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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY ROCHELLE PARK, NJ 07662**

(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
F 000	INITIAL COMMENTS Complaint #s: NJ163566, NJ166367, NJ167186, NJ168560, NJ169565, NJ173055, NJ178204, NJ178367, NJ178833, NJ179065, NJ180762, and NJ180949. A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 01/06/25 - 01/09/25 Survey Census: 182 Sample Size: 43 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		2/7/25

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

Electronically Signed | 02/03/2025

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

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of	F 580	All residents have the potential to be	

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F 580	Continued From page 2 facility policy, the facility failed to ensure notification and/or timely notification was made to two resident's (Resident (R) 278 and R328) representatives (RR) when a change of condition occurred out of a total sample of 43 residents reviewed. This had the potential for the RRs to not be informed of the resident's condition and to be able to make informed decisions regarding the care of the residents. Findings include: Review of the facility's policy titled, "Notification of Change" last revised 12/27/22 revealed "Policy: It is the policy of this facility to inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member of the following changes . . . Procedures: 2. Significant change in the resident's physical, mental or psychosocial status (i.e. a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications) . . . 4. A decision to transfer or discharge the resident from the facility. 1.Review of R278's "Profile" located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was originally admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses of [redacted]. R278 discharged to the hospital on [redacted] and [redacted] the facility. Review of R278's admission "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an assessment reference date (ARD) of [redacted] revealed a Brief Interview for Mental	F 580	affected by this deficient practice. R278 and R238 are not current residents in the facility. Root cause analysis was completed. Nurses identified were re-educated by the Director of Nursing and/or Facility Educator to communicate and document all notification of changes in skin condition and critical labs to the primary contact and primary physician. This documentation is to be recorded in the resident record. All current residents were reviewed for notification of change to the primary contact regarding skin condition changes and critical labs. Documentation of notification is charted in the resident record. No other residents were affected by this deficient practice. Facility educator and/or nursing designee inserviced all nurses on communicating all skin changes and critical labs to the primary contact and physician. Documentation of notification to be charted in the resident record. Unit Manager and/or Nursing Designee will review all labs, new orders and 24 hour documentation daily to assess for any changes in condition and documentation of notification to primary contact in the patient record. Director of Nursing or Nursing Designee will conduct audits, using an audit tool, to assess documentation regarding	

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F 580	Continued From page 3 Status (BIMS) score could not be obtained. The resident was NJ Exec Order 26.4b1 Review of R278's NJ Ex Order 26.4(b)(1) laboratory results, dated NJ Exec Order 26.4b1 and provided by the facility, revealed R278's NJ Exec Order 26.4b1) was NJ Exec Order 26.4b low at NJ Exec Orde normal values: NJ Exec Order 26.4b1). The resident was also noted with a NJ Exec Order 26.4b1). Review of R278's NJ Exec Order 26.4b1 laboratory results, dated NJ Exec Order 26.4b1 and provided by the facility, revealed a NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 The results further revealed the resident had a NJ Ex Order 26.4(b)(1)). Review of R278's EMR revealed no evidence the family was notified of the above NJ Exec Order 26.4b1 Review of R278's U.S. FOIA (b)(6) laboratory results received by the facility on NJ Ex Order 26.4(b)(1) at 11:07 AM, and provided by the facility, revealed a NJ Ex Order 26.4(b)(1) . Review of R278's "Progress Notes" dated NJ Exec Order 26.4b1 located in the EMR under the "Progress Notes" tab revealed R278's U.S. FO was not notified of the NJ Exec Order 26.4b1 values received by the facility on NJ Exec Order 26.4b1 until	F 580	notification of change in the resident record. A minimum of 20 records will be audited monthly for three months and then quarterly for the next two quarters. Director of Nursing will address any concerns immediately and report to the QAPI committee monthly.	

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F 580	Continued From page 4 NJ Ex Order 26.4(b)(1) at 4:13 PM. During an interview on 01/09/25 at 11:30 AM the U.S. FOIA (b)(6) confirmed there was no evidence documented R278's U.S. FO was notified of NJ Exec Order 26.4b1 values for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) also confirmed the U.S. FOI was not notified timely of NJ Exec Order 26.4b1 values received on NJ Exec Order 26.4b1 until NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) confirmed resident's U.S. FO were to be notified of NJ Exec Order 26.4b1 values in order for them to be able to make a decision on treatment decisions. 2. Review of the undated "Admission Record" in the EMR under the "Profile" tab revealed R328 was admitted to the facility on NJ Exec Order 26.4b1 NJ Ex Ord was hospitalized from NJ Exec Order 26.4b1 and readmitted on NJ Exec Order 26.4b1. Pertinent diagnoses included NJ Ex Order 26 NJ Exec Order 26.4b1 Family member (F)328 was R328's emergency contact. Review of the admission " MDS" with an ARD of NJ Exec Order 26.4b1 in the EMR under the "MDS" tab revealed R328 was NJ Exec Order 26.4b1 with a BIMS of NJ Exec Order 26.4b1 R328 had NJ Exec Order R328 discharged NJ Exec Order 2 on NJ Exec Order 26.4b1 and NJ Ex C closed record was reviewed. Review of the Care Plan, dated NJ Exec Order 26.4b1, found under the "RAI [Resident Assessment Instrument" tab revealed a problem of, "[R328] was NJ Exec Order 26.4b1 ..." On NJ Ex Order 26.4(b)(1), the following was added to the care plan problem statement, " NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1	F 580		

