STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING _____ B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT KEARNY	206 BERGEN AVE KEARNY, NJ 07032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Standard Survey: 10/18/22 Census: 98 Sample Size: 20 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.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation interview and review of facility documentation, it was determined that the facility failed to maintain resident call bells accessible and within reach of all residents. This deficient practice occurred for 1 of 20 residents reviewed (Resident #64). This deficient practice was evidenced by the following:	F 558	Call bell for resident#64 was immediately repaired once pointed out by state surveyors. All residents have the potential to be affected Director of maintenance did an immediate call bell audit in all the residents rooms	10/31/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/04/2022

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F 558	Continued From page 1 1. On 10/5/22 at 11:04 AM, two surveyors observed Resident #64 in bed. Resident #64 was disoriented and confused when interviewed. The surveyors observed that the resident did not have a call bell (a bell used to call for staff assistance) within their reach. The surveyor observed that there was a plug in the wall attached to the facility's call bell system but that no wire or button was attached to the plug. The surveyor did not observe another button or bell that the resident could use to call for staff assistance. On 10/6/22 at 11:19 AM, the surveyor observed Resident #64 in bed. The surveyor observed that the resident did not have a call bell within their reach. The surveyor observed that there was a plug in the wall attached to the facility's call bell system but that no wire or button was attached to the plug. The surveyor did not observe another button or bell that the resident could use to call for staff assistance. On 10/7/22 at 10:19 AM, the surveyor observed Resident #64 resting in bed. The surveyor observed that the resident did not have a call bell within their reach. The surveyor observed that there was a plug in the wall attached to the facility's call bell system but that no wire or button was attached to the plug. The surveyor did not observe another button or bell that the resident could use to call for staff assistance. On 10/7/22 at 10:25 AM, the surveyor interviewed the Certified Nursing Assistant (CNA). The surveyor asked how the resident called for staff assistance. The CNA stated that the resident did not use their call bell but that they would call out for help by screaming. The surveyor asked the	F 558	and ensured all call bells were working and in place. All nursing staff were in-serviced by Infection Control RN on notification/ communication process of broken and/or missing call bells, logging issue in the maintenance book and also notifying maintenance department immediately. Director of Maintenance will audit all call bells on a weekly basis to assure they are in place and working properly. Director of Maintenance will conduct weekly call bell audit. Result of these audits will be submitted to the Administrator on a weekly basis. Results of these audits will be reviewed at the QAPI committee for the next 2 quarters.	

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F 558	Continued From page 2	F 558		

CNA to accompany her into Resident #64's room and to locate the resident's call bell. The CNA looked for the resident's call bell and stated, "I don't see it". The CNA gestured towards the wall where the call bell was plugged in and stated, "You see, it's broken and hasn't been replaced." The surveyor asked if she checked that the resident had a call bell today. The CNA stated that she did not yet check that the resident had a call bell because she was assisting other residents.

On 10/7/22 at 10:34 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The surveyor asked how the resident called for help. The LPN stated that the resident would call out, "help, help" when they needed assistance. The surveyor asked if the resident should have a call bell. The LPN stated, "of course we have to make sure that he/she has a call bell." At this time the surveyor asked the LPN to accompany her into Resident #64's room and to locate the resident's call bell. The LPN looked around the resident's room and stated, "I don't see any." The LPN stated that she would ask maintenance to put a call bell in place.

On 10/7/22 at 10:40 AM, The LPN and the surveyor reviewed the Maintenance Request Log. The Maintenance Request Log failed to reveal that Resident #64's broken call bell was previously reported. The LPN recorded the broken call bell on the Maintenance Request Log at this time.

On 10/7/22 at 10:45, the surveyor interviewed the Registered Nurse/ Unit Manager (RN/UM). The surveyor asked if Resident #64 should have access to a call bell. The RN/UM stated that they should.

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On 10/7/22 at 1:11 PM, the surveyor expressed her concern to the Licensed Nursing Home Administrator (LNHA), Vice President of Operations (VPO), and Regional Quality Assurance Nurse (RQAN). The surveyor asked how residents should be able to access staff. The LNHA stated that all residents should be able to call for staff assistance by using the call bell system.

On 10/11/22 at 11:13 AM, the surveyor interviewed the Maintenance Director. The surveyor asked when the Maintenance Director became aware that Resident #64 did not have a call bell. The Maintenance Director stated that he became aware of it on 10/7/22. The surveyor asked what his observation was on 10/7/22 when he went to fix it. The Maintenance Director stated, "The whole wire was broke."

On 10/11/22 at 12:49 PM, the surveyor asked if the resident's broken call bell was brought to the RN/UM's attention. The RN/UM stated that it might have been put on the maintenance log. The surveyor stated that she reviewed the Maintenance Request Log with the LPN and that it was not previously recorded. The surveyor asked who was responsible to make sure that residents have access to call bells and to report them if they are broken. The RN/UM stated that the whole team of care takers (CNA and nurses) was responsible and stated that she did not know why it was not immediately reported.

A review of the resident's electronic medical record revealed the following:

The Admission Record indicated that the resident

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had diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted]

The 8/31/22 quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, revealed that Resident #64 had a Brief Interview for Mental Status score of [redacted] out of 15, which indicated that the resident had Ex.Order 26.4(b)(1) . The MDS further reflected that the resident required total assistance from one or two staff members in most areas of activities of daily living including EX Order 26 § 4b1 [redacted].

The Order Summary Report indicated that Resident #64 had a 2/3/21 active Physician's Order for "Call bell within reach" to be checked for every shift.

Resident #64's [redacted] care plan initiated 1/12/21 indicated that staff should, "Be sure call light is within reach and encourage to use it for assistance as needed."

The facility policy, "Call Bells" with a revised date of 10/2021 indicated under the Procedure section 7. If call bell is defective, report immediately to maintenance." The facility policy also indicated, "8. If unable to be addressed right away, provide resident with a hand bell."

