensed nurses, nurse managers, [U.S. FOIA (b)(6)] and providers were educated by the Director of Nursing and the assistant director of nursing regarding order transcription, identifying duplicate/conflicting orders, following specific monitoring instructions, and obtaining clarification before implementation. Admission/readmission and monthly order review processes were discussed and will be more in-depth review with the involvement of the Director of nursing to identify discrepancies. Monitoring: The DON/designee will audit: All Specialty mattress orders/settings weekly for 4 weeks, then monthly for 2 months All Enteral feeding orders and documentation weekly for 4 weeks, then monthly for 2 months	07/07/2026

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F0658 SS = D	Continued from page 39 supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 5/28/26 at 9:35 AM, Surveyor #1 (S #1) observed Resident #3 lying in bed on a [redacted]. The [redacted] control unit was observed set at [redacted] the maximum setting available. On 5/29/26 at 10:26 AM, S #1 observed Resident #3's [redacted] remained set at [redacted] lbs. The resident stated that the [redacted] was not working properly and believed there was a hole in it because they had repeatedly reported concerns to staff. On 5/29/26 at 10:35 AM, S #1 reviewed the medical record for Resident #3. A review of the Admission Record (AR) or face sheet (an admission summary) revealed diagnoses which included, but were not limited to; [redacted] A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the resident's NJ Ex Order 26, 4B1. A review of the PO, dated as of [redacted], revealed orders for NJ Ex Order 26, 4B1 equipment changes. There was no PO was identified for use of an [redacted]. A review of the electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) revealed a PO to check the function of the NJ Ex Order 26, 4B1 [redacted] every shift, initiated [redacted]. A review of the monthly nursing assessment dated [redacted], revealed the resident's [redacted] was documented as [redacted]. On 5/29/26 at 11:46 AM, both S #1 and the U. S. FOIA (b) (2) [redacted]) went inside the resident's room and observed the mattress setting, and the [redacted] acknowledged that the mattress was set at [redacted] lbs despite the resident	F0658	Continued from page 39 All New/changed orders for duplication/conflict 5 times weekly for 4 weeks, then weekly for 2 months All Medication monitoring orders to ensure proper documentation weekly for 4 weeks, then monthly for 2 months Results will be reviewed in our quarterly Quality assurance and performance improvement meeting.	07/07/2026

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F0658 SS = D	Continued from page 40 weighing approximately [redacted] lbs. The [redacted] stated that the setting was incorrect and that nursing staff were expected to check the mattress settings at least once per shift. The [redacted] further stated that maintenance would be contacted to evaluate the mattress because of the resident's concerns regarding its function. A review of the facility's "Air Mattress Policy", with a reviewed date of 1/2026, included that air mattresses are treatment and preventive medical interventions that should be ordered, monitored, and documented. The policy further included that nursing staff would check mattress function every shift, ensure the mattress was functioning properly, and report malfunction immediately. On 6/4/26 at 10:00 AM, the [redacted] both acknowledged that Resident #3's [redacted] was set at [redacted] despite the resident's documented weight of [redacted] and stated the setting should have reflected the resident's current [redacted] 2. On 6/2/26 at 9:39 AM, Surveyor #2 (S #2) observed Resident #4 sleeping in bed. A review of Resident #4's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] A review of Resident #4's most recent comprehensive MDS (cMDS), an assessment tool used to facilitate the management of care, with an ARD of [redacted], reflected that the resident had a BIMS score of [redacted], which indicated that Resident #4's [redacted]. A review of Resident #4's [redacted] eMAR included the following PO: [redacted] (med)-monitor for [redacted]. Document: 'N' if none of the above observed. 'Y' if any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note (PN) findings every shift with a start date of [redacted] Further review reflected that the nurses had a checkmark to indicate that the order was	F0658		07/07/2026

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F0658 SS = D	Continued from page 41 administered. The nurses were not using the "Y" or "N" as indicated in the order. On 6/3/26 at 11:49 AM, S #2 notified the [U. S. FOIA (b)] the concern that Resident #4's side effect monitoring was not followed. On 6/4/26 at 10:31 AM, in the presence of the [NJ Ex Order] stated that Resident #4's side effect monitoring order was corrected. 3. On 5/29/26 at 9:44 AM, S #2 observed Resident #8 awake in bed. The resident was not interviewable. A review of Resident #8's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [NJ Ex Order 26, 4B1] A review of Resident #8's most recent quarterly MDS (qMDS) with an ARD of [NJ Ex Order 26], reflected that the resident's NJ Exec Order 26.4b1 was [NJ Ex Order 26, 4B1]. A review of Resident #8's [NJ Exec Order 26.4b] eMAR included the following PO: a. NJ Ex Order 26, 4B1 The nurses wrote that [NJ Ex Order 26] was given NJ Ex Order 26, 4B1 which totaled [NJ Ex Order 26, 4] b. [NJ Ex Order 26, 4B1] order every evening shift total volume given in NJ Ex Order 26, 4B1 with a start date of [NJ Ex Order 26]. The nurses wrote [NJ Ex Order 26] each day. The two orders contained different amounts. The nurses were writing that the resident received different amounts. The orders were not clarified. On 6/1/26 at 12:23 PM, S #2 interviewed the U. S. FOIA (b) (2) who stated that if there were different amounts on the orders then the orders should have been clarified. On 6/3/26 at 11:47 AM, S #2 notified the [U. S. FOIA (b) (2)] [NJ Ex Order 26] the concern that Resident #8's had different amounts and that the	F0658		07/07/2026

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F0658 SS = D	Continued from page 42 orders were not clarified. On 6/4/26 at 10:23 AM, Registered [NJ Exec Order 26] #1 ([NJ Ex] #1), in the presence of RD #2, stated that there was a discrepancy in Resident #8's 2 orders. She stated that when the resident entered the nurse must have put in [NJ Ex Order 26] which was the standard for a carton of [NJ Ex Order] but that the resident's order was for [NJ Ex Order 26, 4B1] which came in a carton of [NJ Ex Order 26, On 6/4/26 at 10:27 AM, the survey team met with the U. S. FOIA (b) (2) for their responses to the notified concerns. They did not provide any response to the concern. The [U. S. FOIA (b)] did not provide any additional information. A review of the facility's "Physician Orders Policy" with a revised date of 1/2026, included the following: Policy: It is the policy of this facility to follow all PO. Procedure:1. The licensed nurse receives the order from the physician…2. Orders are transcribed to the electronic medical record, and reviewed to identify any duplicate, conflicting, discontinued, or contraindicated orders and all are acknowledged on the POS (physician order summary), MAR (med administration record) and TAR (treatment administration record). 3. Any questionable, duplicate, incomplete, or conflicting orders shall be clarified with the prescribing practitioner before implementation…5. The licensed nurse shall document all PO were administered and followed to each resident on their medical record. A review of the facility provided policy titled "Medication Administration with Specific Instructions" with a reviewed date of 1/2026, included the following: Policy: It is the policy of this facility to ensure that medications are administered according to all specific instructions provided in the physician's order, medication administration record, pharmacy recommendations and manufacturer guidelines. Procedure: Prior to administration, the nurse shall review the medication order for any special instructions… Administration and any required monitoring shall be documented on the MAR and in the medical record as appropriate. Questions regarding medication administration instructions	F0658		07/07/2026

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F0658 SS = D	Continued from page 43 shall be clarified with the practitioner or consultant pharmacist prior to administration. 3. On 5/28/26 at 10:53 AM, Surveyor #3 (S #3) observed Resident #9 lying on their NJ Ex Order 26, 4B1 bed with NJ Ex Order 26, 4B1 S #3 reviewed Resident #9's medical records and revealed: A review of the AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26, 4B1 . A review of the cMDS, with an ARD of NJ Ex Order 26, , revealed that the resident had NJ Ex Order 26, 4B1 for NJ Exec Order 26.4b1, and NJ Ex Order 26, 4B1 . A review of the Order Summary Report (OSR) revealed the following PO: NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 is a NJ Ex Order 26, 4B1 . Start Date NJ Ex Order 26, . NJ Ex Order 26, 4B1 , give NJ E tart Date NJ Ex Order 26, 4B The above orders for NJ Ex Order 26, 4B1 were transcribed to the NJ Ex Order 26, 4B1 eMAR and were administered on the following dates: NJ Ex Order 26, 4B1 was signed by nurses as administered on NJ Ex Order 26, 4B1 and on NJ Ex Order 26, 4B1 NJ Ex Order 26 was signed NJ Ex Order 26, 4B1 5/21/26 at 8:43 PM. On 5/28/26 at 11:46 AM, Surveyor #4 (S #4) observed Resident #17 in activity room with other	F0658		07/07/2026

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F0658 SS = D	Continued from page 44 residents. S #3 reviewed the medical records of Resident #17 and revealed: A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to: NJ Ex Order 26, 4B1 [redacted] A review of the qMDS with an ARD of [redacted] revealed that the resident had BIMS score of [redacted] A review of the OSR revealed the following PO: NJ Ex Order 26, 4B1 [redacted], give [redacted] Start Date [redacted] NJ Ex Order 26, 4B1 [redacted] Start Date [redacted] NJ Ex Order 26, 4B1 [redacted] Start Date [redacted] NJ Ex Order 26, 4B1 [redacted] Start date [redacted]. On 5/29/26 at 10:06 AM, S #3 in the presence of the NJ Ex Order 26, 4B1 of the above concerns with Residents #9 and #17's duplicate orders for NJ Ex Order 26, 4B1. A review of the facility's "Medication Sequencing Policy" that was provided by the U.S. FOIA (b) with a review date of 1/2026, revealed under policy, it is the policy of the facility to ensure medications are administered safely, accurately, and in the proper sequence according to PO and manufacturer recommendations... On 6/3/26 at 11:03 AM, the survey team met with the U. S. FOIA (b) (2) stated that for Resident #9's duplicate orders, the PO for [redacted] was NJ Ex Order 26, 4B1, and spoke to the doctor about it. The U. S. FOIA further stated that the NJ Ex Order 26, 4B1 for Resident #17 duplicate PO was clarified also. NJAC 8:39-11.2(b); 27.1(a)	F0658		07/07/2026

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F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and review of other pertinent facility provided documentation, the facility failed to ensure a.) the resident's current active care plan contained the interventions that were implemented after each resident's [NJ Ex Or] in order to prevent any additional [NJ Ex Or] b.) [NJ Ex] investigations interventions were appropriate, and c.) [NJ Ex] investigations were thoroughly completed in accordance with standards of practice and facility's policies and procedures for 1 of 2 residents (Resident #17) reviewed for [NJ Ex Orde] This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F0689	Corrective action for affected resident: Resident #17's [NJ Ex Order 26] status, care plan, physician orders, and interventions were immediately reviewed and updated. Appropriate [NJ Ex Order 26, 4B1], including those determined by the interdisciplinary team, were implemented and documented. Missing elements in [NJ Ex Order 26, 4B1] were reviewed with nursing staff, including statements, Interdisciplinary team review, appropriateness of interventions, and care plan updates. Identification of others potentially affected: All residents with falls in the prior 60 days had the potential to be affected. A retrospective audit of recent falls was conducted to ensure investigations were complete, interventions were appropriate, care plans updated, and physician orders present when needed. Systemic changes: Nursing staff, supervisors, and IDT members were re-educated by the Director of Nursing and assistant director of Nursing on comprehensive fall investigation requirements, obtaining statements, timely IDT review, individualized interventions based on cognition/function, and updating physician orders and care plans. A post-fall review tool was implemented. Monitoring: The DON/designee will audit 100% of falls for 4 weeks, then monthly for 2 months for complete investigation, intervention appropriateness, care plan update, and follow-through. Results will be reviewed through our quarterly Quality assurance and performance improvement meeting.	07/06/2026