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F 580	Continued From page 5 NJ Exec Order 26.4b1 ." Review of the "NJ Exec Order 26 Report" record dated NJ Exec Order 26.4b1 in the EMR under the "Assessment" tab revealed a new NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 Measurements were NJ Exec Order 26.4b1 in length by NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 was staged as a NJ Exec Order 26.4b1 dressing NJ Exec Order 26. was completed by the NJ Exec Order 26 care team and instructions were to apply it daily. The NJ Exec Order 26.4b Care" record documented, NJ Exec Order 26.4b1 There was no documentation in the "NJ Ex Order 26.4(Report" showing F328 was notified of the NJ Exec Order 26.4b1. Subsequent weekly "NJ Exec Order 26 Report" records, dated NJ Exec Order 26.4b1 documented the continued presence of the NJ Exec Order 26.4b1 through the last note on NJ Exec Order 26.4b1. R328 was discharged NJ Exec Orde on NJ Exec Order 26.4b1. There was no documentation of the family being notified of the NJ Exec Order 26.4b1 Review of the "NJ Exec Order 26.4b Report," dated NJ Exec Order 26.4b1 in the EMR under the "Assessment" tab, revealed the NJ Exec Order 26.4b1 and was NJ Exec O NJ Ex Order 26.4(b)(1) . The NJ Exec Order 26.4b Report" read, NJ Exec Order 26.4b1 secondary U.S. FOIA (b)(6) per patient, reclassified as NJ Exec Order 26.4b1 ." Current treatment called for application of NJ Exec Order 26.4b1 daily and NJ Exec Order 26.4b1 Review of the Nursing and Physician "Progress Notes" from NJ Exec Order 26.4b1 in the EMR under the "Progress Notes" tab revealed no	F 580		

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F 580	Continued From page 6 mention of [NJ Exec Order] being notified of the [NJ Exec Order 26.4b1] [redacted] first observed on [NJ Exec Order 26.4b1]. Review of the "Discharge Instructions," dated [NJ Exec Order 26.4b1] in the EMR under the "Assessment" tab revealed instructions regarding [NJ Exec Order] care were given to the "patient/family." Although the presence of the [NJ Exec Order 26.4b1] was not documented, under the heading of "Treatments" the instructions read, [NJ Exec Order 26.4b1] [redacted] apply [NJ Exec Order 26.4b1] daily and [NJ Exec Order] [redacted]. Additional Notes - [NJ Exec Order 26.4b1] [redacted]." During an interview on 01/09/25 at 1:15 PM, [U.S. FOIA] [redacted] U.S. FOIA (b) (6)) stated she remembered R328 having a [NJ Exec Order 26.4b1] and something on the [NJ Exec Order 26.4b1] [U.S. FOIA (b)(6)] reviewed R328's EMR and stated there was a [NJ Exec O] from the [NJ Exec Order 26.4b1] and R328 was followed weekly in [NJ Exec Order 26] rounds through discharge. [U.S. FOIA (b)(6)] stated R328 received [NJ Exec Order 26.4b1] application for the [NJ Exec Order 26.4b1] through discharge on [NJ Exec Order 26.4b1]. During an interview on 01/09/24 at 1:37 PM, the U.S. FOIA (b)(6) [redacted] stated families should be notified of new [NJ Exec Order 26.4b1] by the nursing staff. The [U.S. FOIA (b)(6)] stated this should be documented in [NJ Exec Order 26.4b] Notes," in "Physician's Notes" or on the "[NJ Exec Order 26] Reports." The [U.S. FOIA (b)(6)] reviewed R328's EMR and stated she did not see documentation of notification in any location of the [NJ Exec Order 26.4b1] [redacted] to [NJ Exec Orde]. During an interview on 01/09/25 at 5:01 PM, Registered Nurse (RN)3 stated when new	F 580		

