STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING _____ B. WING _____	C 09/27/2024

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 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 #: NJ167344 Survey Dates: 09/24/24 through 09/27/24 Survey Census: 107 Sample Size: 26 Supplemental Size: 8 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.	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 observations, interviews, and facility policy review, the facility failed to ensure the NJ Exec [redacted] was within reach for one of one resident (Resident (R) 69) out of a sample of 26 residents reviewed for NJ Exec Order 26.4b1 and preferences. This failure had the potential to cause R69 to have NJ Exec Order 26.4b1. Findings include: Review of R69's "Face Sheet," located under the "Profile" tab of the electronic medical record	F 558	F558: The NJ Exec Order 26.4 for Resident #69 was immediately placed within reach following identification by the state surveyor. All residents have the potential to be affected. The Director of Nursing immediately created a tracker form to ensure all residents' call bells are within reach. All staff were in-serviced on ensuring call bell lights are within residents' reach by the Administrator.	10/22/24

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

Electronically Signed | 10/17/2024

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 558	Continued From page 1 (EMR), revealed R69 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Orde [redacted]. Review of R69's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b, located under the "RAI (Resident Assessment Instrument)" tab, showed a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1 indicating NJ Exec Order 26.4b1 R69 was assessed to have NJ Exec Order 26.4b1 t and required NJ Exec Order 26.4b1 [redacted]. Review of R69's "Monthly Nursing Summary," dated NJ Exec Order 26.4b1 and located under the "Assessments" tab of the EMR, revealed documentation the resident was NJ Exec O and NJ Exec Order 26.4b to NJ Exec Order 26.4b1 and was able to NJ Exec Order 26.4b1 to staff and NJ Exec Order 26.4b1. Review of R69's "Physician Orders," located in the EMR under the "Orders" tab, revealed a physician order, dated NJ Exec Order 26.4b1 for, NJ Exec Order 26.4b1 within reach every shift." Review of R69's "Care Plan," located in the EMR under the "Care Plan" tab and last revised NJ Exec Order 26.4b1 revealed R69 was at NJ Exec O for NJ Exec O [redacted] Interventions included to be sure NJ Exec Order 26.4b was within reach and encourage to use it for assistance as needed. During an observation and interview on 09/24/24 at 12:29 PM, R69 was observed seated in NJ Exec O	F 558	The nursing department Unit Managers will conduct weekly audits for a period of six months, in four resident rooms per floor, per shift, to ensure compliance. Audit results will be submitted weekly by the Director of Nursing to the Administrator. The Director of Nursing will also present the findings of the audit in quarterly QAPI meetings, and the findings will be reviewed by the QAPI committee for the next two quarters.	

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F 558	Continued From page 2	F 558		

room in [redacted] wheelchair. [redacted] was on [redacted] bed approximately four feet behind [redacted] and out of reach. R69 stated that [redacted] wanted to get back into [redacted] bed, but [redacted] did not know where [redacted] was.

During an observation and interview on 09/25/24 at 8:42 AM, the [redacted] was observed tied to the bedside rail, hanging down the side of the bed, out of sight, and out of reach of the resident. R69 stated [redacted] did not know where [redacted] was.

During an observation and interview on 09/27/24 at 8:45 AM, R69 was observed resting in bed. The resident's [redacted] was observed on the right side of the bed, on the floor. R69 said [redacted] did not know where [redacted] was.

During an interview on 09/27/24 at 8:46 AM, Licensed Practical Nurse (LPN) 1 entered R69's room for medication administration. LPN1 stated that residents' [redacted] should be placed near their laps or within reach. Upon observation of R69's [redacted] on the floor, she confirmed that it was improperly placed and out of reach of the resident. LPN1 said she would place it back within reach of R69. LPN1 stated that all staff were responsible for ensuring [redacted] were accessible.

During an interview on 09/27/24 at 8:48 AM, Registered Nurse (RN) 1 confirmed that all staff were responsible for ensuring [redacted] were in reach of the residents. Upon entering R69's room, LPN1 informed RN1 that she had picked the [redacted] up off the floor and placed it within reach of the resident. RN1 stated that all staff should ensure [redacted] were accessible to residents.