On 10/11/22 at 1:10 PM, the surveyor met with the LNHA, VPO, and RQAN and no further information was provided to explain why the missing call bell for Resident #64 was not addressed.

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F 558	Continued From page 5 NJAC 8:39-4.1(a)11; 31.1(b)	F 558		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment.	F 640		10/31/22

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F 640	Continued From page 6 (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for 1 of 3 residents reviewed for resident assessment, Resident #1. This deficient practice was evidenced by the following: On 10/14/22 at 10:10 AM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. The MDS is a comprehensive tool that is a federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System for Medicad/Medicare. The facility must complete and electronically transmit the MDS up to 14 days of the resident assessment completion.	F 640	MDS for Resident #1 was transmitted on (10/5/22) All residents have the potential to be affected. MDS Nurse was in serviced by Regional Certified Reimbursement Specialist on timely submission of MDS assessments. MDS Nurse will audit 10 MDS□s per month to assure timely submission of MDS. Director of Nursing will monitor results of these audits on a monthly basis and submit the results to the Administrator monthly. Results of these audits will be reviewed at the QAPI committee for the next 2 quarters.	

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Resident #1 was triggered under the survey facility task as "MDS record over 120 days old."

The surveyor reviewed the MDS 3.0 assessments, including all the completed MDS's for Resident #1 which revealed that the resident had a quarterly MDS with an Assessment Reference Date of 7/29/22 and was due to be transmitted no later than 8/26/22. The MDS was not completed and transmitted until 10/5/22.

On 10/17/22 at 9:43 AM, the surveyor interviewed the Registered Nurse MDS Coordinator who was responsible for completing the MDS assessments who stated that the Regional MDS Coordinator (RMDS-C) does the submission after MDS completion.

On 10/18/22 at 10:03 AM, the surveyor interviewed the RMDS-C who stated that the she could not provide a submission validation report of when the MDS was submitted.

According to the latest version of the Center for Medicare/Medicaid Services (CMS) - Resident Assessment Instrument (RAI) 3.0 Manual (updated October 2019) page 2-33 "05. Quarterly Assessment (A0310A = 02).....The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (Assessment Reference Date) (ARD + 14 calendar days)." On Page 2-17 indicated "Transmission Date no later than...MDS completion date +14 calendar days."

On 10/19/22 at 11:30 AM, the surveyor spoke to the Licensed Nursing Home Administrator (LNHA), Regional Quality Assurance Nurse, and the Vice President of Operations regarding the above concern. The LNHA acknowledged that the

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F 640	Continued From page 8 assessment was not submitted timely in accordance with the federal regulations. There were no further information provided. NJAC 8:39-11.2	F 640		
F 658 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, and record review, it was determined that the facility failed to appropriately remove, clarify, accurately administer, and document resident's physician ordered medications. This deficient practice was identified for 4 of 23 residents reviewed (Resident #22, #23, #24, #54, #73, #80, #93 and #57) and 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	F 658	Nurses were all inserviced on the importance of carrying out orders as prescribed by Physician for residents #22 #23 #24 #54 #73 #80 #93 and #57. 1-EX Order 26 § 4b1 was reordered for Resident #22. 2-EX Order 26 § 4b1 was reordered for Resident #23 3-EX Order 26 § 4b1 for resident #24 was removed from medication cart. 4-EX Order 26 § 4b1 has been discontinued by Md for Resident #54 5-Discontinued EX Order 26 § 4b1 was removed from medication cart for Resident# 73 6- Discontinued EX Order 26 § 4b1 was removed from	10/31/22

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F 658	Continued From page 9 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 10/6/22 at 11:32 AM, the surveyor inspected Cart #1 on the 4th floor Unit. EX Order 26 § 4b1 was found with a documented delivery date of 9/2/22 from the Provider Pharmacy and a written opening date on the bottle of 9/4/22 for Resident #22. On 10/6/22 at 12:01 PM, the surveyor interviewed the Registered Nurse Infection Preventionist (RNIP) who inspected the EX Order 26 § 4b1 and stated that the tube was "never opened." The surveyor reviewed Resident #22's hybrid medical records. Review of Resident #22's Face Sheet (an admission summary) (FS) documented diagnoses that included but were not limited to EX Order 26 § 4b1 A review of the 7/13/22 Annual Minimum Data Set (MDS), an assessment tool used to facilitate the	F 658	medication cart for Resident# 80 7-Resident #93 MD was notified and order was changed from EX Order 26 § 4b1 EX Order 26 § to EX Order 26 § 4b1 daily which is crushable. 8-Resident # 57□s EX Order 26 § 4b order was clarified and corrected. Four Medication Pass Audits per month will be conducted by the Director of Nursing, Unit Manager, Charge RN and/or Pharmacist to assure compliance with medication pass procedures.Nurse Managers and/or Pharmacist will audit medication carts on a monthly basis to ensure eye drops are being administered according to doctors□ orders. Nurse□s Medication Carts will also be audited by nurse managers once a week for removal of discontinued medications. Nurses were in serviced by Quality Assurance RN On ensuring all medications are discharged from the EMAR when a resident is discharged from the facility. Nurse managers will check all discharges once resident is discharged from facility to assure medications are discontinued per policy. Director of Nursing will monitor results of these audits on a weekly basis and submit	

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F 658	Continued From page 10 management of care, revealed a Brief Interview for Mental Status (BIMS) score of [redacted] of 15 which reflected that the resident's cognition was [redacted]. The surveyor reviewed the Order Summary Report (OSR) which documented an active physician's order (PO) for [redacted] 1 application in both [redacted] daily The PO for [redacted] had an original start date of 10/25/21. The surveyor reviewed Resident #22's Electronic Medical Record (eMAR) for June, July, August, September, and October 2022 and noted that the order for the [redacted] was documented as administered daily for all the months reviewed. On 10/11/22 12:31 PM, the surveyor interviewed the RPh who stated that [redacted] The RPh stated that there's no way to exactly calculate the number of doses in each tube since there was no exact amount in the directions. The RPh also stated that it would not last more than 28 days since the [redacted] was a small tube. The RPh stated that there was a previous delivery of another tube on 7/24/22. The RPH stated that if the [redacted] was opened as dated on 9/4/22, the tube should not appear full. 2. On 10/6/22 at 11:32 AM, the surveyor inspected Cart #1 on the 4th floor Unit. [redacted] was found with a documented delivery date of 7/15/22 from the Provider Pharmacy and a written opening date on the bottle of 7/17/22 for Resident #23.	F 658	results to the Administrator on a monthly basis. All findings will be reported and reviewed monthly by the Director of Nursing and reported quarterly during QAPI meeting for the next quarter by Director Of Nursing. Evaluation by the committee to determine continuing frequency of audits The Director Of Nursing /Unit Manager/ Charge nurse will review all orders and ensure they are being followed.	