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F 580	Continued From page 7 NJ Exec Order 26.4b1 were discovered the physician and family were both notified right away. RN3 stated the notification should be documented in Progress Notes. During an interview on 01/09/25 at 6:54 PM, the U.S. FOIA (b)(6) stated notification of the NJ Exec Order 26.4b1 was covered at discharge in the "Discharge Instructions" regarding the application of NJ Exec O NJ Exec Order 26.4b1. TheU.S. FOIA (b)(6) stated she did not know if the family was notified prior to that.	F 580		
F 756 SS=D	NJAC 8:39-13.1(a)(d) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		2/7/25

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F 756	Continued From page 8 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure pharmacy recommendations were responded to by the physician for one resident (Resident (R)160) out of five residents reviewed for unnecessary medications out of a total sample of 43 residents. This had the potential for the resident to have unmet health needs by not providing medication management. Findings include: Review of the facility policy titled, "Consultant Pharmacy Reports" last revised 04/2024 revealed, "It is the policy of the facility that a Licensed Nurse along with the Consultant Pharmacist will review the resident drug regimen upon admission, throughout the stay depending on the resident condition and in any event of risk of adverse consequences . . . Any irregularities will be reported and documented to the attending	F 756	All residents have the potential to be affected by this deficient practice. Unit Manager clarified R160 pharmacy recommendations regarding the NJ Exec Order 26.4b1 with the primary medical doctor and documented in R160 record. Family notified. Root cause analysis was completed. Nurses identified were re-educated by the Facility Educator to document in the resident record the primary doctor's response to the pharmacist's recommendation. All current pharmacy reviews were assessed for orders, recommendations and documentation in the resident record. No other residents were affected by this deficient practice.	

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F 756	Continued From page 9 physician and DON [Director of Nursing] . . . Procedure . . . 4. Any medication irregularities identified will be documented on a separate, written report and notification to the attending physician, and director of nursing, listing the resident name, relevant drug irregularity that was identified with the resolution noted by the physician . . . 6. If the physician chooses not to act upon the pharmacy consultant recommendations, the physician will communicate with a licensed professional. Review of R160's "Profile" located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on [redacted] with diagnoses of NJ Ex Order 26.4(b)(1) [redacted]. Review of R160's quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of [redacted] revealed a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the resident was NJ Exec Order 26.4b1 [redacted]. Review of R160's "Physician's Orders" located in the EMR under the "Orders" tab revealed R160 was ordered NJ Exec Order 26.4b1 [redacted]), give[redacted] table NJ Exec Order 26.4b1 for [redacted] with a start date of [redacted] and an order for NJ Exec Order 26.4b1 [redacted], by U.S. FOIA (b)(6) day for [redacted] with a start date of [redacted]. Review of the 'U.S. FOIA (b)(6) [redacted] Monthly Progress Notes" provided by the facility dated [redacted], revealed the U.S. FOIA (b)(6) recommended to consider increasing the resident's [redacted] after four weeks. Under the	F 756	Unit Manager will review pharmacy recommendations with the primary doctor and document the response in the resident record. Primary doctor will approve or decline the recommendation on the pharmacy consultant report. Director of Nursing or Nursing Designee will conduct audits, using an audit tool, to assess recommendation and documentation in the resident record. A minimum of 20 pharmacy review audits will be audited monthly for three consecutive months and then quarterly for the next two quarters. Director of Nursing will address any concerns immediately and report findings to the QAPI Committee.	

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F 756	Continued From page 10 section titled "Please consider implementing these recommendations and document below any changes made in response to the recommendations written, or should the recommendations be rejected, please document a rationale." There were initials in the space with no response documented. Review of the 'U.S. FOIA (b)(6) Monthly Progress Notes" provided by the facility dated NJ Exec Order 26.4b1 revealed the pharmacist requested to consider increasing the dosage of R160's NJ Exec Order 26.4b1. Under the section titled "Please consider implementing these recommendations and document below any changes made in response to the recommendations written, or should the recommendations be rejected, please document a rationale." There were initials in the space with no response documented. Review of R160's "Medication Administration Record (MAR)" from NJ Exec Order 26.4b1 revealed the resident was still receiving the same ordered dosage of NJ Exec Order 26.4b1 that was originally ordered on NJ Exec Order 26.4b1. During an interview on 01/09/25 at 5:00 PM with the NJ Exec Order 26.4b1 confirmed the U.S. FOIA (b)(6) had made physician recommendations for R160's NJ Exec Order 26.4b1 to be increased three separate times and there was no documentation from the physician agreeing with the recommendations and/or any rationale as to why the recommendations were not agreed upon. During an interview on 01/09/25 at 6:00 PM with the U.S. FOIA (b)(6) revealed the	F 756		