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F0689 SS = D	Continued from page 46 On 5/28/26 at 11:46 AM, Surveyor #1 (S #1) observed Resident #17 in activity room with other residents. Licensed Practical Nurse #1 (LPN #1) stated that for the past [redacted], the resident had [redacted] incident in their room, the roommate stated that Resident #17 wanted to use the bathroom, [redacted]. LPN #1 further stated that the [redacted] showed [redacted], and no other [redacted] after that. On 5/29/26 at 8:33 AM, Surveyor #2 (S #2) with Certified Nursing Aide #1 (CNA #1) entered Resident #17's room and both observed the resident was lying on the bed. There were no [redacted]. On 5/29/26 at 8:42 AM, S #2 was accompanied by the [redacted]) inside Resident #17's room, and there were no [redacted]. Surveyor #2 (S #2) reviewed the medical records of Resident #17 and revealed: A review of the Admission Record or face sheet (an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; unspecified fracture of [redacted] A review of the [redacted] investigations provided by the [redacted] for Resident #17 for the last [redacted] revealed: On 9/8/25, a [redacted] incident was reported by LPN #1, reflected that the [redacted] happened in resident's room, at approximately 11:55 AM, assessment was done and revealed [redacted]. Statements: no statements found. On [redacted], the IDT (interdisciplinary team) met and discussed the [redacted] interventions that included but were not limited to [redacted]. On [redacted], a [redacted] incident was reported by LPN #1, reflected that the [redacted] happened in resident's room, at approximately 1:00 PM, assessment was done and revealed [redacted]. Statements: no statements found.	F0689		07/06/2026

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F0689 SS = D	Continued from page 47 On 11/11/25, the IDT met and discussed the [redacted] with interventions that included but were not limited [redacted] stated [redacted] would be getting new [redacted] will screen, and medications will be reviewed. On [redacted], incident was reported by Registered Nurse #1 (RN #1), reflected that the [redacted] happened in resident's bathroom area, a [redacted] assessment was done and noted with [redacted], and the resident claimed [redacted] Statements: RN #1. On [redacted] the IDT met and discussed the [redacted] with interventions that included but were not limited to educated and encouraged Resident #17 to use the call bell for assistance, and [redacted] screen. On [redacted] a [redacted] incident was reported by RN #2, reflected that the [redacted] happened in resident's room, at 5:30 PM, assessment was done and revealed [redacted]. Statements: CNA #2 and RN #2. On 1/25/26, the IDT met and discussed the [redacted] with interventions that included but were not limited to reminded to use the call bell for assistance and [redacted] screen. On [redacted], a [redacted] incident was reported by LPN #2, reflected that the [redacted] happened in resident's room, at 7:30 PM, assessment was done and noted with [redacted]. Immediate Action taken: assessment, [redacted] (med) [redacted] was administered, [redacted] checks were initiated, and physician and [redacted] were notified. Statements: LPN #2. There was no IDT meeting. On [redacted] a [redacted] incident was reported by LPN #1, reflected that the [redacted] happened in resident's room, at approximately 8:00 AM, assessment was done and the resident [redacted] and [redacted]. Immediate Action taken: assessment [redacted], [redacted] was	F0689		07/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	**96 PARKWAY , ROCHELLE PARK, New Jersey, 07662**

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F0689 SS = D	Continued from page 48 notified and ordered stat (means immediately or without delay) NJ Ex Order 26, 4B1, and RR was notified. Statements: No statements found. There was no IDT meeting. A review of the comprehensive MDS (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted] and quarterly MDS (qMDS) with an ARD of [redacted], revealed in Section NJ Exec Order 26.4b1 a brief interview for mental status (BIMS) score of [redacted], which reflected NJ Ex Order 26, 4B1. Section [redacted] Conditions were coded with no [redacted] A review of the discharge return anticipated (DRA) MDS with an ARD of [redacted] revealed in Section [redacted] that the resident had [redacted] with [redacted] and a [redacted] with NJ Ex Order 26, 4B1. A review of the qMDS with an ARD of [redacted], revealed that the resident had BIMS score of [redacted] Section [redacted] was coded with [redacted] with [redacted]. A review of the personalized care plan (CP) revealed there was no documentation about [redacted] intervention on IDT meeting [redacted] for [redacted]. A review of the physician orders revealed there was no order for [redacted] Further review of the medical records of Resident #17, revealed no documentation as to why the intervention for [redacted] were not followed. On 6/1/26 at 10:14 AM, S #2 interviewed the [redacted] in [redacted] floor nursing station regarding the resident's [redacted]. The [redacted] confirmed there were no [redacted] two days of observations, and the order for [redacted] were "probably" dropped when the resident went to the [redacted] because it was previously ordered in NJ Exec Order 26.4b1, when the resident had a [redacted] incident. She further stated that there should be an order for the [redacted] At that same time, S #2 notified the [redacted] of the concern that the [redacted] were not in the CP until surveyor's inquiry. The [redacted] acknowledged that it should have been in the CP. On 6/2/26 at 12:41 PM, the survey team met with the U. S. FOIA (b) (2) [redacted]	F0689		07/06/2026

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F0689 SS = D	Continued from page 49 U. S. FOIA (b) (2), and S #2 notified them of the above findings and concerns about Resident #17's NJ Ex O incidents that not all NJ Ex O investigations had statements for NJ Exec Order 26.4b1 NJ Ex Order 26, 4 interventions were not in the CP[redacted] interventions for education and encouraged to use call bell for a resident with BIMS score o[redacted] NJ Ex Order 26, 4B1), and not all NJ Ex investigations had an IDT meeting. A review of the facility's "Accident/Incident Report Policy" that was provided by the U.S. FOIA (b) with a reviewed date of 1/2026, revealed under policy, the facility has a system whereby all resident incidents/accidents are reported to the department supervisor and implementation of timely interventions to establish a reduction of repeated incidents/accidents. Procedure...2. Obtain witness statements using the designated facility statement form. For injuries of unknown origin-obtain statements from employees 72 hours prior to the incident. 3. Attach witness statements to the incident report to be kept on file in the DON office. 4. Review entire file for completion and discuss with IDCP team members for appropriate interventions. 5. Carry out physician orders and ensure appropriate interventions are in place. Update CP with new interventions as appropriate. 6. All incident/accident reports are tracked and reviewed by the IDCP team for trends and appropriateness of current interventions... A review of the facility's "Interdisciplinary Plan of Care Policy" that was provided by the U.S. FOIA (b) with a reviewed date 1/2026, revealed under policy, this facility shall provide an individualized, interdisciplinary plan of care for all residents that shall be appropriate to the residents' needs, strengths, and goals. Procedures...Care Planning shall be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals for the resident that are reasonable and measurable... On 6/3/26 at 11:03 AM, the survey team met with the U. S. FOIA (b) (2) stated "we" started to re-educate the staff about NJ Ex Order 26, 4B1, appropriateness of interventions because Resident #17 was unable to understand, with BIMS score o NJ Ex to ensure the resident able to understand when putting intervention. N.J.A.C. 8:39-27.1 (a)	F0689		07/06/2026

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F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to, a.) ensure that a resident with NJ Ex Order 26, 4B1 was monitored routinely for NJ Ex Orde output and documented and b.) ensure the NJ Exec Order 26.4b1 used to empty NJ Ex Order 26, 4B1 were maintained clean and stored properly, in accordance with physician's order and facility's policy and procedure for 1 of 2 residents (Resident #48) reviewed for NJ Ex Order 26 . This deficient practice was evidenced by the following:	F0690	Corrective action for affected resident: Resident #48's NJ Ex Order 26, 4B1 documentation was reviewed with nursing staff, and the collection NJ Ex Order 26, 4B1 were replaced and stored appropriately. U. S. FOIA were re-educated that separate clean collection containers are to be maintained for each resident and cleaned/stored properly. The physician order for measuring and recording NJ Ex Order 26, 4B1 each shift was reinforced. Identification of others potentially affected: All residents with urinary catheters or urine output monitoring orders had the potential to be affected. A facility-wide audit of catheter care, urine measurement documentation, and collection container storage was completed. Systemic changes: U. S. FOIA (b) (2) were re-educated by the U. S. FOIA and U. S. FOIA (b) on NJ Ex Order 26, 4B1, collection bag emptying, measuring/reporting/documenting output, and maintaining clean resident-specific containers. Supervisors were instructed to review documentation completeness each shift. Monitoring: The DON/designee will audit all catheter residents 3 times weekly for 4 weeks, then weekly for 2 months for output documentation and proper collection container storage. Findings will be trended in our quarterly Quality assurance and performance improvement meeting.	07/07/2026

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F0690 SS = D	Continued from page 51 On 5/28/26 at 11:40 AM, Surveyor #1 (S #1) observed Resident #48's outside door with posted signs for NJ Exec Order 26.4b1), PPE (Personal Protective Equipment, refers to specialized gear and clothing worn by healthcare workers, patients, and visitors to create a physical barrier against germs, bodily fluids, and infectious diseases), ABHR (alcohol base hand rub). The resident was lying in an NJ Ex Order 26, 4B1 . Surveyor #2 (S #2) reviewed the medical records of Resident #48, and revealed: A review of the Admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26, 4B1 A review of the quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of NJ Ex Order 26 revealed in Section NJ Exec Order 26.4b1, a brief interview for mental status (BIMS) score of NJ Ex Order 26, 4B1, which reflected that the resident's NJ Ex Order 26, 4B1. Section NJ Exec Order 26.4b1 revealed that the resident was coded for an NJ Ex Order 26, 4B1. A review of the personalized care plan (CP) revealed a focus that the resident with NJ Ex Order 26, 4B1 that was initiated on NJ Ex Order 26, 4 and revised on NJ Ex Order 26, that included interventions that was not limited to, NJ Ex Order 26, 4B1 ...that was initiated on NJ Ex Order 26, 4B. A review of the Order Summary Report with a physician order that included and not limited to: Measure and record NJ Ex Order 26, 4B1 shift. Start date NJ Ex Order 26. The above order was transcribed to the NJ Exec Order 26.4b electronic Treatment Administration Record (eTAR) plotted for 6:30 AM, 2:30 PM, and 10:30 PM, and revealed: At 6:30 AM, for dates NJ Exec Order 26.4b1, the eTAR had missing nurses' initials and amount of NJ Ex Order and did not follow the PO to measure and record NJ Ex Order 26, 4B1 NJ Exec Order	F0690		07/07/2026