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The surveyor reviewed Resident #23's hybrid medical records.
Review of Resident #80's FS documented diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted].

A review of the 7/13/22 Annual MDS revealed a BIMS score of [redacted] of 15 which reflected that the resident's cognition was [redacted].

The surveyor reviewed the OSR which documented an active PO with an original start date of 6/30/21 for T[redacted] Instill 1 drop in both [redacted] a day for [redacted]

The surveyor reviewed Resident #23's eMAR for June, July, August, September, and October 2022 and noted that the order for the [redacted] was documented as administered daily for all the months reviewed.

On 10/06/22 at 12:01 PM, the surveyor in the presence of the [redacted] poured the liquid from the bottle of [redacted] into a graduated cup. The liquid that remained in the [redacted] bottle measured [redacted].

On 10/11/22 12:31 PM, the surveyor interviewed the Provider Pharmacy Registered Pharmacist (PPRPh) who stated that EX Order 26 § 4b1 [redacted], which calculates to [redacted]. The PPRPh notified the surveyor that [redacted] had only been recently delivered to the facility for Resident #23 on 4/14/22 and 7/15/22 (opened for use on 7/17/22).

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Review of the eMAR for July, August, and September 2022 is documented with a daily administration of 6 doses per day of [EX Order 26 § 4b1] to Resident #23, this bottle should have been completed by 9/15/22.

3. On 10/6/22 at 11:32 AM, the surveyor inspected Cart #1 on the 4th floor Unit. [EX Order 26 § 4b1] was found with a documented delivery date of 7/6/22 from the Provider Pharmacy and a written opening date on the bottle of 8/5/22 for Resident #24.

The surveyor reviewed Resident #24's hybrid medical records.
Review of Resident #24's FS documented diagnoses that included but were not limited to EX Order 26 § 4b1.

A review of the 7/13/22 Quarterly MDS for Resident #24, revealed a BIMS score of [EX Or] of 15 which reflected that the resident's cognition was Ex.Order 26.4

A Review of Resident #24's June 2022 OSR disclosed that the PO for the EX Order 26 § 4b1

A review of Resident #24's July and August 2022 OSR disclosed that there was an additional PO for the EX Order 26 § 4b1. This order had a start date of 7/6/22 and a discontinuation date of 8/5/22.

Review of the June, July and August eMAR documented administration by nursing of [EX Order 26 § 4b1], and for

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30 days from 7/6/22 to 8/5/22.

On 10/6/22 at 12:01 PM, the surveyor interviewed the 3rd floor Unit Manager who stated that any medication that has been discontinued by a physician, should be removed from the current medication stock in the medication cart.

4. On 10/6/22 at 11:32 AM, the surveyor inspected Cart #1 on the 4th floor Unit. EX Order 26 § 4b1 The EX Order 26 § 4b1 was found appearing full with a documented delivery date of 7/24/22 from the Provider Pharmacy and a written opening date on the bottle of 8/1/22 for Resident #54.

On 10/6/22 at 11:35 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) that was performing medication administration utilizing Cart #1 on the 4th floor. The LPN stated that she worked the last 2 morning shifts, and the resident refused the medication. She added, "I should call the Physician and discontinue the order."

The surveyor reviewed Resident #54's hybrid medical records.
Review of Resident #54's FS documented diagnoses that included but were not limited to EX Order 26 § 4b1

A review of the 8/25/22 Quarterly MDS, revealed a BIMS score of [redacted] of 15 which reflected that the resident's cognition was Ex.Order 26.4(b)(1).

The surveyor reviewed the OSR which documented an active PO with an original start date of 7/1/21 for EX Order 26 § 4b1 1 spray in each nostril

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daily for allergic rhinitis.

The surveyor reviewed Resident #54's eMAR for July, August, September, and October 2022 and noted that the order for the [redacted] was documented as administered daily for all the months reviewed. The review of the October eMAR, which including the two days that the LPN stated that Resident #54 refused the [redacted] were documented as administered.

On 10/06/22 at 12:01 PM, the surveyor in the presence of the RNIP evaluated the bottle with the opening date of 8/1/22 of [redacted], which she stated, "appears full."

On 10/11/22 12:31 PM, the surveyor interviewed the PPRPh who stated that [redacted]. The PPRPh calculated that the bottle of [redacted] sent for Resident #54 was a [redacted]. If the bottle was documented as opened on 8/1/22, the [redacted] should have been completed on or about 10/1/22.

5. On 10/06/22 at 10:53 AM, the surveyor inspected Cart #2 on the 3rd floor Unit. [redacted] was found with a documented delivery date of 8/3/22 from the Provider Pharmacy and a written opening date on the bottle of 8/8/22 for Resident #73.

The surveyor reviewed Resident #73's hybrid medical records.
Review of Resident #73's FS documented diagnoses that included but were not limited to [redacted]

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A review of the 9/7/22 Annual MDS, revealed a BIMS score of Ex.Ord of 15 which reflected that the resident's cognition was Ex.Order 26.4(b

The surveyor reviewed the August 2022 OSR which documented a PO with an original start date of 8/3/22 for EX Order 26 § 4b1 [redacted]
This PO was documented as discontinued by the Physician on 8/31/22.