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F 756	Continued From page 11 reason she requested to increase the resident's NJ Exec Order 26.4b1 after four weeks was due to the resident being on a low dose at the beginning and you want to NJ Ex Order 26.4(b)(1 to get the maximum effectiveness of the medication. The U.S. FDA confirmed she also made follow-up recommendations to the physician to increase the NJ Exec Order 26.4b1 two more times and the recommendations were not responded to by the physician. She revealed the two medications are intended to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1	F 756		
F 921 SS=D	NJAC 8:39-29.3 Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Maintenance Logbook, and facility policy review, the facility failed to ensure eight resident rooms (Rooms 225W, 213W, 209, 211D, 227P, 262, 230 and 229) on the second floor of the north building was maintained to promote a homelike environment. The facility further failed to ensure formica coverings on a half wall in the Activity room was repaired to potentially prevent injury. This affected eight rooms of 38 resident rooms occupied on the second floor of the north building and the Activity room. This had the potential for the residents not to have a home like room in good repair and had the potential to cause an injury.	F 921	Rooms 225w, 213w, 209, 211D, 227, 262, 230 and 229 identified areas of improvement were addressed. Closet handles were replaced, paint was touched up, ceiling tile replaced, cracks around the sink were filled with waterproof silicone and heating unit cover was repaired. The formica covering in the Activity Room was repaired. Root cause analysis completed. New maintenance staff, including new Maintenance Director, recently started and facility is currently under renovations. Staff observed not consistent with using	2/13/25

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY ROCHELLE PARK, NJ 07662**

(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
F 921	Continued From page 12 Findings include: Review of the facility policy titled, "Maintenance Repairs" last revised 05/24 revealed, "Policy: To maintain a safe, clean, and functional environment for residents, staff, and visitors through timely repairs, routine maintenance, and room inspections. Procedures: 1. The Maintenance Department is responsible for conducting routine checks, repairs, and inspections throughout the facility . . . 3. Staff report issues (e.g., broken equipment, hazards) to the Maintenance Department. 4. Submit repair requests via the maintenance logbook on the designated floor of the issue . . . 6. The Maintenance Department checks the logbook for needed repairs and logs completion status/date in the logbook. 7. Maintenance performs routine checks/inspections of common areas, hallways, and safety systems (e.g., lighting, HVAC, and plumbing) on daily rounds . . . 12. Maintenance ensures fixtures, furniture, and systems are inspected for damage and repaired as needed. During observations on 01/08/25 at 3:10 PM with the U.S. FOIA (b) (6)) and the facility U.S. FOIA (b) (6)) revealed the following concerns in residents' rooms on the second floor of the north building: -In room 225W the closet doors would not shut, there was a missing handle/knob on one of the doors on the closet, there was paint peeling off the closet doors, there was paint peeling off the walls that surround the sink in the middle of the room. There was one ceiling tile sagging above the bed by the door; -In room 213W there was paint peeling all around	F 921	the maintenance log to document environmental areas requiring attention. Facility Educator inserviced staff to document in the Maintenance Log Book for any environmental repairs needed. Administrator inserviced Maintenance Staff to check the Maintenance Log Book daily. Maintenance Director or designee will round in each resident room at least once a month to assess for any repairs needed. Common areas on all units will be assessed weekly for any repairs needed. Findings of rounds will be documented in the Physical Plant Checklist audit tool. Any issues identified will be immediately addressed. Findings will be reviewed with the Administrator weekly and reported to the QAPI committee for three consecutive months and quarterly for two consecutive quarters.	

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ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY ROCHELLE PARK, NJ 07662**

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F 921	Continued From page 13 the sink in the middle of the room with cracks between the sink and the wall; -In room 209 there was paint peeling off the walls around the sink in the middle of the room; -In room 211D there was paint peeling off the walls around sink in the middle of the room. The heating unit (radiator) had paint peeling and it was rusted; -In room 227P there was paint peeling off walls by the window and the top of heating vent (radiator) was rusted; -In room 262 the closet doors had paint peeling, there was paint peeling off the walls surrounding the sink in the middle of the room; -In room 230 above the resident headboard of the bed by the window had a large section of peeling paint approximately 12 inches by 12 inches. A ceiling tile above the entrance to the door was sagging; -In room 229 the walls surrounding the sink in the middle of the room was peeling. -In the Activity room there was a half side wall surrounding the activity room with formica (laminated composite) covering the top ledge. A piece was broken off the top of the ledge leaving a sharp pointed piece of formica sticking up. The wall was approximately three feet in height, making it the same height for a resident in a wheelchair and if they would use the wall to help propel themselves it had the potential to stick the resident in the hand or arm and cause an injury. Review of the "Daily Maintenance Logbook" provided by the facility dated 2024 and 2025 revealed there were no requests completed by staff to complete any painting, repair any closet doors, repair any sagging ceiling tiles, or to fix the wall surrounding the Activity room. Further review of the logbook was an entry dated 01/09/25	F 921		