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F0690 SS = D	Continued from page 52 At 2:30 PM, for dates NJ Exec Order 26.4b1, the eTAR had missing nurses' initials and NJ Ex Order 26, 4B1, and did not follow the PO to measure and record NJ Ex Order 26, 4B1 At 10:30 PM, for dates NJ Exec Order 26.4b1, the eTAR had missing nurses' initials and NJ Ex Order 26, 4B1 and did not follow the PO to measure and record NJ Ex Order 26, 4B1. Further review of the resident's medical records revealed no documented evidence that the NJ Ex Orde were obtained for the above dates. On 5/29/26 at 8:33 AM, S #2 with the U. S. FOIA (b) (2) observed Resident #48 lying on their bed with NJ Ex Order 26, 4B1 At that same time, both S #2 and the CNA went inside the resident's NJ Exec O room and observed NJ Ex O . Both S #2 and the CNA observed NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1 were not properly stored in a bag and with no label. On 5/29/26 at 8:42 AM, S #2 asked the U. S. FOIA (b) (2)) to accompany S #2 inside the resident's room. Inside Resident #48's toilet room, S #2 asked the U. S. FOIA (b) (2 about the NJ Ex O , and the U. S. FOIA (b) (stated that should not be like that. The U. S. FOIA (b) (also stated that the emptying of the NJ Ex Order 26, 4B1 was the responsibility of the CNA, and the CNA would report the amount to the nurse, the nurse would document the amount in the eTAR, and there should be no blanks in the eTAR. On 5/29/26 at 10:06 AM, S #2 notified the U. S. FOIA (b) (2) of the above concerns with regard to the blanks in the NJ Ex Order 26, 4B1 documentation and the NJ Ex Order 26, 4B1 A review of the facility's "Catheter Care, Urinary Policy" that was provided by the LNHA, with a reviewed date of 1/2026, revealed under policy, the facility to prevent catheter-associated urinary tract infections and to maintain the dignity and privacy of residents utilizing urinary catheters… Catheter Care: Maintain an accurate record of the resident's daily output…	F0690		07/07/2026

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F0690 SS = D	Continued from page 53 Empty the drainage bag regularly using a separate, clean collection container for each resident. Empty the collection bag at least every shift… On 6/3/26 at 11:03 AM, the survey team met with the U. S. FOIA (b) (2) stated that Resident #48's NJ Ex Order 26 were replaced, and education was provided. The U. S. FOIA further stated that when they empty it they have to clean it but if it looks dirty they have to replace it and not to recycle, NJ Ex Order 26, 4B NJAC 8:39-19.4(a)5; 33.2(c)5	F0690		07/07/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including NJ Ex Order 26, 4B1 and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a) ensure NJ Ex Order 26, 4B1 was labeled and dated in accordance with physician orders and facility protocol for 1 of 8 residents (Resident #118) and b) provide ordered NJ Ex Order 26, 4B1 consistent with professional standards of practice for 1 of 8 residents (Resident #206), reviewed for NJ Ex Order 26, 4B1 This deficient practice was evidenced by the following: Reference: National Institutes of Health defines oxygen (O2) as a colorless, odorless and tasteless gas. It will support life. It is noncombustible, but will actively support the burning of combustible materials. Some materials that will not burn in air will burn in O2. Materials that burn in air will burn more vigorously in O2. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act	F0695	Corrective action for affected residents: Resident #118's NJ Ex Order 26, 4B1 equipment were discarded and replaced with labeled/dated ones in accordance with physician order and facility protocol. Resident #206's NJ Ex Order 26 was corrected immediately to match the physician order, and staff were re-educated regarding verifying NJ Exec Order 2 settings every shift. Identification of others potentially affected: All residents receiving oxygen therapy or respiratory care had the potential to be affected. A house-wide respiratory equipment audit was conducted to on all residents to verify orders, settings, tubing dates, humidifier labels, and documentation. Systemic changes: U. S. FOIA (b) (2) were re-educated by U. S. FOIA (b) (2) on NJ Ex Order 26, administration, labeling/dating tubing and humidifier bottles, and verification of flow rates against physician orders. U. S. FOIA (b) (2) added respiratory equipment checks to routine rounds. Monitoring: Respiratory care/oxygen audits for all residents will be completed by the DON/designee weekly for 4 weeks, then monthly for 2 months. Audit elements will include order accuracy, flow rate, tubing date, and humidifier labeling for all residents. Results will be reported at our quarterly Quality Assurance and Performance Improvement meeting.	07/07/2026

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F0695 SS = D	Continued from page 54 for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 5/28/26 at 8:40 AM, Surveyor #1 (S #1) observed Resident #118 lying in bed inside their room. S #1 observed an NJ Ex Order 26, 4B1 was observed at the bedside and set at 2 liters per minute (lpm). The NJ Ex Order 26, 4B1 connected to the NJ Exec Order 26.4b1 was observed without a date label. The NJ Exec Order 26.4b1 was also observed without a visible date label. A NJ Exec Order 26.4b1 was observed positioned over the resident's NJ Ex Order 26, 4B1 On 5/29/26 at 9:05 AM, S #1 observed Resident #118 with an NJ Ex Order 26, 4B1 remained without a date label. The resident stated that they believed staff changed the NJ Ex Order 26, 4B1. On 5/29/26 at 9:55 AM, S #1 reviewed the medical record for Resident #118. A review of the Admission Record (AR) or face sheet (an admission summary) revealed diagnoses which included, but were not limited to: NJ Ex Order 26, 4B1 A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of NJ Ex Order 2, revealed a Brief Interview for Mental Status (BIMS) score of NJ Ex , indicating the resident's NJ Ex Order 26, 4B1 Further review of the MDS revealed the resident received NJ Ex Order 26, 4B1.	F0695		07/07/2026

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F0695 SS = D	Continued from page 55 A review of the resident's comprehensive care plan (CP) revealed a focus area that the resident had a NJ Ex Order 26, 4B1 to maintain an NJ Ex Order 26, 4B1 and NJ Ex O delivery related to NJ Ex Order 26, 4B1. Interventions included NJ Ex Order 26, 4B1 as ordered, providing humidified NJ Ex O as prescribed, and monitoring NJ Ex Order 26, 4B1 status. A review of physician orders (PO) included an order dated NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 every 7 days during the night shift every Saturday. On 5/29/26 at 10:05 AM, S #1 interviewed the U. S. FO who observed the NJ Ex Order 26, 4B1 with no date. The U. S. FO stated the NJ Ex Orde should have the date on it. The U. S. FO further stated NJ Ex Order 26, 4B1 were changed weekly and as needed (PRN) and that nursing staff document completion on the electronic Medication Administration Record (eMAR) or electronic Treatment Administration Record (eTAR). The NJ Ex O also stated that NJ Ex Order 26, 4B changes were performed according to physician orders (PO) and facility protocol. A review of the facility's "Respiratory Tubing Policy, reviewed 1/2026, included that staff should mark the bottle with the date and initials, change O2 cannula and tubing according to facility protocol, and ensure respiratory equipment is properly maintained and stored. On 6/4/26 10:00 AM, S #1 interviewed the U. S. FOIA (b) (2) who acknowledged that NJ Ex Order 26, 4B was expected to be dated and labeled. The further stated that NJ Ex Order 26, 4B should be labeled and changed in accordance with the PO and facility protocol. 2. On 5/28/26 at 11:05 AM, Surveyor #2 (S #2) observed Resident #206 in bed, receiving NJ Ex via a NJ Ex Order 26, 4B1 S #2 observed that the NJ Ex Order 26, 4B1 was NJ Ex On 5/29/26 at 10:55 AM, S #2 conducted a second observation of Resident #206 in bed, receiving NJ Ex S #2 observed that the NJ Ex Order 26, 4B1 was set at NJ Ex Order 26 At this time, S #2 interviewed the U. S. FOIA (b) (2)) who stated that the order for Resident #206 was "NJ Ex Order 26, 4B1 every shift check every shift." The U. S. FOIA, in the presence of S	F0695		07/07/2026

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F0695 SS = D	Continued from page 56 #2, observed the resident's [redacted] The [redacted] stated that the [redacted] was currently set at [redacted] and that it was supposed to be set at [redacted]. The [redacted] then adjusted the setting to [redacted] per the PO. The [redacted] stated that [redacted] should be administered as ordered by the physician, and the nurses were expected to check the setting every shift. A review of the AR revealed that Resident #206 was admitted to the facility with diagnoses that included, but were not limited to: [redacted] A review of the comprehensive MDS, with an ARD of [redacted], revealed that Resident #206 had a BIMS score of [redacted], which indicated [redacted]. A review of the Order Summary Report for Resident #206 revealed a PO with a start date of [redacted], for [redacted]) every shift check every shift. A review of the [redacted] eMAR for Resident #206, revealed that the nurses recorded [redacted] use every shift on [redacted] well as day shift on [redacted]. A review of the CP report, initiated [redacted], revealed that Resident #206 "has [redacted] related to [redacted]." Interventions included, but were not limited to, "Provide [redacted] as ordered." On 6/3/26 at 11:04 AM, S #2, in the presence of the survey team, discussed the concern with the [redacted] On 6/4/26 at 10:28 AM, the survey team met with the [redacted] stated they knew what needs to be corrected, in-serviced, and audited. A review of the facility's "Oxygen Administration policy", last reviewed 1/2026, revealed, verify that there is a PO for this procedure. Review the PO or facility protocol for O2 administration. NJ 8:39-25.2(c)3; 27.1(a)	F0695		07/07/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0725 SS = D	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure a.) residents received timely and appropriate [NJ Ex Order 26, 4B1] for 1 of 4 residents (Resident #59) and b.) controlled medications accountability log was accurately endorsed and accounted for 1 of 3 nurses ([U. S. FOIA (b) (2)] observed during medication administration, to achieve highest practical wellbeing of residents. This deficient practice was evidenced by the	F0725	Corrective action for affected residents/processes: Resident #59's [NJ Ex Order 26, 4B1] concerns were reviewed immediately, and double-briefing was addressed with staff as unacceptable practice unless clinically justified and care planned, which was not the case here. The [NJ Exec Order 26.4b1] discrepancy process involving the identified nurses was investigated, and counseling/re-education was provided. Identification of others potentially affected: All residents had the potential to be affected by staffing insufficiency and hand-off failures. Staffing patterns, weekend coverage, agency staffing, assignments, and overtime/double-shift practices were reviewed. Medication/cart endorsement processes on all units were also reviewed. Systemic changes: The [U. S. FOIA (b) (2)] reviewed staffing coverage practices and implemented enhanced supervisory oversight for weekend and call-out coverage. All Agency staff orientation was reinforced, including expectations regarding continence care. All Licensed nurses were re-educated by the [U. S. FOIA (b) (2)] on end-of-shift endorsement, narcotic count process, escalation of discrepancies, and reporting when staffing concerns impact care delivery. Monitoring: The Administrator/DON will review daily staffing, callouts, replacement efforts, and unit assignments 5 times weekly for 4 weeks, then weekly for 2 months. Continence care observations for all residents applicable and narcotic endorsement audits for all narcotics will be conducted weekly by the DON for 4 weeks, then monthly for 2 months. Findings will be reviewed at our quarterly Quality Assurance and Performance Improvement meeting.	07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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F0725 SS = D	Continued from page 58 following: 1. On 6/1/26 at 6:23 AM, Surveyor #1 (S #1) went to NJ Ex Order 26, 4B1 nursing unit and met with the U. S. FOIA (b) (2)) who was currently on her medication (med) cart, and informed S #1 that she was helping the U. S. FOIA in the NJ Ex Order 26, 4B U. S. FOIA (b) (2) She stated that there was U. S. FOIA (b) (2) in the unit and U. S. FOIA (b) (2), and she would get back to S #1 for the census (total number of residents) in the unit. On 6/1/26 at 6:26 AM, S #1 and the U. S. FOIA went inside Resident #59's room for NJ Ex Order 26, 4B1, and both observed the resident with NJ Ex Order 26 . The resident informed both S #1 and the U. S. FOIA that they did not NJ Ex Order 26, 4B1 Resident #59 further stated that the 11-7 shift U. S. FOIA (b) (2) was the one who did it, and the resident asked the U. S. FOIA as to why they had NJ Ex Ord and the U. S. FOIA responded that it was because the resident NJ Ex Orde On that same date and time, outside the resident's room, the U. S. FOIA stated that Resident #59 was NJ Ex Order 26, 4B1 She further stated that it was not their practice to use NJ Ex Order 26 and the U. S. FOIA confirmed that the resident NJ Ex Order 26, 4 S #1 asked who the U. S. FOIA was last night, and she responded that she would get back to S #1. A review of the care plan (CP) of Resident #59, revealed that the resident had NJ Ex Order 26, 4B1 , and there was no documented intervention to provide NJ Ex Order 26, 4B1 A review of the NJ Ex Order 26, 4B1 floor 11-7 shift U. S. FOIA assignment, that was provided by the U. S. FOIA (b) (2) , dated NJ Ex Order 26, revealed a census of 45 with three CNAs. CNA #1 with 15 residents, CNA #2 with 16 residents that included Resident #59, and CNA #3 with 14 residents. A review of the NJ Ex Order 26, 4 Daily Schedule Report Sunday Night shift that was provided by the U. S. FOIA (b revealed that there was one U. S. FOIA (b) (2)), RN #1, for 11:00 PM-7:00 AM, and three CNAs, CNA #1, CNA #2, and CNA #3 in 2 NJ Ex Order On 6/1/26 at 6:36 AM, S #1 went to the NJ Ex Order 26, 4B1 floor unit and interviewed CNA #4, who stated that she was the aide from 11-7, and she had 15 residents in her assignment.	F0725		07/07/2026