A review of the August 2022 eMAR for Resident # 73 indicated that there was only one administration of EX Order 26 § 4b1 for dry eyes, documented on 8/5/22.

6. On 10/6/22 at 11:02 AM, the surveyor inspected Cart #1 on the 3rd floor Unit.
Ex.Order 26.4(b)(1) ml bottle (used to treat Ex.Order 26.4(b)(1)) was found with a documented delivery date of 8/5/22 from the Provider Pharmacy and a written opening date on the bottle of 8/7/22 for Resident #80.

The surveyor reviewed Resident #80's hybrid medical records.
Review of Resident #80's FS documented diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted]

A review of the 9/9/22 MDS), BIMS score of [redacted] of 15 which reflected that the resident's cognition was Ex.Order 26.4(b)(1).

A Review of Resident #80's August 2022 documented a PO for the EX Order 26 § 4b1 [redacted] Instill 1 drop in both Ex.Order 26

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two times a day for allergies/redness for 7 days ordered on 8/6/22 and discontinued by the physician on 8/13/22.

A review of the August 2022 eMAR for Resident #80 indicated that there was daily administration of EX Order 26 § 4b1 documented from 8/6/22 to 8/13/22.

7. On 10/12/22 at 8:08 AM, the surveyor observed the 3rd floor Registered Nurse (RN) prepare medications for Resident #93. The surveyor observed as the RN removed EX Order 26 § 4b1 from its unit dose container and place it in a bag for crushing. The RN then proceeded to crush the tablet and mix with apple sauce for ease in swallowing.

The surveyor interviewed the RN right after she administered the medication to Resident #93. The RN stated that Resident #93 had a specialized diet order for mechanical soft and she felt that the resident's medication should be crushed, to avoid choking.

The surveyor reviewed Resident #93's hybrid medical records.
Review of Resident #22's FS documented diagnoses that included but were not limited to EX Order 26 § 4b1 .

A review of the 7/13/22 Quarterly MDS revealed a BIMS score of EX out of 15, which reflected that the resident's cognition was Ex.Order 26.4(b)(1). The Nutritional section (K) of the Quarterly MDS revealed that Resident #93 received a mechanically altered diet.

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A review of the Speech Therapy Evaluation dated 9/24/22, under "#10a. Consistency of pills/medication: whole."

Review of Resident #93's October 2022 OSR, documented an active order for Mechanical Soft texture diet (foods that can be blended, mashed, pureed, or chopped) with thin liquids. There were no physicians' orders for medication to be crushed.

On 10/12/22 at 11:16 AM, the surveyor interviewed the Consultant Registered Pharmacist who stated that EX Order 26 § 4b1 [redacted] should not be crushed.

8. The surveyor reviewed the hybrid medical records of Resident #57 which revealed the following:

Review of the FS revealed that the resident was readmitted to the facility from the hospital with diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted]

The Admission MDS dated 8/22/22, indicated that the facility assessed the resident's cognitive status resulting in a BIMS score of [redacted] out of 15. This score indicated that Resident #57 was EX Order 26 § 4b1 [redacted].

A review of the OSR indicated that Resident #57 had the following active POs:
a) "EX Order 26 § 4b1 [redacted]

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EX Order 26 § 4b1 [redacted] " with a start date of 10/11/22.

A review of the October 2022 eMAR for Resident #57 revealed that both POs for [redacted] were administered on 10/11/22 and 10/12/22 at 10 pm.

A review of the electronic Progress Notes dated 10/11/22 revealed that the resident was readmitted to the facility on Ex.Order 26.4(b)(1).

On 10/13/22 at 10:07 AM, the surveyor interviewed the LPN assigned to Resident #57 who stated that the resident was transferred to the hospital on Ex.Order 26.4(b)(and was readmitted to the facility on Ex.Order 26.4(b)(1). The surveyor and the LPN reviewed Resident #57's October 2022 OSR and eMAR. The LPN confirmed that there were two active orders of [redacted] and stated, "There should only be one order for [redacted]. The other one is a duplicate." The LPN further stated that the [redacted] order with a start date of 8/13/22 should have been discontinued. The surveyor asked if the two PO of Ex.Order 26.4(b)(were administered on 10/11/22 and 10/12/22 at 10 PM. The LPN stated, "it looks like."

On 10/13/22 at 11:03 AM, the surveyor discussed the above concern with the Licensed Nursing Home Administrator (LNHA), Regional Quality Assurance Nurse (RQAN), and Vice President of Operations (VPO). No additional information provided at this time.

On 10/14/22 at 11:09 AM, the surveyor

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interviewed the RNIP who confirmed that there were two active POs of the [EX Order 26 § 4(b)]. She stated, "All orders should have been discontinued when the resident is discharged from the facility." She acknowledged that the [EX Order 26 § 4(b)] PO dated 8/13/22 should have been discontinued when Resident #57 was transferred from the facility to the hospital. The RNIP added that when the resident was readmitted to the facility on [Ex.Order 26.4(b)(1)], the orders should have been confirmed / verified with the physician and entered into the eMAR as new orders. She further stated, "We do have admission audits and every nurse should go over them every shift. It is the responsibility of the unit manager or director of nursing to review orders for residents who are newly admitted and readmitted to the facility."

On 10/14/22 at 12:16 PM, the surveyor interviewed the RN via phone who stated, "the order for [Ex.Order 26.4(b)(was a duplicate and I only gave 1 dose of the [Ex.Order 26.4(b)(at 9 PM" on October 11 and 12, 2022. The RN acknowledged to the surveyor that the PO of [EX Order 26 § 4(b)] dated 8/13/22 should have been discontinued. She further stated, "We should have discontinued the previous order of [EX Order 26 § 4(b)] when the resident was discharged from the hospital and readmitted to the facility."

The surveyor reviewed the facility policy titled, "Transcribing Physician Orders" with an approved date of September 2022. The policy revealed under "Procedure: 5. Upon discharge, all medications will be discontinued in the computer system."