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	315494	A. BUILDING _____ B. WING _____	C 01/09/2025

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ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY ROCHELLE PARK, NJ 07662**

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F 921	Continued From page 14 revealed there were no maintenance issues reported by staff or found on maintenance rounds. During an interview with the U.S. FOIA (b)(6) at the time of the above observations, they confirmed the rooms needed to be painted and the closet doors needed to be repaired.	F 921		
F 924 SS=D	NJAC 8:39-31.4(a) Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of Maintenance Logbooks, and facility policy review, the facility failed to ensure handrails located in the corridors throughout the second floor of the north building on all four hallways had handrails in good repair and/or were not missing. This had the potential for the residents to potentially injure themselves when using the handrails during ambulation. This affected all four hallways of the second floor in the north building out of three floors in the building. Findings include: Review of the facility policy titled, "Maintenance Repairs" last revised 05/24 revealed, "Policy: To maintain a safe, clean, and functional environment for residents, staff, and visitors through timely repairs, routine maintenance, and room inspections. Procedures: 1. The Maintenance Department is responsible for	F 924	All identified broken/missing handrails have been repaired or replaced. Root cause analysis completed. New maintenance staff, including new Maintenance Director, recently started and facility is currently under renovations. Staff observed not consistent with using the maintenance log to document any handrail concerns. Administrator inserviced Maintenance Staff to check the Maintenance Log Book daily. Facility Educator inserviced all staff to document handrail concerns in the Maintenance Log Book located at the Nurses Station on each unit. Maintenance Director and/or designee will assess siderails for any repairs needed weekly. Findings of rounds will be	2/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY ROCHELLE PARK, NJ 07662**

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F 924	Continued From page 15 conducting routine checks, repairs, and inspections throughout the facility . . . 3. Staff report issues (e.g., broken equipment, hazards) to the Maintenance Department. 4. Submit repair requests via the maintenance logbook on the designated floor of the issue . . . 6. The Maintenance Department checks the logbook for needed repairs and logs completion status/date in the logbook. 7. Maintenance performs routine checks/inspections of common areas, hallways, and safety systems (e.g., lighting, HVAC, and plumbing) on daily rounds . . . 12. Maintenance ensures fixtures, furniture, and systems are inspected for damage and repaired as needed. During observations on 01/08/25 at 3:10 PM with the U.S. FOIA (b)(6) and the facility U.S. FOIA (b)(6) revealed the following concerns with handrails in the corridors on the second floor of the north building: -Handrail between rooms 226 and 228 had duct tape with foam around the ends of the handrails; -Handrail on the left side of the hall starting right before room 267 had duct tape on the ends securing the handrail to the wall; -Handrail on the left side of the hallway between the soiled utility room and MDS office door had duct tape on both ends of the handrail; -Missing handrail in front of the women's shower on the north hall; -Missing handrail in between the elevators; -Handrail to the right of the elevator had duct tape on both ends; -Handrail in front of the TV room was loose and pulled away from the wall. Review of the "Daily Maintenance Logbook" provided by the facility dated 2024 and 2025	F 924	documented in the Physical Plant Checklist audit tool. Any issues identified will be immediately addressed. Findings will be reviewed with the Administrator weekly and reported to the QAPI commitee monthly for three consecutive months and quarterly for two consecutive months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY ROCHELLE PARK, NJ 07662**

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F 924	Continued From page 16 revealed there were no requests to fix handrails on the corridors of the second floor. Review of the entry in the logbook dated 01/09/25 revealed there were no maintenance issues reported by staff or found on maintenance rounds related to handrails. During an interview at the time of the above observations the U.S. FOIA said they were waiting on caps to come into place on the ends of the handrails so they could be replaced. A request was made for a copy of the invoice showing handrails and caps were ordered so the handrails could be fixed. The U.S. FOIA said they would not be able to produce any invoices for copies of any orders to show replacement parts for the handrails had been ordered. During an interview on 01/09/25 at 9:25 AM Interview with the U.S. FOIA (b)(6) U.S. FOIA (b) (6) U.S. FOIA (b) (6) revealed she was not sure how long the handrails were in need of repair and confirmed there was no record in the logbooks of the needed repairs for the handrails. During an interview on 01/09/25 at 9:30 AM Licensed Practical Nurse (LPN)2 she was unsure how long the duct tape and foam had been on several of the handrails. She said she knew they were working on the handrails last night. During an interview with the U.S. FOIA (b)(6) [redacted] on 01/09/25 at 1:30 PM revealed she had heard there was a plan to remodel the second floor but did not know when that would be started. NJAC 8:39-31.2(e)	F 924		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315494 Y1	A. Building B. Wing Y2	3/28/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	96 PARKWAY ROCHELLE PARK, NJ 07662