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F0725 SS = D	Continued from page 59 On 6/2/26 at 12:41 PM, the survey team met with the U. S. FOIA (b) (2), and S #1 notified them of the above findings and concerns about Resident #59's NJ Ex Order 26, 4B1. On 6/3/26 at 11:03 AM, the survey team met with the U. S. FOIA (b) (2) stated that the assigned CNA of Resident #59 who NJ Ex Order 26, 4B1 to the resident was an NJ Exec Order CNA, CNA #4, who will not be NJ Exec Order 26,4B1 A review of the NJ Ex Order 26, 4 Daily Schedule Report Sunday Night shift that was provided by the U. S. FOIA (b) revealed that there was one RN, RN #2, for 11:00 PM-7:00 AM, and there were U. S. FOIA (b) (2) in NJ Ex Order 26, that included CNA #4. A review of the NJ Ex O floor (also known as the NJ Ex Order 26) 11-7 shift CNA assignment, that was provided by the U. S. FOIA (b) dated 5/31/26, with U. S. FOIA (b) (2), revealed a census of 55. CNA #4 with 15 residents, CNA #5 with 12 residents, CNA #6 with 15 residents, and CNA #7 with 17 residents. Further review of the above 5/31/26 daily schedule report Sunday night and 11-7 shift CNA assignment sheet did not match with census provided, and CNA #4 was NJ Ex Order 26, 4B1 assignment sheet and not in the NJ Ex Order 26, 4B1 floor U. S. FOIA assignment sheet where Resident #59 was observed during NJ Ex Order 26, 4B1 round. On 6/4/26 at 9:35 AM, Surveyor #2 (S #2) met with the U. S. FOIA (b) (2) during QAPI (quality assurance performance improvement) meeting. The U. S. FOIA (b) stated the ratio for CNAs in the NJ Ex Order 2 Pavillion was the same in the NJ Ex Order 2 Pavillion (included NJ Ex Order 26, 4B1), "we" follow the State regulations which were day shift 1 CNA per 8 residents 1:8; evening 1:10, and night shift 1:14. He further stated that "We" go above the requirement for NJ Ex Order because of the vent (ventilator) unit. On that same date and time, the U. S. FOIA (b) informed S #2 that he was aware of the short staffing especially during weekends, and the short staff was because of call outs. 2. On 6/2/26 at 8:34 AM, the survey team met with the U. S. FOIA (b) (2) The U. S. FOIA stated that the U. S. FOIA (b) (2) had to work a double shift on 5/31/26 from 11:00 PM to 7:00 AM, and 6/1/26 from 7:00 AM to 3:00 PM, because the	F0725		07/07/2026

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F0725 SS = D	Continued from page 60 facility was short-staffed on 6/1/26 for the 7:00 AM to 3:00 PM shift that was why the [U. S. FOIA] forgot to notify the incoming nurse from 7-3 shift of concern with controlled med bingo card discrepancy. A review of the facility's assignment sheets revealed that the [U. S. FOIA] worked on [NJ Ex Order 28.1] from 11:00 PM to 7:00 AM on the [NJ Ex Orde] floor, and 6/1/26 from 7:00 AM to 3:00 PM on the second floor. On 6/3/26 at 11:04 AM, Surveyor #3 (S #3), in the presence of the survey team, discussed the concern with the [U. S. FOIA (b) (2)] about controlled med accountability log discrepancy and short staff during med administration observation. A review of the facility's "Staffing Policy" that was provided by the LNHA, with a reviewed date of 1/2026, revealed under policy statement, the facility provides adequate staffing to meet needed care and services for our resident population. Policy Interpretation and Implementation: 1. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. CNAs are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive CP… On 6/4/26 at 10:28 AM, the survey team met with the [U. S. FOIA (b) (2)] stated they knew what needed to be corrected, in-serviced, and audited. NJAC 8:39-25.2(b); 27.2(h)	F0725		07/07/2026
F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by	F0732	Corrective action for affected posting process: The posted staffing reports were corrected, and the process for daily posting of current staffing and census at the beginning of each shift was reviewed with staffing coordinators and reception personnel. Weekend posting responsibility was reassigned to ensure coverage 7 days per week. Identification of others potentially affected: All posted staffing reports had the potential to be inaccurate and all residents have the potential to be affected. A retrospective review of recent postings was conducted to verify retention and identify any additional discrepancies.	07/07/2026

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F0732 SS = D	Continued from page 61 the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure the accurate daily report of licensed nurses, certified nursing assistant staffing, and the resident census was posted at the beginning of the current shift for 2 of 6 days during the annual re-certification survey.	F0732	Continued from page 61 Systemic changes: A weekend/holiday posting process was implemented. The staffing report workflow was clarified, including who generates, verifies, sends, posts, and checks accuracy. Both [redacted] were educated by the [redacted] Backup coverage was assigned to ensure current postings are displayed every day and each shift as required. Monitoring: The Administrator/designee will audit posted staffing data daily for 4 weeks, then weekly for 2 months for date, census, staffing categories, and visibility. Results will be reported in our quarterly Quality assurance and performance improvement meeting.	07/07/2026

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F0732 SS = D	Continued from page 62 This deficient practice was evidenced by the following: On 5/28/26 at 8:53 AM, the survey team entered the facility [NJ Ex Orde] building reception area and Surveyor #1 (S #1) observed the Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the main lobby. The posted NHRCSR was dated 5/27/26 for the [7:00 AM to 3:00 PM] day shift with a census of 189, with 21 Certified Nursing Assistants (CNA), and a ratio of 1 CNA to 7.9 residents. There was no NHRCSR posted for 5/28/26. On 6/1/26 at 6:48 AM, Surveyor #2 (S#2) observed in the lobby area on the reception desk a posted sign for NHRCSR dated 5/31/26 for 7-3, 3-11, and 11-7 shifts with census of 191. On 6/1/26 at 9:00 AM, S#1 observed the posted NHRCSR was dated 6/1/26, with a census of 189. S#1 asked the [U. S. FOIA (b) (2)] what the census was for 6/1/26, and he confirmed the census was 189 that morning. On 6/1/26 at 10:47 AM, S#1 reviewed the staffing sheets provided by Staffing Coordinator #1 (SC #1) which revealed for [NJ Ex Order 26, 4B1] the Active Residents in house for the [NJ Ex Order 2] building were 120 residents and the [NJ Ex Order 2] building 69 residents (120 +69 In House=189 residents). Further review of the above posted NHRCSR for [NJ Ex Order 26, 4B1] a census of 191 did not match the provided copy of SC #1 census of 189 for [NJ Ex Order 26]. On 6/2/26 at 11:23 AM, S#1 interviewed the SC#1 in the [NJ Ex Orde] building regarding the process for posting. SC #1 stated that the SC #2 from the [NJ Ex Order 2] Building was responsible for posting the NHRCSR including on Saturdays. S #1 and the SC #1 from the [NJ Ex Order] building conferenced called SC #2 from the [NJ Ex Order] building. SC #2 stated she was responsible for posting and that every morning she obtained the numbers from SC #1 [NJ Ex Order 26] and adds them with her numbers [NJ Ex Order 2], then she e-mails it to the front desk receptionist, and it was posted on the front desk. SC #2 further stated, if no one was at the front desk, she will post it herself. SC #2 stated that on the weekends, she would post on Saturdays, "but unfortunately no one was there on Sundays to change or update" the NHRCSR. She stated they must wait until Monday morning to update the posting. At that same time, S #1 asked about the posting on Thursday, 5/28/26, day #1 of recertification survey that it was dated 5/27/26 upon entry, and she confirmed the date was incorrect	F0732		07/07/2026

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F0732 SS = D	Continued from page 63 because, "It was not updated yet until I came in." S#1 asked about the NHRCSR posting on Monday 6/1/26, which revealed the census for Sunday, 5/31/26, was inaccurate, and she confirmed there was no one on Sunday to correct the posting. S #1 asked SC #2 if she was familiar with the State regulation for posting and she responded, "I do not know how to answer to you right now." On 6/3/26 at 11:25 AM, the survey team met with the U. S. FOIA (b) (2) regarding inaccurate posted NHRCSR for two days, and that no one in the facility updated the NHRCSR during weekends. On 6/4/26 at 10:29 AM, survey team met with U. S. FOIA stated, "We know what needs to be done." The U. S. FOIA replied, "We will be doing additional in-services to address all the concerns mentioned." A review of the facility's "Staffing Policy", with a revision date of 6/2/26, revealed, daily staffing (as reported to state agencies) is posted at reception, while reflecting accurate staffing numbers, and current census for the day. NJAC 8:39-41.2	F0732		07/07/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F0755	Corrective action for affected resident/process: The NJ Ex Order 26, 4b1 count discrepancy for Resident #127 was investigated. The involved nurses were counseled and re-educated on NJ Exec Order 26.4b1 counts, documentation, wasting procedures, and shift-to-shift endorsement. NJ Exec Order 26.4b1 accountability records were reviewed for completeness. Identification of others potentially affected: All residents receiving controlled substances and all medication carts had the potential to be affected. A house-wide audit of controlled substance count sheets, current on-hand counts, and wastage documentation was completed. Systemic changes: U. S. FOIA (b) (2) were re-educated by the U. S. FOIA on controlled substance handling, required two-nurse counts at shift change, proper documentation of wastage, prohibition against solo wasting, and immediate reporting of discrepancies. Supervisory oversight of narcotic count reconciliation will be a strong focus for each supervisor on shift.	07/06/2026