Review of the Discharged Medications Policy and Procedure revised on 5/10/21 identified, "1. Upon discharge of a resident from the facility, all

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medications will be removed from the medication/treatment cart, and they will be secured in the medication room. 2. Upon discontinuation of a medication, the medication will be removed from the medication/treatment cart, and they will be secured in the medication room."

Review of the Provider Pharmacy Administration of Medications Policy and Procedure revised on 12/08 and supplied to the surveyor by the facility, "K. After Medication Administration 1. Document necessary medication administration/treatment information (e.g., when medications are administered, medication injection site, refused medications and reason, prn (as needed) medications, etc.) on appropriate forms."

On 10/6/22 at 2:55 PM and 10/12/22 at 2:00 PM, the surveyor discussed the identified concerns with the Licensed Nursing Home Administrator (LNHA), Regional Quality Assurance Nurse (RQAN), and Vice President of Operations (VPO). The VPO and LNHA both stated that discontinued medications should be removed from the medication cart when the orders are discontinued. The LNHA, RQAN and VPO did not provide any additional information to explain why medications were left in the medication carts long after being discontinued by the Physician.

The LNHA, RQAN and VPO could not explain why there was so much medication left over, even though the nurse's documented information was that it was always administered to the resident.

On 10/14/22 at 1:16 PM, the surveyor discussed all identified concerns with the LNHA, RQAN, and

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F 658	Continued From page 21 VPO. The LNHA stated that the nurses should "Review the resident's orders. In the event of a duplicate order, one needs to be discontinued." She further stated the nurse should follow up and get clarification from the physician. The RQAN stated, "All orders should be discontinued" when the resident gets discharged from the facility, and that upon readmission all new orders should be entered into the eMAR computer system when the resident gets readmitted to the facility. NJAC 8:39-11.2 (b); 29.2 (d)	F 658		
F 695 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 tracheostomy care 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, and record review, it was determined that the facility failed to obtain a physician's order for the administration of oxygen. This deficient practice was observed for 1 of 3 residents (Resident #62) reviewed for respiratory care. This deficient practice was evidenced by the following: On 10/5/2022 at 11:20 AM, the surveyor observed Resident #62 in bed. The resident received	F 695	No corrective measure was done for resident #62 as resident has been discharged home All residents on oxygen have the potential to be affected. In-service for nurses conducted by Infection Preventionist Nurse that all residents on Oxygen needs an active order. Director Of Nursing, Unit Manager and/or Charge to conduct weekly audits	10/31/22

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F 695	Continued From page 22 EX Order 26 § 4b1 [redacted] The surveyor reviewed the hybrid medical record. The Admission Record indicated that the resident had medical diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted] The 8/26/2022 Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care indicated no evidence of oxygen use and no evidence of shortness of breath. The Brief Interview for Mental Status (BIMS) score was EX [redacted] out of 15, which indicated that the resident's cognition was EX Order 26 § 4b1 [redacted] The Interdisciplinary Team (IDT) Note dated 8/22/2022 was reviewed by the surveyor. The IDT note indicated that Resident #62 was EX Order 26 § 4b1 [redacted]. Review of the 7/2/2022 EX Order 26 § 4b1 [redacted] that Resident #62 had EX Order 26 § 4b1 as needed related to history of EX Order 26 § 4b1 exchange; history of EX Order 26 § 4b1. Review of the Order Recap Report (physician's orders) for the month of October 2022 failed to indicate a physician order for EX Order 26 § 4b1. On 10/12/2022 at 9:41 AM, the surveyor interviewed the Certified Nurse Assistant (CNA) assigned to Resident #62, who stated that Resident #62 was receiving EX Order 26 § 4b [redacted] most of the	F 695	on all residents on oxygen and ensure there is an order supporting treatment. QAPI monitoring for 2 quarters by Director Of Nursing, Unit Manager and/or Charge Nurse on all residents on oxygen.	

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time since they were taking care of them. The CNA could not remember the date Resident #62 started receiving [redacted].

On 10/12/2022 at 9:50 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) and confirmed that Resident #62 was receiving oxygen as needed (PRN). The RN/UM stated that she did not remember when Resident #62 started receiving [redacted].

On 10/12/22 at 10:50 AM, the RN/UM shared the "Order Listing Report" with the surveyor. The RN/UM stated that the resident's last active order for oxygen was discontinued on 6/28/22. The RN/UM stated that Resident #62 did not have an active physician's order for [redacted] for October.

The surveyor reviewed the October 2022 electronic Treatment Administration Record (eTAR) for any orders directed to the administration of [redacted]. The reviewed October 2022 eTAR did not reflect an active physician's order for [redacted].

Review of the facility policy, "[redacted]" dated 9/2018 indicated that "[redacted] is administered only as ordered by a physician or as an emergency measure until an order can be obtained. The physician's order will specify the rate of oxygen flow."

On 10/14/2022 at 1:16 PM, the surveyor discussed the concern with the Licensed Nursing Home Administrator (LNHA), Vice President of Operations, and Regional Quality Assurance Nurse. No information was provided to the surveyor as to why [redacted] was being administered to Resident #62 without an active physician's order.

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F 695	Continued From page 24	F 695		
F 849 SS=D	NJAC 8:39-27.1(a) Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 849		10/31/22

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(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal

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	315192	A. BUILDING _____ B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT KEARNY	206 BERGEN AVE KEARNY, NJ 07032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 26	F 849		

illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in

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the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both