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0580	Correction	ID Prefix F0756	Correction	ID Prefix F0921	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.90(i)	Completed
LSC	02/07/2025	LSC	02/07/2025	LSC	02/13/2025
ID Prefix F0924	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(i)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/13/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/9/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**01/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/09/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/09/25 and the facility and 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 2006. It is composed of Type I 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 number of beds occupied was 56 out of 73 during the survey. The second floor is not used by the residents of the facility. There is a ventilator unit on the first floor with eleven beds.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by	K 000		

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

Electronically Signed | 02/03/2025

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

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K 000	Continued From page 1 Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/09/25 and the facility and 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 the 1980's. It is composed of Type II construction and is divided into sixteen smoke compartments. The facility has a complete 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 129 out of 175 during the survey.	K 000		
K 311 SS=F	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. This REQUIREMENT is not met as evidenced	K 311		2/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 311	Continued From page 2 by: Based on observation and interview, 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. The deficient practice had the potential to affect 35 residents. Findings include: An observation on 01/09/25 at 11:42 AM of the designated exit stairwell by Room 300 revealed a two-inch overcut around a conduit penetration above the ceiling. During an interview at the time of the observation, the U.S. FOIA (b)(6) confirmed the finding and stated the facility was unaware of the unsealed penetration at the stairwell. NJAC 8:39-31.2(e)	K 311	Residents living near the exit stairwell door by room 300 have potential to be affected by this practice. Root cause analysis completed. New Maintenance Director and team members recently started. Maintenance team re-inserviced by the Regional Maintenance Director, on assessing for penetrations in the ceiling and walls. Maintenance Director sealed the penetration above the ceiling by the exit stairwell by room 300 with a fire resistant block. All rooms checked for penetration above fire barrier and smoke doors; no other findings on the South Pavilion. Maintenance Director or Designee will round on each unit weekly and resident rooms at least once a month using an audit tool to assess for penetrations. Findings will be immediately addressed and reported to the Administrator. Monthly reports will be reviewed with the QAPI committee for three consecutive months and quarterly thereafter for two quarters.	
K 311 SS=F	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	K 311		2/7/25

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K 311	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on observations and interview, 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. The deficient practice had the potential to affect 45 residents. Findings include: Observations on 01/09/25 at 9:13 AM of the designated exit stairwell by Room 400 revealed a three-inch overcut around an orange pipe penetration and a four-inch hole in the wall above the door. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was unaware of the unsealed penetrations and gaps in the stairwell rated wall. NJAC 8:39-31.2(e)	K 311	Residents living on the unit identified have potential to be affected by this deficient practice. Root cause analysis completed. New Maintenance Director and team members recently started. Maintenance team inserviced by the Regional Maintenance Director, on assessing for any gaps in the walls, ceilings, duct work, fixtures or any unsealed penetrations. Findings to be immediately addressed. Maintenance Director sealed the penetration around the pipe and wall above the door by the designated exit stairwell by Room 400 with a fire resistant block. All rooms checked for penetration above fire barrier and smoke doors. Maintenance Director or Designee will round on each unit weekly and resident rooms at least once a month using a monthly rounds audit tool to assess for penetrations. Findings will be immediately addressed and reported to the Administrator. Monthly reports will be reviewed with the QAPI committee for three consecutive	