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F0755 SS = D	Continued from page 64 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure accurate documentation for the inventory of Resident #127's [redacted] for 1 of 3 medication carts (side [redacted] floor), identified during the medication pass. This deficient practice was evidenced by the following: On 6/1/26 at 8:15 AM, the surveyor observed Licensed Practical Nurse #1 (LPN #1) preparing medications (meds) for Resident #127. The surveyor observed that LPN #1 popped out [redacted] from Resident #127's [redacted] card [redacted] Then, LPN #1 signed the Individual [redacted] At that time, the surveyor observed that Resident #127's [redacted] cards containing [redacted] contained a total of [redacted]. The resident's [redacted] did not match the number of tabs in the [redacted] cards, as the [redacted] reflected a balance of [redacted]. On 6/1/26 at 8:35 AM, the surveyor interviewed LPN #1 who stated the expectation was that when a nurse pops out a controlled medication (med) from a resident's [redacted] card, the nurse must sign the [redacted] which was supposed to reflect the correct count. On 6/1/26 at 8:46 AM, LPN #1 spoke to the [redacted] about the above concern. LPN #1 and the [redacted], in the presence of the surveyor, searched for a loose tablet (tab) in the [redacted] floor med cart, including the	F0755	Continued from page 64 Monitoring: The DON/designee will conduct narcotic count audits on all carts 3 times weekly for 4 weeks, then weekly for 2 months. Consultant pharmacist findings and nursing audits will be trended through our quarterly Quality assurance and performance improvement meeting.	07/06/2026

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F0755 SS = D	Continued from page 65 NJ Exec Order 2 box, but they did not find one. The U. S. FOIA (b) stated to the surveyor that they were going to inform the U. S. FOIA (b) (2) of the issue. On 6/1/26 at 12:53 PM, two surveyors met with the U. S. FOIA (b) (2) to discuss the concern. The U. S. FOIA stated the process was that two nurses were expected to do a count of the controlled meds at the change of each shift, and the NJ Exec Order 26 should match the number of tabs in the bingo cards. On 6/2/26 at 8:43 AM, two surveyors met with the U. S. FOIA (b) (2) stated they conducted an investigation, which revealed the following concerns: -On 6/1/26, toward the end of LPN #2's shift of 11:00 PM to 7:00 AM, LPN #2 found one loose NJ Ex Order 26, 4B1 in the NJ Exec Order 2 box and wasted it in the drug buster without a second nurse. -LPN #2 did not sign that they wasted the NJ Ex Order 26, 4B1 -LPN #2 did not do an outgoing count of the controlled meds with the incoming nurse, LPN #1. -LPN #2 and LPN #1 did not perform an endorsement with each other (nurse-to-nurse communication during shift transitions to convey patient information). The U. S. FOIA further stated to the surveyors that the expectation was the outgoing shift nurse had to have an endorsement and do a count of the controlled meds with the incoming shift nurse. Moreover, the U. S. FOIA stated that the protocol was to waste a controlled med with another nurse, and LPN #2 did not waste it the right way. The U. S. FOIA stated that LPN #2 failed to follow the facility's protocol. The U. S. FOIA (b) stated the nurses were wrong. The U. S. FOIA (b) and U. S. FOIA stated they gave LPN #1 and LPN #2 counseling, did an audit, and started in-servicing the staff. A review of the Admission Record (AR) or face sheet (an admission summary) revealed that Resident #127 was admitted to the facility with diagnoses that included, but were not limited to, NJ Ex Order 26, 4B1. A review of the Order Summary Report for Resident #127, revealed physician's orders (PO) which included, but were not limited to, the following: -NJ Ex Order 26, 4B1 give NJ Ex Order	F0755		07/06/2026

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F0755 SS = D	Continued from page 66 NJ Ex Order 26, 4B1 The PO started on NJ Ex Order 26, NJ Ex Order 26, 4B1 The PO started on NJ Ex Order 26, 4 A review of the Facility Assessment, updated NJ Exec Order 2, revealed...the facility is able to care for residents that are on NJ Ex Order 26, 4B1 dependence or NJ Exec O management only at levels that can be provided by the facility pharmacy. The level of treatment is determined by the physician and dosed accordingly...The facility will secure the med in the med cart, double locked. Resident will be assigned to a physician who is experienced with managing NJ Ex Order 26, 4B1 On 6/3/26 at 11:04 AM, the surveyor, in the presence of the survey team, discussed the concerns with the U. S. FOIA (b) (2). On 6/4/26 at 10:28 AM, the survey team met with the U. S. FOIA (b) (2) stated they knew what needs to be corrected, in-serviced, and audited. A review of the facility's "Controlled Substance Handling Policy", reviewed 1/2026, revealed...if one or more doses of controlled substance are removed from the container for administration but refused by the resident or not given for any reason, the doses cannot under any circumstances be returned to the container or taped back into the blister pack. They must be destroyed in the presence of two licensed nurses, and the disposal documented by both nurses on the accountability record...A physical inventory of all controlled drugs is made at the change of each shift by two licensed nurses and is documented on an audit record... NJAC 8:39-29.2; 29.7	F0755		07/06/2026
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by:	F0759	Corrective action for affected resident: Resident #82's medication administration timing issue was reviewed with the U. S. FOIA (b) (2) . The physician was notified as appropriate, and staff were re-educated on administering medications within the allowable time frame and following instructions such as "with breakfast." Identification of others potentially affected: All residents receiving medications had the potential to be affected. A focused medication pass	07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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F0759 SS = D	Continued from page 67 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication administration observation on 6/1/26, the surveyor observed 3 nurses administering medications to 6 residents. There were 38 opportunities, and 4 errors were observed which resulted in a medication error rate of 10.53%. This deficient practice was identified for 1 of 6 residents (Resident #82), that was administered by 1 nurse. This deficient practice was evidenced by the following: On 6/1/26 at 10:49 AM, the surveyor observed the U. S. FOIA (b) (2)) preparing medications (meds) for Resident #82. The meds included, but were not limited to, the following physician's orders (POs): NJ Ex Order 26, 4B1 give with NJ Ex Order 26, 4B1. The PO started on NJ Ex Order 2. NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 The PO started on NJ Ex Order 26, 4B1 giv NJ Ex Order 26, 4B1 The PO started on NJ Ex Order 26 NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 less than NJ Ex Ord NJ Ex Order 26, 4B1). The PO started on NJ Ex Order 26 On 6/1/26 at 10:49 AM, the surveyor observed the POs above were highlighted in red on the electronic medication administration record (eMAR), indicating the meds were overdue. On 6/1/26 at 11:10 AM, the surveyor observed the U. S. FO administering the meds to Resident #82. A review of the Medication Administration Audit Report NJ Exec Order 26.4 for Resident #82 revealed the following: NJ Ex Order 26, 4B1 and documented on NJ Exec Order at 11:11 AM.	F0759	Continued from page 67 observation audit was completed on all shifts to assess timeliness and compliance with scheduled administration instructions. Systemic changes: U. S. FOIA (b) (2) were re-educated by the U. S. FOIA (b) (2) on medication timing windows, prioritization of med pass workflow, documentation of delayed medications, physician notification when indicated, and escalation when workload interferes with timely administration. Monitoring: The DON/designee will complete 2 medication pass observations 3 times weekly for 4 weeks, then weekly for 2 months. Medication timing variances will be reviewed and trended in our quarterly Quality assurance and performance improvement meeting.	07/07/2026

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F0759 SS = D	Continued from page 68 -NJ Ex Order 26, 4B1 was scheduled for NJ Ex Order 26 at 9:00 AM, was administered on NJ Ex Order 26 at 11:11 AM, and documented on NJ Ex Order 2 at 11:11 AM. -NJ Ex Order 26, 4B1 was scheduled for NJ Ex Order 2 at 9:00 AM, was administered on NJ Ex Order 2 at 11:11 AM, and documented on NJ Ex Order 2 at 11:11 AM. -NJ Ex Order 26, 4B1 was scheduled for NJ Ex Order 2 at 9:00 AM, was administered on NJ Ex Order 26 at 11:10 AM, and documented on NJ Ex Order 2 at 11:11 AM. On 6/1/26 at 11:15 AM, the surveyor interviewed the U. S. FO who stated the expectation was to give the meds within an hour before or an hour after their scheduled times. The U. S. FO acknowledged that they administered the POs listed above late to Resident #82, and did not follow the instructions to give NJ Ex Order 26, 4B1 with breakfast. The U. S. FO stated they should have followed the POs. On 6/1/26 at 12:05 PM, the surveyor interviewed the U. S. FOIA (b) (2) who confirmed the expectation was to give the meds within an hour before or an hour after their scheduled times. On 6/2/26 at 11:50 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that if NJ Ex Order 26, 4B1 emergencies had actually occurred, then other nurses, the U. S. FOIA (b) (2), and a U. S. FOIA (b) (2) would have been there as well, and they were not there. The surveyor requested the 24 Hours Report of NJ Ex Order 2 (a report that includes residents that have had any condition changes within the past 24 hours and remarks from the nurses) from the U. S. FOIA (b) (2) for the district on the unit that would include the RN's residents. However, the U. S. FOIA (b) (2) could not find that report and did not provide it to the surveyor. At that same time, the U. S. FOIA (b) (2) stated that the RN should have been able to administer Resident #82's meds on time with proper time management. Moreover, the U. S. FOIA (b) (2) further stated that the nurses could always ask for help from another U. S. FOIA (b) (2), the U. S. FOIA (b) (2) or a U. S. FOIA (b) (2). A review of the U. S. FOIA (b) (2)'s Nursing Progress Note (PN), effective NJ Exec Order revealed that the doctor was "notified and aware of delay in medication (med) administration of NJ Ex Order 26, 4B1 However, the PN did not include that the doctor was notified about the other meds that were administered late, including NJ Ex Order 26, 4B1 .	F0759		07/07/2026

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F0759 SS = D	Continued from page 69 On 6/2/26 at 11:55 AM, the surveyor interviewed the [U. S. FOIA (b)] who stated that the expectation was to document in their PN that they notified the doctor of the delay of all of the resident's meds that were administered late. The [U. S. FOIA (b)] acknowledged that they should have included all of the resident's meds that were late in the PN. On 6/3/26 at 11:04 AM, in the presence of the survey team, the surveyor discussed the concerns with the[U. S. FOIA (b) (2)]. On 6/4/26 at 10:28 AM, the survey team met with the [U. S. FOIA (b) (2)], and the [U. S. FOIA] stated the [U. S. FOIA (b)] entered a clarification PN to now include that the doctor was notified of the delay of all the resident's meds that were administered late after surveyor's inquiry. The [U. S. FOIA (b)] stated they knew what needs to be corrected, in-serviced, and audited. A review of the facility's "Medications Administration Policy," reviewed 1/2026, revealed...Meds must be administered in accordance with the orders, including any required time frame...Meds may not be prepared in advance and must be administered within one hour of their prescribed time, unless otherwise specified... A review of the facility's "Medication Administration with Specific Instructions Policy," reviewed 1/2026, revealed...Meds shall be administered according to the ordered requirements, including: Before, with, or after meals... NJAC 8:39-29.2	F0759		07/07/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services by ensuring the accurate administration of a medication, [NJ Ex Order 26, 4B1] [redacted], with a parameter according to the physician's order and professional standards of practice to meet the needs of the resident for 3 of 6 residents reviewed (Resident #4, #7 and #8).	F0760	Corrective action for affected residents: Residents #4, #7, and #8's [NJ Ex Order 26, 4B1] orders and eMAR build were reviewed and corrected to ensure the NJ Exec Order 26.4b1 is clearly visible and documented before administration/holding. Staff were re-educated on obtaining and documenting required [NJ Ex] readings and administering/holding the medication strictly per order. Identification of others potentially affected: All residents with medications requiring parameters, including blood pressure, pulse, blood glucose, or other clinical thresholds, had the potential to be affected. A facility-wide audit of parameter-based medication orders and eMAR build was completed.	07/06/2026