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ALARIS HEALTH AT KEARNY	206 BERGEN AVE KEARNY, NJ 07032

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F 849	Continued From page 28 the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to immediately notify the hospice agency about a significant change in a resident's condition and a resident's death. This deficient practice was identified for 1 of 3 residents, Resident #83, reviewed for hospice/end-of-life care. The deficient practice was evidenced by the following: The surveyor reviewed the closed medical record for Resident #83. The reviewed Admission Record indicated that the resident had medical diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted] Review of the 9/14/22 significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, revealed that Resident #83 had a Brief Interview for Mental Status score of [redacted] which indicated that the resident was Ex.Order 26.4(b)(1) [redacted] The MDS also reflected that the resident was under hospice care. The Patient Information Sheet from the hospice	F 849	No corrective measure was done for resident #83 as resident EX Order 26 § 4b1. All resident on hospice have the potential to be affected. Nurses In-serviced on notification of change in status Infection Preventionist Nurse In- service for nurses by hospice designee on their expectations and proper notification process for change in condition of patients under hospice care. All patients on hospice services reviewed with nurses and the communication expectation with hospice of any change in condition. Director Of Nursing will conduct an audit to review documentation for 3 hospice residents per month to assure hospice was notified of change in condition. QAPI Monitoring for 2 quarters by Director of Nursing. Director of Nursing and Unit Managers will monitor all hospice communication/ notifications during daily clinical morning	

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agency indicated that Resident #83 was admitted to the hospice care on Ex.Order 26.4(with a diagnosis of Ex.Order 26.4(.

The Order Summary Report (physician's order) indicated that Resident #83 had an active physician order for "Hospice care and treatment initiated 9/7/22" dated 9/9/22.

Review of the hospice care plan initiated on 9/9/22, indicated that the facility should, "Notify MD, family and Hospice nurse if there are any changes in condition."

Review of the Interdisciplinary Team (IDT) Note dated 10/3/22 and submitted at 2:02 AM, written by the Registered Nurse (RN) indicated that at 8:00 PM Resident #83 was noted, "for first time with EX Order 26 § 4b1 upon taking respiration, resident unable to cough or clear secretions upon assessment, EX Order 26 § 4b1 The IDT note had continued entries that at 12:00 AM, "Resident noted looking EX Order 26 § 4b1 The IDT had another entry documenting that at 1:25 AM, "Resident is noted in bed with no rise in chest, pulse oximeter unable to read oxygen saturation, unable to be acquired upon multiple checks, EX Order 26 § 4b1 " The IDT note also revealed that at 1:29 AM, "Resident pulse unable to be felt, auscultation of the heart for one minute revealing no heart sounds or beating. Resident EX Order 26 § 4b1 EX Order 26 § 4b1 called. Family EX Order 26 § 4b1 called and

meetings for proper notification process.

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F 849	Continued From page 30 arranged for pick up." Further review of the Progress Notes failed to reveal any communication with the hospice agency during Resident #83's change of status or after they [redacted]. On 10/17/22 at 12:27 PM, the surveyor interviewed the RN Case Manager (RN/CM) from the hospice agency. The surveyor described the IDT note from the night that Resident #83 [redacted] and asked what should have happened. The RN/CM stated that if there was a change in status then the hospice agency should have been contacted. The surveyor asked if the hospice agency was contacted. The RN/CM stated, "I don't believe they contacted us." The surveyor asked if the hospice agency was contacted after the resident's [redacted]. The RN/CM stated that the resident's sister informed her of the resident's [redacted]. On 10/17/22 at 12:44 PM, the surveyor interviewed the RN. The RN confirmed that he was the nurse for Resident #83 on the night that the resident [redacted] The surveyor asked the RN if he had called anyone when the resident had a significant change in their medical condition on 10/3/22. The RN stated that he informed the primary care provider and the resident's family. The surveyor asked if the RN called the hospice agency. The RN stated that he was busy trying to care for the resident and that he could not remember if he called hospice. The RN acknowledged that the hospice agency should have been notified when the resident had a significant change in their medical status and when they [redacted].	F 849		

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On 10/18/22 at 9:07 AM, the surveyor conducted a follow up interview with the RN/CM for the hospice agency. The RN/CM confirmed that she received no communication from the facility on 10/1, or 10/2, and that she found out that the resident died from the resident's family member on 10/3. The RN/CM stated that she normally expects the facility to contact the hospice agency in the event of a change of condition or death. The RN/CM explained that a change of condition would include, "shortness of breath, agitation, fever, nausea and vomiting, or a fall." The RN/CM stated that hospice should have been notified when Resident #83's EX Order 26 § 4b1 .

The surveyor reviewed the Communication Notes provided by the hospice agency. They revealed a 10/3/22 note from the RN/CM, which indicated that she received a text message from Resident #83's family member that the resident Ex.Order 26.4(b)(on Ex.Order 26.4(b)(at 1:30 AM. The RN/CM informed the surveyor that she confirmed the resident's time of Ex.Order 26.4 with the facility's 3rd floor unit clerk.

The Communication Notes failed to reveal that the hospice agency was notified by the facility when the resident had a significant change of status or when the resident EX Order 26 § 4b .

Review of the Agreement for Nursing Facility Services dated 12/29/2010, indicated under Facility Responsibilities "b. Shall immediately notify the Hospice if: i. A significant change in patient's physical, mental, social or emotional status occurs; iv. The hospice patient Ex.Order ."

On 10/17/22 at 1:54 PM, the surveyor expressed concern to the Licensed Nursing Home Administrator, Regional Quality Assurance RN,

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F 849	Continued From page 32 and Vice President of Clinical Operations. No further information was submitted to explain why hospice was not notified by the facility when there was a significant change of status for Resident #83. NJAC 8:39-27.1(a)	F 849		

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
315192 Y1	A. Building B. Wing Y2	1/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT KEARNY	206 BERGEN AVE KEARNY, NJ 07032

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 F0558	Correction	ID Prefix F0640	Correction	ID Prefix F0658	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	10/31/2022	LSC	10/31/2022	LSC	10/31/2022
ID Prefix F0695	Correction	ID Prefix F0849	Correction	ID Prefix	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.70(o)(1)-(4)	Completed	Reg. #	Completed
LSC	10/31/2022	LSC	10/31/2022	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	
10/18/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING **01** B. WING _____	**10/18/2022**