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K 311	Continued From page 4	K 311	months and quarterly thereafter for two quarters.	
K 353 SS=F	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 _____ 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 REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all 175 residents at the facility. Findings include: A review of the facility's sprinkler system records provided by the facility revealed the facility failed	K 353	Residents living on the North Pavilion have potential to be affected by this deficiency. Root cause analysis completed. New Maintenance Director and team members recently started. Maintenance team inserviced by the Regional Maintenance Director, on monthly inspection of the electric fire pump. Maintenance Director contacted the	2/7/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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
K 353	Continued From page 5 to conduct the monthly test and inspection of the electric fire pump. The most recent monthly inspection was August 3, 2024. During an interview on 01/09/25 at 3:26 PM, the U.S. FOIA (b)(6) confirmed the finding and stated the facility was unable to provide documentation of the monthly fire pump test. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K 353	contracted vendor to test and inspect the fire pump. Maintenance Director or Designee will conduct monthly inspection of the electric fire pump and will log the date/minutes of the run pump time. Any findings will be immediately addressed and reported to the Administrator and Regional Maintenance Director. Monthly reports will be reviewed with the QAPI committee for three consecutive months and quarterly thereafter for two quarters.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the stored-pressure fire extinguishers had a six-year internal examination and were equipped with a verification of service collar in accordance with NFPA 10 (Standard for Portable Fire Extinguishers) 2010 Edition Sections 7.3.1.2.1 and 7.3.3.2.2. This deficient practice had the potential to affect 30 residents in the facility. Findings include:	K 355	Residents living on the wings identified have potential to be affected by this deficient practice. Root cause analysis completed. New Maintenance Director started. A recent inspection was done. Facility had replacement extinguishers in house but was not instructed on what extinguishers needed to be replaced. Maintenance team inserviced by the Regional Maintenance Director, regarding the six year internal	2/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**01/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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
K 355	Continued From page 6 An observation on 01/09/25 at 9:33 AM of the fire extinguisher located in the corridor by the smoke wall on the fourth floor revealed the Verification of Service Collar for the six-year internal examination was dated June 2018 and past due. An observation on 01/09/25 at 9:57 AM of the fire extinguisher located in the corridor by Room 319 revealed the Verification of Service Collar for the six-year internal examination was dated 2017 and past due. An observation on 01/09/25 at 10:30 AM of the fire extinguisher located in the Dining Room by the Smoking Area revealed the Verification of Service Collar for the six-year internal examination was dated 2018 and past due. During an interview at the time of observations, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was unaware the fire extinguishers were past due for the six-year internal examinations. The facility recently had an inspection and was given five fire extinguishers by the vendor but did not know where to put them. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K 355	examination of all fire extinguishers. Maintenance Director replaced the fire extinguishers with the new extinguishers that include the Verification of Service Collar for the six-year internal examination. Maintenance Director or Designee will conduct monthly inspections of the fire extinguishers to assure all are assessed for the six year internal examination and equipped with a verification of service collar. Maintenance Director will document findings using a monthly check list. Any findings will be immediately addressed and reported the Administrator and Regional Maintenance Director. Monthly reports will be reviewed with the QAPI committee for three consecutive months and quarterly thereafter for two quarters.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for	K 363		2/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**01/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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
K 363	Continued From page 7 at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.6.3. This deficient	K 363	Residents living on identified wing have potential to be affected by this practice. Root cause analysis completed. New Maintenance Director and team members recently started. Maintenance team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**01/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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
K 363	Continued From page 8 practice had the potential to affect 30 residents. Findings include: Observations on 01/09/25 at 11:58 AM of the Clean Utility Storage Room by the Nurses' Station revealed the corridor door hit at the door frame and failed to self-close and latch. The room measured over 50 square feet in size and contained combustibles (pads, paper products). During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the finding and stated the facility was unaware the door was not closing and latching prior to the survey. NJAC 8:39-31.2(e)	K 363	re-inserviced by the Regional Maintenance Director, on assessing all doors to assure they latch into the frame. Maintenance Director replaced the latch on the clean utility storage room by the Nurse's station and assured it latched into the frame. All doors checked to assure doors self-close and latch. No other findings. Facility Educator or Designee inserviced all staff to record any doors not latching in the Maintenance Log book located on each unit. Regional Maintenance Director inserviced maintenance staff to check the maintenance log book daily. Maintenance Director or Designee will round on each unit weekly and resident rooms at least once a month using a rounds audit tool to assess that all doors self-close and latch. Findings will be immediately addressed and reported to the Administrator. Monthly reports will be reviewed with the QAPI committee for three consecutive months and quarterly thereafter for two quarters.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core	K 363		2/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**01/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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
K 363	Continued From page 9 wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code	K 363	Residents living on the North Pavilion have potential to be affected by this deficiency. Root cause analysis completed. New	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**01/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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
K 363	Continued From page 10 (2012 Edition) Section 19.3.6.3. This deficient practice had the potential to affect 75 residents. Findings include: Observations on 01/09/25 at 9:42 AM of Room 324 revealed the corridor door failed to close and latch in the frame. The door hit at the door frame and the strike plate. Observations on 01/09/25 at 9:46 AM of Room 303 revealed the corridor door failed to latch in the frame. The door closed, but the hardware did not latch into the door frame. Observations on 01/09/25 at 9:55 AM of Room 355 revealed the corridor door failed to close and latch in the frame. The door hit at the door frame and the strike plate. An observation on 01/09/25 at 10:03 AM of Room 263 revealed the corridor door failed to positive latch in the door frame. Observations on 01/09/25 at 10:08 AM of Room 208 revealed the corridor door failed to close and latch in the frame. The door hit at the door frame and the strike plate. An observation on 01/09/25 at 11:05 AM of the Maintenance Shop revealed the corridor door hardware was taped over, preventing it from latching in the frame. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was unaware the doors were not closing and latching prior to the survey.	K 363	Maintenance Director and maintenance team members recently started. Maintenance team inserviced by the Regional Maintenance Director, on assessing all doors to assure they latch into the frame and keep free from any obstacle preventing the door from latching and closing. Maintenance Staff educated by the Regional Director to check the maintenance log book daily. Facility Educator and/or designee inserviced all staff to keep all doors free of any obstacles that can prevent it from latching. Any doors observed not properly closing to be communicated in the Maintenance Log book located on each unit. Maintenance Director made adjustments or replaced the strike plate/hardware and assured proper latching of door into the frame for rooms 324, 303, 355, 263, and 208. The tape over the hardware of the Maintenance Shop Door was removed and maintenance staff was re-educated on keeping the hardware free from any obstacle preventing the door from latching and closing. Maintenance Director or Designee will conduct weekly inspection of all doors to assure proper latching and log findings into the Maintenance Audit tool. Any findings will be immediately addressed and reported the Administrator and Regional Maintenance Director. Monthly reports will be reviewed with the QAPI committee for three consecutive months and quarterly thereafter for two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**01/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