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F0760 SS = D	Continued from page 70 The deficient practice was evidenced by the following: 1. On 6/2/26 at 9:39 AM, the surveyor observed Resident #4 sleeping in bed. A review of Resident #4's Admission Record (AR) or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] A review of Resident #4's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that Resident #4's [redacted]. A review of Resident #4's [redacted] electronic Medication Administration Record (eMAR) included the following physician order (PO): [redacted] Further review revealed the following: The medication (med) was administered once in the month of [redacted] a [redacted] of [redacted]. The resident's [redacted] was not less than [redacted] and should not have been administered. Further review of Resident #4's [redacted] eMAR included the following: An order to check vital signs every shift reflected that Resident #4's [redacted] on the night shift on [redacted] was [redacted], and on [redacted] was [redacted]. The [redacted] was less than [redacted] and there was no documented evidence that the PRN [redacted] order was administered.	F0760	Continued from page 70 Systemic changes: U. S. FOIA (b) (2) were re-educated by the [redacted] on medications with parameters, required assessments prior to administration, documentation expectations, and physician clarification of incomplete or incorrectly built orders. The Emar build process for such orders was reviewed with nursing leadership/pharmacy/Information technology support as applicable. Monitoring: The DON/designee will audit all parameter-based medications 3 times weekly for 4 weeks, then weekly for 2 months to verify required assessments and correct administration/holding. Results will be reviewed in our quarterly Quality assurance and performance improvement meeting.	07/06/2026

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F0760 SS = D	Continued from page 71 2. On 5/29/26 at 9:31 AM, the surveyor observed Resident #7 asleep in bed. A review of Resident #7's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] A review of Resident #7's most recent discharge return anticipated MDS with an ARD of [redacted], reflected that the resident's [redacted] for daily decision making was [redacted] A review of Resident #7's [redacted] eMAR included the following PO: [redacted] give [redacted]. Hold for [redacted] greater than [redacted] with a start date of [redacted]. Further review of the eMAR reflected that the nurses either administered the med indicated by a check mark or did not administer the med indicated by a number code that described why it was not given. There were no [redacted] listed on the eMAR for the order. 3. On 5/29/26 at 9:44 AM, the surveyor observed Resident #8 awake in bed. The resident was not [redacted] A review of Resident #8's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited [redacted] A review of Resident #8's most recent quarterly MDS with an ARD of [redacted] reflected that the resident's [redacted] was [redacted] A review of Resident #8's [redacted] eMAR included the following PO: [redacted] give [redacted]	F0760		07/06/2026

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F0760 SS = D	Continued from page 72 NJ Ex Order 26, 4B1 HOLD for NJ Ex Order 26, 4B1 above NJ Ex Order 26, 4B1 with a start date of NJ Ex Order 26, 4 Further review reflected that the 12:00 AM dose had five days that the NJ Ex was not listed and marked with an X; the 6:00 AM dose had three days that the NJ Ex was not listed and marked with an X and one day the NJ Ex Order 26, 4B1 was administered for a NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 which was outside the parameter; and the 6:00 PM dose had one day that the NJ Ex was not listed and marked with an X. On 6/1/26 at 12:28 PM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that if a med order had a parameter for a U. S. FO then it should be checked. She added that if the was above the hold parameter then the nurse would have to hold the med (not administer it). The surveyor asked the U. S. FOIA to view Resident #8's NJ Ex Order 26, 4B1 eMAR NJ Ex Order 26, 4B1. The U. S. FOIA stated that there should be a U. S. FO listed and not an X. She added that she was not sure what X meant. The U. S. FOIA stated that the NJ Ex Order 26, 4B1 should not have been given on NJ Ex Order 26 when the NJ Ex was outside the parameter. On 6/2/26 at 11:29 AM, in the presence of the U. S. FOIA the surveyor interviewed the U. S. FOIA (b) (2) who stated that for NJ Ex Order 26, 4B1 order with parameters that the NJ Ex O would be taken first and that the med could not be given if it was above the parameter. She added that if the med was not administered, then the nurse would put in a code to indicate that. The U. S. FOI stated that the nurse has to put in the NJ Ex. The surveyor asked how a NJ Ex Order 26, 4B1 prn order was administered. The U. S. FOI stated that it depended on the order parameter and that it may be if NJ Ex Order 26, 4B1 was NJ Ex Order 26, 4B1 give NJ Ex Order 26, 4B1 She added that there was an order for vital signs every shift and that may determine if the prn med was to be given. At that same time, the surveyor asked if a resident had a listed NJ Ex O that was less than NJ Ex O would the expectation be to see a NJ Ex Order 26, 4B1 order for less than NJ Ex Orde administered. The stated that she would expect to see it administered. The surveyor then asked the U. S. FOIA and U. S. FOIA to view Resident #4's NJ Ex Order 26, 4B1 eMAR NJ Ex Order 26, 4B1 order. The RNS stated that the NJ Ex Order 26, 4B1 should not have been given on NJ Ex Order 26 for the NJ Ex Order 26, 4B1 that was NJ Ex Orde The U. S. FOI stated that they check NJ Exe every shift and then confirmed that the NJ Ex Order 26, 4B1 order should have been given for the NJ Ex that was below NJ Ex Orde on NJ Exec Order 26.4b1 The surveyor then asked the U. S. FOIA (b) (2) view Resident #7's NJ Ex Order 26, 4B1 eMAR	F0760		07/06/2026

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F0760 SS = D	Continued from page 73 [U. S. FOIA (b) (2)] order. The [U. S. FOIA] confirmed that the eMAR did not have a section to document the [NJ Ex] for the [NJ Ex Order 26, 4B] order and she was going to add it in the computer. She added that the person who put in the order did not set up the order in the computer correctly. On 6/3/26 at 11:47 AM, the surveyor notified the [U. S. FOIA (b) (2)] the concerns that Resident #4 received [NJ Ex Order 26, 4B] outside of the ordered parameter on 5/30/26, and that the resident did not receive [NJ Ex Order 26, 4B] for a [NJ Ex] within the ordered parameter on 5/5/26 and 5/7/26; Resident #7 had an order for [NJ Ex Order 26, 4B] with a hold parameter but that there were no [NJ Ex Ord] listed on the eMAR when the med was given; and Resident #8 [NJ Ex Order 26, 4B] order with a hold parament did not have [NJ Ex] (had an X) listed on the eMAR when held and received [NJ Ex Order 26, 4B] outside the ordered parameter on [NJ Ex Order 26, 4]. On 6/4/26 at 10:31 AM, in the presence of the [U. S. FOIA (b)] stated that the staff were educated regarding [NJ Ex Order 26, 4B] orders. The [U. S. FOIA (b)] did not provide any additional information. A review of the facility's "Medication Administration with Specific Instructions Policy" with a reviewed date of 1/2026, included the following: Policy: It is the policy of this facility to ensure that meds are administered according to all specific instructions provided in the PO, med administration record, pharmacy recommendations and manufacturer guidelines. Procedure: Prior to administration, the nurse shall review the med order for any special instructions. Meds shall be administered according to ordered requirements, including:…BP, pulse, or blood glucose… Required assessments shall be completed and documented prior to administration when indicated. Administration and any required monitoring shall be documented on the MAR and in the medical record as appropriate. Questions regarding med administration instructions	F0760		07/06/2026

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F0760 SS = D	Continued from page 74 shall be clarified with the practitioner or consultant pharmacist prior to administration. N.J.A.C. 8:39 11.2 (b); 29.2(a,d)	F0760		07/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056301	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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H0000	Initials Comments A Recertification Survey was conducted and it was determined that the faciilty was not in compliance with the requirements under N.J.A.C. 8:43 E General Licensure Procedures And Standards Applicable To All Licensed Facilities.	H0000		07/02/2026
S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		07/01/2026
H5750	Mandatory use of Universal Transfer Form CFR(s): 8:43E-13.4(b) (b) A licensed healthcare facility or program shall complete all sections of the Universal Transfer Form, to the best of the licensed healthcare facility or program's ability. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of the medical records, and other facility documentation, it was determined that the facility failed to complete all the sections of the New Jersey Universal Transfer Form (UTF) as part of the medical record for 1 of 3 residents reviewed for hospitalizations (Resident #18). This deficient practice was evidenced by the following: Reference: New Jersey Administrative Code 8:43 E General Licensure Procedures and Standards: Section 8:43E-13.4 - Mandatory use of Universal Transfer Form	H5750	Corrective Action Resident #18's medical record and transfer documentation were reviewed. Nursing staff were re-educated by the DON regarding completion of all required sections of the New Jersey Universal Transfer Form prior to resident transfer. Identification of Other Residents All residents that are transferred to another facility/hospital have the potential to be effected. An audit of all hospital transfers occurring within the previous 30 days was completed to verify that required UTF sections were completed. Any identified omissions were corrected when possible and addressed with the responsible staff member. Systemic Changes The Director of Nursing (DON) and Unit Managers implemented a transfer checklist requiring verification that all sections of the UTF are	07/07/2026

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

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H5750	Continued from page 1 (a) A licensed healthcare facility or program shall use the UTF, HFEL-7, provided as N.J.A.C. 8:43E-13 Appendix, incorporated herein by reference, and available on the Department's website at http://web.doh.state.nj.us/apps2/forms/, in either paper or electronic version, whenever a patient is transferred to another licensed healthcare facility or program. 1. Emergency departments are exempt from mandatory use of the UTF but shall follow hospital procedures regarding documentation. (b) A licensed healthcare facility or program shall complete all sections of the UTF, to the best of the licensed healthcare facility or program's ability. 1. UTF is not complete if medication information is not attached. (c) A licensed healthcare facility or program shall send a completed, paper copy of the UTF with a patient when a patient is transferred. (d) A licensed healthcare facility or program shall retain a completed copy of the UTF sent with a patient when a patient is transferred as part of the patient's medical record. On 5/28/26 at 11:03 AM, the surveyor observed Resident #18 lying in bed with NJ Ex Order 26, 4B1. The Resident stated they came back from the NJ Exec Order 2 about NJ Exec Order 26.4b1 due to NJ Ex Order 26, 4B1 The resident further stated that they went back to the NJ Exec Order 2 at different times due to the NJ Ex Order 26, 4B1 not working and another time for NJ Ex Order 26, 4B1 On 6/1/26 at 9:17 AM, the surveyor reviewed the admission records of Resident #18 which revealed diagnoses that included but not limited to; NJ Ex Order 26, 4B1 A review of the progress notes and the Minimum Data Set (MDS-an assessment tool which facilitates the plan of care) revealed that the resident had NJ Ex O NJ Ex Order 26, 4B1 dated NJ Ex Order 26, 4B1 On NJ Ex Order 26, 4B 12:35 PM, the Director of Nursing (DON) provided copies of the UTFs dated NJ Ex Order 26, 4B1. A review of the	H5750	Continued from page 1 completed before a resident leaves the facility. Nursing staff received education from the DON regarding NJ Universal Transfer Form requirements. Monitoring The DON or designee will audit 100% of hospital transfers weekly for 4 weeks, then monthly for 2 months. Audit results will be reviewed during the Quality Assurance and Performance Improvement (QAPI) meeting.	07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056301	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	**96 PARKWAY , ROCHELLE PARK, New Jersey, 07662**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
H5750	Continued from page 2 UTFs that were provided, which consisted of 29 sections, were not completed in their entirety. The UTF copy dated [redacted] revealed missing information for sections: NJ Ex Order 26, 4B1 [redacted] was not filled in. The UTF copy dated [redacted] revealed missing information for sections: NJ Ex Order 26, 4B1 [redacted] facility contact not filled out. On 6/2/26 at 9:30 AM, the Assistant DON (ADON) stated the facility should have a copy of the UTF when the residents go out to the [redacted] for the purpose of communicating important health information and should be completed in its entirety. On 6/3/26 at 11:25 AM, the survey team met with the License Nursing Home Administrator (LNHA), Assistant Administrator (AA), and the DON concerning the facility did not complete two of the UTFs entirety. On 6/4/26 at 10:29 AM, the survey team met with the DON, AA, and the LNHA stated, "We know what needs to be done." The DON added, "We will be doing additional in-services to address all the concerns mentioned." A review of the facility's "Universal Transfer Form Policy", with a revised date of 1/2026, revealed under Policy, the purpose of the UTF is to communicate pertinent, accurate clinical patient care information at the time of an emergency... patient transfer between health care facilities.... Under Procedure: #1 Number 1-29 items must be completed on the New Jersey UTF...	H5750		07/07/2026
H5790	Mandatory use of Universal Transfer Form CFR(s): 8:43E-13.4(d) (d) A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer	H5790	Corrective Action The facility reviewed Resident #18's transfer record and ensured that a completed copy of the Universal Transfer Form was maintained in the medical	07/08/2026