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ALARIS HEALTH AT KEARNY	**206 BERGEN AVE** **KEARNY, NJ 07032**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/12/22 and 10/13/22, 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 The facility is a 4-story building that was built in 30's, It is composed of Type I fire resistant construction. The facility is divided into 14 smoke zones. The generator does approximately 50% of the building. The building has an electric fire pump. The LTC unit uses floors 3 and 4 of the building. The LTC unit opened 12/1/1982. The building has no kitchen and uses the sister facility's kitchen, a few blocks away called Alaris @ Belgrove.	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD) on 10/13/22, the facility failed to provide emergency	K 281	Building owner has installed missing egress lighting, inside emergency exit light and the outside egress lighting.	11/8/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/04/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 281	Continued From page 1 illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice was evidenced for 1 of 4 exteriors and evidenced by the following: At 12:00 PM, the Surveyor, MD, and RPOD observed outside stairwell #7 that there was no emergency lighting either continuously in operation or capable of automatic operation without manual intervention. The findings were verified by the MD and RPOD, at the times of the observation's. The Administrator was informed of the findings at the Life Safety Code exit conference on 10/13/22. NJAC 8:39-31.2(e)	K 281	Outside Stairwell #7 emergency lighting installed by building Landlord. All residents residing in the facility are potentially affected. Quarterly inspections with Kearny Fire Department. Director of Maintenance will complete QAPI on exit/emergency light efficiency for the next 2 quarters. Director of Maintenance and Building Landlord will audit exit/emergency lighting monthly to ensure compliance and provide copy of audit to the Administrator. Results of these audits will be reviewed at the QAPI committee for the next 2 quarters.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/13/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator and fire pump transfer	K 291	New emergency backup lighting placed by transfer switch room and generator room. All residents residing in the facility are potentially affected.	11/3/22

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K 291	Continued From page 2 switches, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 3 of 3 transfer switches and was evidenced by the following: 1). At 11:09 AM, the surveyor observed in the fire pump room, that the transfer switch did not have any emergency lighting independent of the building's electrical system. 2). At 11:28 AM, the surveyor observed in the mechanical/generator room, that the (2) two transfer switches, did not have any emergency lighting independent of the building's electrical system. The Maintenance Director and Regional Plant Operations Director, both confirmed the finding's at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit on 10/13/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	Quarterly inspections with Kearny Uniform Fire Department. Director of Maintenance will complete QAPI on lighting efficiency for the next 2 quarters. Director of Maintenance and Building Landlord will audit the emergency backup lighting monthly to ensure compliance. Results of these audits will be reviewed at the QAPI committee for the next 2 quarters.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		11/23/22

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K 345	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/13/22, it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents in the facility and was evidenced by the findings below: On 10/13/22 at 10:38 AM, in the presence of the facility's Maintenance Director (MD) and Regional Plant Operations Director (RPOD) observed that the fire alarm annunciator panel in the O2 cylinder storage room on floor #4, indicated trouble mode. The amber trouble light was activated in the Siemens fire alarm panel. due to the disabled macro not working. The fire alarm vendor indicated on their document that the entire building would sound off when testing a Siemens smoke detector or pull station, so the fire alarm document dated 5/18/22 indicated that the fire alarm vendor was only conducting a visual test of their devices. (Siemens) on floor #4. An interview was conducted during the document review with the RPOD where he stated that he was aware of the fire alarm documentation stating that the main fire panel (Silent Knight) in normal mode and the (Siemens) panel in trouble mode were having issues, but he indicated the function of the fire alarm system completely worked throughout the building. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 10/13/22.	K 345	Fire alarm annunciator located in the 02 cylinder room on 4th floor fixed trouble mode on fire panel cleared. All residents residing in the facility are potentially affected. Semi-annual Fire Alarm Inspections conducted by vendor. Director of Maintenance will complete QAPI on fire alarm annunciator for the next 2 quarters to ensure no display of error messages. Monthly audits by Director of Maintenance to ensure Fire and smoke alarms are working properly. Results of these audits will be reviewed at the QAPI committee for the next 2 quarters.	

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K 345	Continued From page 4 NFPA 70 NFPA 72 NJAC 8:39-31.2(e)	K 345		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/14/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), the facility did not provide complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment. Also, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012	K 351	1-Stairwell# 7 floor #4(top), #1 first accessible landing exit/egress door to public way fire sprinkler scheduled to be installed by Building Owner. 2- Stairwell #6 4th floor (top) and #1 first accessible landing exit/egress door to the public way fire sprinkler scheduled to be installed by Building Owner.	12/21/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING **01** B. WING _____	**10/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT KEARNY	**206 BERGEN AVE** **KEARNY, NJ 07032**

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K 351	Continued From page 5 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in this area. The deficient practice was evidenced for 3 of 3 stairwells observed by the following: 1. At 10:18 AM, the surveyor observed with the MD and RPOD, that the #7 stairwell floor #4 (top) and floor #1 first accessible landing exit/egress door to the public way, was observed to not have any fire sprinkler coverage. 2. At 10:27 AM, the surveyor observed with the MD and RPOD, that the #6 stairwell floor #4 (top) and floor #1 first accessible landing exit/egress door to the public way, was observed to not have any fire sprinkler coverage. 3. At 10:38 AM, the surveyor observed with the MD and RPOD, that the #5 stairwell floor #4 (top) and floor #1 first accessible landing exit/egress door to the public way, was observed to not have any fire sprinkler coverage. An interview was conducted with the MD and RPOD, who both stated and agreed that the areas above did not have fire sprinkler coverage. The Administrator was informed of the finding's at the Life Safety Code exit conference on 10/13/22. NJAC 8:39-31.2(e)	K 351	3- Stairwell #5 4th floor (top) and #1 first accessible landing exit/egress door to the public way fire sprinkler scheduled to be installed by Building Owner. All residents residing in the facility are potentially affected. Quarterly Sprinkler Inspections by vendor. 15 Minute Fire watch rounds implemented by Director of Maintenance of stairwells. Director of Maintenance will complete QAPI on on sprinklers to check for compliance for the next 2 quarters Weekly fire pump tests conducted by Building Landlord to ensure sprinkler system is working and meets fire code. Results of these inspections will be reviewed at the QAPI committee for the next 2 quarters	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 374		10/31/22