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K 363	Continued From page 11 NJAC 8:39-31.2(e)	K 363	quarters.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect 50 residents. Findings include: An observation on 01/09/25 at 11:36 AM of the smoke barrier located inside Room 312 revealed a six-inch unsealed gap in the wall above the television and ceiling. An observation on 01/09/25 at 12:00 PM of the	K 372	Residents on the unit identified have potential to be affected by this deficiency. Root cause analysis completed. New Maintenance Director and team members recently started. Maintenance team inserviced by the Regional Maintenance Director, on assessing for any gaps in the walls, ceilings, duct work, fixtures or any penetrations. Findings to be immediately addressed. Maintenance Director filled the unsealed gap in room 312 with fire resistant installation. Maintenance Director filled the unsealed gap above the smoke doors/ceiling located by the pantry on the	2/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**01/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

(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
K 372	Continued From page 12 smoke barrier located by the Pantry and Nurses' Station on the first floor revealed a two-inch unsealed gap in the wall right of the ductwork above the smoke doors and ceiling. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers. NJAC 8:39-31.2(e)	K 372	first floor with a fire-resistant installation. All rooms checked for unsealed gaps in the wall. Maintenance Director or Designee will round on each unit weekly and resident rooms at least once a month using a monthly rounds audit tool to assess for unsealed gaps in the wall. Findings will be immediately addressed and reported to the Administrator. Monthly reports will be reviewed with the QAPI committee for three consecutive months and quarterly thereafter for two quarters.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable	K 372	Residents living on the North Pavilion have potential to be affected by this deficiency.	2/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315494	A. BUILDING **01, 02** B. WING _____	**01/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	**96 PARKWAY** **ROCHELLE PARK, NJ 07662**

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K 372	Continued From page 13 of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect 129 residents. Findings include: An observation on 01/09/25 at 9:21 AM of the smoke barrier located inside Room 410 revealed a five-inch unsealed hole in the wall above the ceiling. An observation on 01/09/25 at 9:47 AM of the smoke barrier located inside Room 310 revealed a six-inch unsealed hole in the wall above the ceiling and wall lights. Observations on 01/09/25 at 10:05 AM of the smoke barrier located at the Day Room by Room 211 revealed a four-inch unsealed hole in the wall and a two-inch gap at the top of the wall. An observation on 01/09/25 at 10:45 AM of the smoke barrier located on the first floor by the vending machines and Lobby revealed a three-inch unsealed overcut around a group of wire penetrations above the ceiling tile. During an interview at the time of the observations, the U.S. FOIA (b)(6) confirmed the findings and stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers. NJAC 8:39-31.2(e)	K 372	Root cause analysis completed. New Maintenance Director and team members recently started. Maintenance team re-inserviced by the Regional Maintenance Director, on sealing any unsealed gaps/penetrations in the smoke barriers. Maintenance Director sealed findings in room 410, 310, 2nd floor Dayroom by room 211 and around the wire penetration above the ceiling tile on the first floor with a fire-resistant block. Maintenance staff assessed all resident rooms and common areas for any unsealed gaps/penetrations. Maintenance Director or Designee will conduct weekly inspection of all units and monthly for all resident rooms for any unsealed gaps/penetrations in the smoke barriers and document findings in the monthly maintenance audit tool. Any findings will be immediately addressed and reported the Administrator and Regional Maintenance Director. Monthly reports will be reviewed with the QAPI committee for three consecutive months and quarterly thereafter for two quarters.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315494 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	3/28/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	96 PARKWAY ROCHELLE PARK, NJ 07662

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 02/07/2025	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 02/07/2025	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 02/07/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
1/9/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315494 Y1	A. Building 02 - FORMERLY ROCHELLE PARK BUILDING B. Wing Y2	3/28/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE CHATEAU	96 PARKWAY ROCHELLE PARK, NJ 07662

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	02/07/2025	LSC K0353	02/07/2025	LSC K0355	02/07/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0363	02/07/2025	LSC K0372	02/07/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/9/2025	☐ YES ☐ NO