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H5790	Continued from page 3 Form sent with a patient when a patient is transferred as part of the patient's medical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of the medical records, and other facility documentation, it was determined that the facility failed to maintain a copy of the New Jersey Universal Transfer Form (UTF) as part of the medical record for 1 of 3 residents reviewed for hospitalizations (Resident #18). This deficient practice was evidenced by the following: On 5/28/26 at 11:03 AM, the surveyor observed Resident #18 lying in bed with [redacted] in use. The Resident stated they came back from the [redacted] about [redacted] ago due to [redacted]). The resident further stated that they went back to the [redacted] at different times due to the [redacted]) not working and another time for [redacted] On 6/1/26 at 9:17 AM, the surveyor reviewed the admission records or face sheet (an admission summary) of Resident #18 which revealed diagnoses that included but not limited to; [redacted] A review of the progress notes and the Minimum Data Set (MDS-an assessment tool which facilitates the plan of care) revealed that the resident had [redacted] dated [redacted] On 6/1/26 at 10:01 AM, the surveyor interviewed the [redacted] U. S. FOIA (b) (2), who stated she would then complete the UTF form when resident was to transfer to the [redacted] Both the surveyor and the UM reviewed the hybrid (both paper and electronic) medical records of the resident for the five hospitalizations. There was a UTF dated [redacted]. The UM could not find the UTFs for the [redacted] transfers on [redacted] On 6/1/26 at 10:19 AM, the Assistant Director of Nursing (ADON) stated the missing UTF forms should be in the thinned chart in Medical Records and stated she would get the thinned chart to look for the UTF forms that were missing.	H5790	Continued from page 3 record. Identification of Other Residents All residents that are transferred to another facility/hospital have the potential to be affected. A review of all resident transfers within the previous 30 days was conducted to verify that completed UTFs were retained in the medical record. Systemic Changes The facility revised its transfer process to require nursing staff to file a completed copy of the UTF in the resident's medical record immediately following transfer. All staff were in serviced by the DON. Monitoring The Medical Records Director and DON will audit all transfers weekly for 4 weeks and monthly thereafter for 2 months to ensure completed UTFs are retained. In the absence of them both the supervisor on shift will be responsible. Results will be presented in our quarterly Quality assurance and performance improvement meeting.	07/08/2026

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H5790	Continued from page 4 On 6/2/26 at 9:30 AM, the ADON stated to the surveyor that they found a UTF dated [redacted] and there were no UTFs found for [redacted]. The ADON stated they looked everywhere. She confirmed the facility should have a copy of the UTF when the residents go out to the [redacted] for the purpose of communicating important health information. On 6/3/26 at 11:25 AM, the survey team met with the License Nursing Home Administrator (LNHA), Assistant Administrator (AA), and the Director of Nursing (DON) concerning the facility had no copies of UTFs for [redacted] hospitalizations. On 6/4/26 at 10:29 AM, the survey team met with the DON, AA, and the LNHA stated, "We know what needs to be done." The DON added, "We will be doing additional in-services to address all the concerns mentioned." A review of the facility's policy and procedure titled, "Universal Transfer Form", with a revised date of 1/2026, revealed under Policy, the purpose of the UTF is to communicate pertinent, accurate clinical patient care information at the time of an emergency... patient transfer between health care facilities....	H5790		07/08/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Assistant) staffing for 6 of 14-day shifts. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	S0560	Corrective Action The Administrator and DON reviewed staffing schedules and staffing patterns associated with the cited dates. Additional staffing resources were secured through recruitment efforts, agency utilization as needed, and schedule adjustments to maintain required staffing levels. Identification of Other Residents All residents residing in the facility had the potential to be affected. Current staffing schedules were reviewed to ensure compliance with New Jersey staffing requirements. Systemic Changes Staffing coordinators were in serviced by the DON/ADMIN about the staffing requirements. The	07/06/2026

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S0560	Continued from page 5 Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a	S0560	Continued from page 5 facility implemented enhanced staffing oversight including: Daily staffing review by the DON/designee Staffing contingency plan for call-outs Increased recruitment and retention efforts Weekly review of staffing ratios by Administration Monitoring The DON/Admin will review staffing levels daily and maintain documentation demonstrating compliance with State requirements. Results will be reviewed monthly at our quarterly Quality assurance and performance improvement meeting for six months.	07/06/2026

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S0560	Continued from page 6 nursing home to increase staffing levels, at any time, beyond the established minimum ... On 6/2/26 at 11:39 AM, the surveyor interviewed the two Staffing Coordinators (SCs) from the North building (SC #1) and the South building (SC #2-via phone conference), regarding staffing. SC #2 stated over the phone, "We make" the monthly schedule for the full time, part time, per diem CNAs; any gaps we fill with others who want to take that place. SC #1 stated, “We" staff for the day shift, 1 CNA per 8 residents (1:8), 3 PM-11 PM shift 1:10 and 11 PM-7 AM shift 1:14. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 5/10/2026 to 5/23/2026 for the Annual Standard Recertification survey, the facility was deficient in CNA staffing for residents on 6 of 14-day shifts as follows: -5/12/26 had 23 CNAs for 195 residents on the day shift, required at least 24 CNAs. -5/13/26 had 23 CNAs for 195 residents on the day shift, required at least 24 CNAs. -5/16/26 had 22 CNAs for 194 residents on the day shift, required at least 24 CNAs. -5/18/26 had 23 CNAs for 194 residents on the day shift, required at least 24 CNAs. -5/19/26 had 23 CNAs for 194 residents on the day shift, required at least 24 CNAs. -5/23/26 had 22 CNAs for 192 residents on the day shift, required at least 24 CNAs. A review of the facility's "Staffing Policy", with a revision date of 6/2/26, revealed under Policy Interpretation and Implementation #2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan and in accordance with NJ Mandated Nursing hours: CNA staffing ratio: day shift 1:8, evening shift 1:10, night shift 1:14.	S0560		07/06/2026
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a)	S1405	Corrective Action All identified employee files cited	07/07/2026

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S1405	Continued from page 7 The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of employee files and health records, it was determined that the facility failed to ensure that a newly hired employee completed a health history and received an examination by a physician, an advanced practice nurse, or a licensed physician assistant within two weeks prior to the first day of employment or upon employment for 3 of 79 (Staff #2, #57, and #70) new employee files reviewed. This deficient practice was evidenced by the following: On 5/28/26 at 12:20 PM, the Regional Nurse informed the surveyor that there were 78 new hires from the last annual recertification survey. On 6/1/26 at 11:30 AM, the surveyor reviewed the newly hired employee files from the most recent annual re-certification. The review of the physical examinations revealed the following: 1. Staff #2, Dietary: Date of Hire (DOH) was [redacted]. The Employee Health Examination Record revealed the Registered Nurse (RN) assessment dated [redacted] (3 days after DOH) was cleared to start work. The Physician's Health Examination was completed on [redacted] On 6/3/26 at 9:47 AM, the surveyor continued to review the new employee files. The files included an additional newly hired employee which brought up the number of newly hired employees from last recertification from 78 to 79 new employees. 2. Staff #57, License Practical Nurse (LPN): DOH was [redacted]. The Employee Health Examination Record revealed the RN assessment dated [redacted] (4 days after DOH) was cleared to start work. The	S1405	Continued from page 7 during survey were immediately audited. Missing health history forms, physical examination documentation, TB screening results, and/or required employee health records were obtained and placed in the personnel files. Any employee lacking required documentation was removed from duty until compliance was verified. Identification of Other Employees at Risk No additional residents were affected, but all residents have the ability to be affected by this deficient practice. The Human Resources Director and Infection Preventionist conducted a 100% audit of all active employee files to identify any additional staff members lacking required pre-employment health screenings, physical examinations, TB testing, or annual health documentation. Systemic Changes The facility revised its Employee Health Screening Policy to ensure compliance with N.J.A.C. 8:39-19.5. A standardized Employee Health Checklist was implemented for all new hires. Human Resources staff were re-educated by the DON regarding required health histories, physical examinations, TB testing requirements, and documentation timelines. No employee will be permitted to work without completion of all required pre-employment health documentation. The Infection Preventionist will review employee health records monthly to ensure ongoing compliance. Monitoring to Ensure Sustained Compliance: The Human Resources Director/ or designee will conduct monthly audits of 10 employee files monthly for three months and then quarterly thereafter.	07/07/2026

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S1405	Continued from page 8 Physician's Health Examination was completed on [NJ Ex Order 26] 3. Staff #70, Speech Language Pathologist (SLP): DOH was [NJ Ex Order 26]. The Employee Health Examination Record revealed there was no RN assessment done-no RN signature. The Physician's Health Examination was completed late on [NJ Ex Order 26.] (15 days after DOH). On 6/3/26 at 10:45 AM, the Director of Nursing (DON) stated that the Assistant DON (ADON) was responsible for employee physicals for new hires and oversees that part. On 6/3/26 at 11:25 AM, the survey team met with the License Nursing Home Administrator (LNHA), Assistant Administrator (AA), and the DON regarding concerns with employee physicals for new hires. The surveyor asked the DON what the process was for employee physicals for new hires, and she responded that the physicals can be done first day of hire, the RN can do it, and "we do have" 30 days for Medical Doctor (MD) to do physical from DOH. On 6/3/26 at 12:54 PM, the survey team met with the ADON and the DON regarding physicals for new employees. The ADON stated that the physicals was done within 30 days after DOH, the RN does it first on day of general orientation. The surveyor asked ADON if she was familiar with the State regulation for employee physicals for new hires, and the ADON responded, "No I am not." On 6/4/26 at 10:29 AM, the survey team met with the DON, AA, and the LNHA stated, "As far as the new hires physical, we clarified, we have 30 days to do the physical." A review of the facility's "New Hire Process Policy", with a reviewed date of 1/2026, revealed under Policy, this facility hires qualified individuals in compliance with federal and New Jersey regulations...Under Procedure #3. All offers of employment are conditional upon successful completion of the following: Health screen. The facility Policy and Procedure did not include the timeframe to conduct employee physicals according to State regulations.	S1405	Continued from page 8 Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified deficiencies will be corrected immediately and trends addressed through performance improvement activities. .	07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 08/05/2026, in relation to the 06/10/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056301	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