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ALARIS HEALTH AT KEARNY	**206 BERGEN AVE** **KEARNY, NJ 07032**

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K 374	Continued From page 6 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation on 10/13/22, it was determined that the facility failed to provide smoke barrier wall doors that completely closed to resist the passage of smoke, flame, or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1. This deficient practice was observed for 1 of 7 sets of double smoke doors tested for closure and was evidenced by the following: At 11:05 AM, the surveyor, Maintenance Director (MD) and Regional Plant Operations Director (RPOD), observed the set of smoke-doors by resident room 306, that when released from the magnetic hold-open device and the two doors fully closed, there was a gap approximately 1/4 inch in size, compromising the integrity of the smoke zone. At that time, the surveyor	K 374	Smoke Doors by resident room 306 was aligned and added a second asterisk. All residents residing in the facility are potentially affected. Monthly fire door inspection to be conduct by Director of Maintenance. Director of Maintenance will complete QAPI on smoke barrier doors to check for compliance for the next 2 quarters. Director of Maintenance will keep a log of all monthly audits a provide Administrator with copies. Results of these audits will be reviewed at the QAPI committee for the next 2 quarters.	

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	315192	A. BUILDING **01** B. WING _____	**10/18/2022**

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ALARIS HEALTH AT KEARNY	**206 BERGEN AVE** **KEARNY, NJ 07032**

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K 374	Continued From page 7 interviewed the MD who acknowledged that the smoke doors must resist the passage of smoke to be compliant. An interview was conducted with the MD and RPOD, during the observations, where they stated and confirmed that the smoke doors must fully close to resist the passage of smoke, flames, or gases during a fire. The Administrator was informed of the findings at the Life Safety Code exit conference on 10/13/22. NJAC 8:39-31.2(e)	K 374		
K 521 SS=F	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 REQUIREMENT is not met as evidenced by: Based on the surveyor's documentation review in the presence of the Maintenance Director and Regional Plant Operations Director on 10/12/22, it was determined that the facility failed to ensure that the heating boilers were inspected annually as required. This deficient practice is illustrated by the following for 5 of 5 facility boiler document's provided.	K 521	Boiler Inspection completed. All residents residing in the facility are potentially affected. Building owner/Landlord to request boiler inspection 2 months prior to renewal date Director of Maintenance will complete	11/4/22

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K 521	Continued From page 8 The required boiler inspections were not conducted as required, during the past 12 months. The last documented boiler inspection was conducted on 11/16/20 and expired 11/16/21. An interview was conducted with the Maintenance Director and Regional Plant Operations Director during the document review. They stated that they were aware that the boiler certifications expired and were reaching out to have them inspected as soon as possible. The Administrator was informed of the finding's at the Life Safety Code Exit Conference on 10/13/22. NJAC 8:39-31.1 (d), (e) NFPA 101-2012 edition Life Safety Code: 19.5.2.2 (1)&(2)	K 521	QAPI on boiler system for compliance for the next 2 quarters. Director of Maintenance to follow up with Building Landlord 2 months before inspection expires and obtain proof of scheduled inspection.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key	K 531		1/3/23

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K 531	Continued From page 9 recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: During record review on 10/12/22, in the presence of the Maintenance Director (MD), and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure 1) there was no documented evidence that all existing elevators; having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes conformed with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key.19.5.3, 9.4.2, 9.4.3). 2) it was determined that the facility failed to test and inspect the elevator's annually with the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Division. This deficient practice was evidenced by the following: 1). An interview was conducted with the MD and RPOD, during the record review and they confirmed currently there is no firefighter's monthly service log. 2). A review of the facility's elevator inspection certificate, revealed that 2 of 2 elevator devices #3 and #4 were last inspected 6/30/21 and are good for use until 6/30/22. In an interview, at 11:30 AM, the facility's MD and RPOD, stated they will communicate with their	K 531	Elevator inspection has been schedule. All residents residing in the facility are potentially affected. Building owner to request Elevator inspection 4 months prior to inspection expiration. Director of Maintenance will complete QAPI on monthly elevator inspections conducted by elevator vender for the next 2 quarters. Results of these montly inspections will be reviewed at the QAPI committee for the next 2 quarters Director of Maintenance/ Administrator to follow up with Building Landlord 4 months before inspection expires and obtain proof of scheduled inspection	

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K 531	Continued From page 10 contracted elevator vendor to have the firefighter's monthly service log conducted and DCA to schedule an inspection as soon as possible. The Administrator was informed of the findings at the Life Safety Code exit conference on 10/13/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to	K 918		11/4/22

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K 918	Continued From page 11 manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility documents on 10/12/22, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for 1-generator log provided by the RPOD and MD by the following: At 09:30 AM, a review of the generator records for the previous twelve months did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. An interview was conducted with the Regional Plant Operations Director at the time of record review, who confirmed no transfer times were currently documented on the facility log provided.	K 918	Generator time documentation will now reflect on report to indicate transfer time of 10 seconds or less to supply service. All residents residing in the facility are potentially affected. Director of Maintenance/ Building Landlord will ensure that the generator vendor is documenting transfer time on monthly service reports. Director of Maintenance will complete QAPI on monthly generator inspections to ensure transfer time is documented next 2 quarters Director of Maintenance will audit/inspect monthly reports from vendor to confirm transfer time is included in report on day of inspection. Results of these montly inspections	

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K 918	Continued From page 12 The Administrator was informed of the findings at the Life Safety Code Exit Conference on 10/13/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918	will be reviewed at the QAPI committee for the next 2 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
315192 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT KEARNY	206 BERGEN AVE KEARNY, NJ 07032

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 K0281	11/08/2022	LSC K0291	11/03/2022	LSC K0345	11/23/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	12/21/2022	LSC K0374	10/31/2022	LSC K0521	11/04/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0531	01/03/2023	LSC K0918	11/04/2022	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?
10/18/2022	☐ YES ☐ NO