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H0000	Initials Comments An offsite/desk review of the facility's Plan of Correction was conducted on 08/05/2026 in relation to the 06/10/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code for Long Term Care Facilities.	H0000		
S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 08/05/2026 in relation to the 06/10/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/08/2026,06/09/2026 and 06/10/2026. Alaris Health at the Chateau (South) was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Alaris Health at the Chateau (South) is a three-story building with a partial basement that was constructed in 1955. It is composed of Type II (111) construction and is divided into eleven smoke compartments. The facility has a complete automatic sprinkler system (wet) that is supplied by city water and does not have a fire pump. The two diesel generators power 50% of the building. The second floor is not used by the residents of the facility. There is a ventilator unit with eleven beds, and a dialysis center on the first floor. The number of beds occupied was 51 out of 73 during the survey.	K0000		06/24/2026
K0311 SS = F Bldg. 01	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.	K0311	Corrective Action The following actions were completed; The center exit stairway door on the first floor was repaired to eliminate the gap between the top edge of the door and the door frame and maintain the required fire resistance rating of the vertical opening. Identification of Others Potentially Affected The U. S. FOIA (b) (2), or designee, reviewed stairway doors serving the facility to confirm no additional deficiencies were identified. The facility acknowledges all residents could be	07/08/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01 - MAIN BUILD...** B. WING	**06/10/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	**96 PARKWAY , ROCHELLE PARK, New Jersey, 07662**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0311 SS = F Bldg. 01	Continued from page 1 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 06/08/2026, in the presence of U. S. FOIA (b) (2) it was determined that the facility failed to maintain the fire resistance rating of vertical openings as required by NFPA 101 Life Safety Code (2012 Edition), Section 19.3. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations conducted on 06/08/2026 at approximately 8:17AM, revealed that the center exit stairway door on the first floor had a gap between the top edge of the door and the door frame. In an interview at the time, the U. S. FO confirmed the finding. The facility's U. S. FOIA (b) (2) was informed of the deficient practices at the Life Safety Code exit conference on 06/10/2026 at 2:35 PM. N.J.A.C 8:39-31.2(e)	K0311	Continued from page 1 potentially affected by this condition but respectfully submits that no residents were affected. Systemic Changes NJ Ex Order 26, 4B1 U. S. FOIA (b) (2) were educated by the regarding maintaining stairway doors to ensure they remain free of gaps between the door and frame. The Maintenance Director, or designee, will verify stairway door clearances through monthly reviews for three (3) months. Quality Assurance Results of the verification reviews will be presented at the quarterly QAPI meetings. If substantial compliance is not met, verification will continue and be brought to QA meetings until substantial compliance is met. Responsible Party Administrator Substantial Compliance	07/08/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K0353	Corrective Action The following actions were completed; Paint was removed from the sprinkler head located in the staff lounge and the missing ceiling tiles in the staff lounge, record room, telephone room, and mechanical storage room were reinstalled to maintain the integrity of the sprinkler system and smoke-resistant ceiling assembly. Identification of Others Potentially Affected The U. S. FOIA (b) (2), or designee, reviewed sprinkler heads and ceiling tiles serving the facility to confirm no additional deficiencies were identified.	07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	96 PARKWAY , ROCHELLE PARK, New Jersey, 07662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0353 SS = F Bldg. 01	Continued from page 2 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 06/08/2026, in the presence of U. S. FOIA (b) (2)), it was determined that the facility failed to properly maintain the sprinkler system and smoke -resistant ceiling assembly. Specifically, sprinkler heads were not maintained in accordance with NFPA 101, 2012 Edition, Section 9.7.5, 9.7.7, 9.7.8, NFPA 25, 2011 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 06/08/2026 at approximately 8:23 AM, in staff lounge room revealed that five ceiling tiles were not in place. Further observation revealed that one of two sprinkler heads in the room was painted. Observations on 06/08/2026 at approximately 10:36 AM, in the record room revealed that four ceiling tiles were not in place. Observations on 06/08/2026 at approximately 10:23 AM, in the telephone room revealed that four ceiling tiles were not in place. Observations on 06/08/2026 at approximately 10:40 AM, in the mechanical storage room revealed that one ceiling tile was not in place. In an interview at the time, the U. S. FO confirmed the finding. The facility's U. S. FOIA (b) (2) was informed of the deficient practices at the Life Safety Code exit conference on 06/10/2026 at 2:35 PM. N.J.A.C 8:39-31.2(e) NFPA 25	K0353	Continued from page 2 The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected. Systemic Changes U. S. FOIA (b) (2) were educated by the U. S. FOIA (b) (2) regarding maintaining sprinkler heads free from paint and ensuring ceiling tiles are properly installed. The Maintenance Director, or designee, will verify ceiling tile placement and sprinkler head conditions through monthly reviews for three (3) months. Quality Assurance Results of the verification reviews will be presented at the quarterly QA meetings. If substantial compliance is not met, verification will continue and be brought to QA meetings until substantial compliance is met. Responsible Party Administrator Substantial Compliance	07/03/2026
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K0321	Corrective Action The following actions were completed on 6/10/2026	07/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	96 PARKWAY , ROCHELLE PARK, New Jersey, 07662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321 SS = D Bldg. 01	Continued from page 3 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 06/08/2026, in the presence of U. S. FOIA (b) (2), it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1,7.2.1.8,9.7,8.4. This deficient practice had the potential to affect 16 of 51 residents, and was evidenced by the following: Observations made on 06/08/2026 at approximately 8:21 AM, revealed that the staff lounge contained more than 200 boxes of combustible materials stored	K0321	Continued from page 3 Excess combustible storage was removed from the staff lounge. Identification of Others Potentially Affected The U. S. FOIA (b) (2), or designee, reviewed hazardous areas serving the facility to confirm no additional deficiencies were identified. The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected. Systemic Changes U. S. FOIA (b) (2) were educated by the U. S. FOIA (b) (2) regarding maintaining hazardous areas free from excessive combustible storage. The Maintenance Director, or designee, will verify that the staff lounge is maintained free of combustible storage through monthly reviews for three (3) months. Quality Assurance Results of the verification reviews will be presented at the quarterly QA meetings for three (3) months. If substantial compliance is not met, verification will continue and be brought to QA meetings until substantial compliance is met. Responsible Party Administrator	07/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/10/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	**96 PARKWAY , ROCHELLE PARK, New Jersey, 07662**

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K0321 SS = D Bldg. 01	Continued from page 4 on pallets. Further observation revealed that the room's self-closing door did not close and latch to the frame, leaving an approximately 8-inch opening, which could compromise the room's ability to contain smoke and fire. In an interview at the time, the [redacted] confirmed the finding. The facility's [redacted] was informed of the deficient practices at the Life Safety Code exit conference on 06/10/2026 at 2:35 PM. N.J.A.C 8:39-31.2(e)	K0321		07/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - FORMERLY R... B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	96 PARKWAY , ROCHELLE PARK, New Jersey, 07662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 02	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/08/2026,06/09/2026 and 06/10/2026. Alaris Health at the Chateau (North) was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Alaris Health at the Chateau (North) is a four-story building with a partial basement that was constructed in 1955. It is composed of Type II (111) construction and is divided into sixteen smoke compartments. The facility has a completely automatic sprinkler system (wet) that is supplied by city water and an electric fire pump. The two diesel generators power 50% of the building. The number of beds occupied was 142 out of 178 during the survey.	K0000		06/24/2026
K0521 SS = E Bldg. 02	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 06/09/2026, in the presence of U. S. FOIA (b) (2) it was determined that the facility failed to ensure that residents air conditioning system was maintained in accordance with NFPA 101:2012 Edition, Sections 19.5.2.1 and 9.2. This deficient practice had the potential to affect 55 of 142 residents and was evidenced by the following: Observations conducted on 06/09/2026 at	K0521	Corrective Action The following actions were completed on 6/10/2026 Air filters were installed in the air conditioning units serving resident rooms NJ Ex Order 26, 4B1 and the dirty air filter in the second floor residents' dining area was replaced. Identification of Others Potentially Affected The U. S. FOIA (b) (2), or designee, reviewed resident room air conditioning units and the second floor residents' dining area air conditioning unit to confirm no additional deficiencies were identified. The facility acknowledges all residents could be potentially affected by this condition but respectfully submits that no residents were affected.	07/02/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - FORMERLY R... B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	96 PARKWAY , ROCHELLE PARK, New Jersey, 07662

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K0521 SS = E Bldg. 02	Continued from page 1 approximately 1:13 PM, in residents' room #[NJ Ex Ord] revealed that the Air conditioning unit was not provided with air filter. Observations conducted on 06/09/2026 at approximately 1:15 PM, in residents' room #[NJ Ex Ord] revealed that the Air conditioning unit was not provided with air filter. Observations conducted on 06/09/2026 at approximately 1:19 PM, in residents' room #[NJ Ex Orde] revealed that the Air conditioning unit was not provided with air filter. Observations conducted on 06/09/2026 at approximately 1:24 PM, in residents' room #[NJ Ex Ord] revealed that the Air conditioning unit was not provided with air filter. Observations conducted on 06/09/2026 at approximately 1:31 PM, in residents' room #[NJ Ex Ord] revealed that the Air conditioning unit was not provided with air filter. Observations conducted on 06/09/2026 at approximately 1:38 PM, in residents' room #[NJ Ex Orde] revealed that the Air conditioning unit was not provided with air filter. Observations conducted on 06/09/2026 at approximately 1:42 PM, in residents' room #[NJ Ex O], revealed that the Air conditioning unit was not provided with air filter. Observations conducted on 06/09/2026 at approximately 1:44 PM, in residents' room #[NJ Ex Ord] revealed that the Air conditioning unit was not provided with air filter. Observations conducted on 06/09/2026 at approximately 2:01 PM, in residents' dining area on the second floor, revealed that the Air conditioning unit air filter was dirty. In an interview at the time, the [U. S. FO] confirmed the findings. The facility's [U. S. FOIA (b) (2)] was informed of the deficient practices at the Life Safety Code exit conference on 06/10/2026 at 2:35 PM. N.J.A.C 8:39-31.2(e)	K0521	Continued from page 1 Systemic Changes [U. S. FOIA (b) (2)] were educated by the [U. S. FOIA (b) (2)] regarding maintaining air conditioning units with properly installed and clean air filters. The Maintenance Director, or designee, will conduct monthly reviews for three (3) months to ensure air filters remain present and clean in resident room and common area air conditioning units. Quality Assurance Results of the verification reviews will be presented at the monthly QA meetings for three (3) months. If substantial compliance is not met, verification will continue and be brought to QA meetings until substantial compliance is met. Responsible Party Administrator	07/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	**96 PARKWAY , ROCHELLE PARK, New Jersey, 07662**

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 06/08/2026,06/09/2026 and 06/10/2026. The facility was found to be in compliance with 42 CFR 483.73.	E0000		06/24/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **08/03/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	**96 PARKWAY , ROCHELLE PARK, New Jersey, 07662**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 08/03/2026 in relation to the 06/04/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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 reverse for further 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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315494	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - FORMERLY R...** B. WING	(X3) DATE SURVEY COMPLETED **08/03/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at The Chateau	**96 PARKWAY , ROCHELLE PARK, New Jersey, 07662**

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K0000 Bldg. 02	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 08/03/2026 in relation to the 06/04/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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 reverse for further 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.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 08/03/2026 in relation to the 06/04/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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 reverse for further 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.

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