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F 558	Continued From page 3	F 558		
F 561 SS=E	NJAC 8:39-4.1(A) Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to honor residents'	F 561	F561: All alert and oriented residents were	10/22/24

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F 561	Continued From page 4 choices to have their food warmed by staff members daily for 99 of 107 residents that received meals in the facility. This failure resulted in the residents' choices being denied. Findings include: During a group meeting of 19 alert and oriented residents on 09/26/24 at 2:01 PM, the residents stated they had concerns related to staff not being allowed to heat food up for them if they wanted something heated up after 7:00 PM. The residents stated that in the past, the nurse aides could take food to the breakroom and heat it up for the residents, but they could no longer do that. The residents stated they had been told it was facility policy that foods could not be heated up for them after 7:00 PM because dietary staff were no longer present at the facility. During an interview on 09/27/24 at 3:22 PM, Certified Nursing Aide (CNA) 4 confirmed she was not allowed to heat up food for residents and residents could not have their food warmed up after 7:00 PM daily. During an interview on 09/27/24 at 3:27 PM, the U.S. FOIA (b)(6) confirmed dietary staff were the only staff trained and allowed to reheat food for the residents, and residents, family members and nursing staff were not allowed to reheat food. The U.S. FOIA (b)(6) acknowledged the kitchen hours were from 5:30 AM to 7:00 PM daily, so residents could have their food warmed up during those hours. The US FOIA (b) (6) also stated that only allowing the kitchen staff to reheat food for the residents was to prevent unsafe temperatures of the food.	F 561	informed by the Administrator, Director of Nursing, and Activity Director that they may request their food to be warmed at any time. They were advised to report concerns about food warming immediately to the Administrator, Director of Nursing or Shift supervisor. All residents have the potential to be affected. Immediate training of all staff was carried out by the facility Dietitian to make sure temperatures are met and measured if residents' food is warmed during the after-hours. Additional education was provided by the Infection Prevention Nurse to ensure that all infection control guidelines are met by staff when handling residents' food and temperature measuring devices. Resident microwave food log created and implemented on the floor including date, time, and whether temperatures were checked for compliance. The log will be on each unit of the building. An updated Policy on the warming of resident's food was drafted, reviewed and passed by the administrative staff. Weekly audits of the food warming log will be conducted by the Administrator, with results reported by the Administrator and reviewed by the QAPI committee for the next two quarters.	

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F 561	Continued From page 5	F 561		

During an interview on 09/27/24 at 3:51 PM, the US FOIA (b) (6) and US FOIA (b) (6) for Hospitality verified that dietary staff were allowed and trained to reheat the resident's food in the facility. The U.S. FOIA (b)(6) stated the dietary staff were trained to prevent food borne illnesses while other staff, residents, and families were not trained.

During an interview on 09/27/24 at 4:22 PM, Resident (R) 8 stated residents had until 7:00 PM to ask the kitchen staff to warm their food as they were the only staff allowed to do it.

During an interview on 09/27/24 at 4:32 PM, CNA3 indicated the kitchen staff heated up food for residents during hours of operation. CNA3 also indicated nursing staff were not allowed to heat up food for residents.

During an interview on 09/27/24 at 4:38 PM, R49 indicated NJ Exempt had asked the nursing staff to heat up NJ Exempt food after 7:00 PM and was told the kitchen staff had to do it when they were open.

Review of the facility's undated policy titled, "Resident Rights," provided by the facility, revealed, "Purpose: To ensure all facility staff (including employees, consultants, contractors, volunteers, and other caregivers who provide care and services to residents on behalf of the facility) observe and respect residents' right. Policy: All facility staff shall observe resident rights. Facility staff will recognize and respect residents right to make individual choices. Facility staff will educate and provide risk vs [versus] benefits if applicable . . ."

Review of the facility's policy titled "Food

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F 561	Continued From page 6 Reheating," dated 01/24/24 and provided by the facility, revealed, "Policy: To ensure the safe reheating of food for residents, this policy outlines the procedure for reheating meals. Procedure: Only dietary staff are permitted to reheat food for residents to the appropriate temperature at their request. Reheating services are available from 5:00 AM to 7:00 PM daily by the dietary department. A list of available food, snacks, and beverages will be provided and served by the nursing department during off hours." NJAC 8:39-4.1(a)	F 561		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		10/22/24

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F 656	Continued From page 7 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan directing measurable goals and interventions related to the use of an NJ Exec Order 26.4b1 for one of five resident (Resident (R) 105) reviewed for unnecessary medications out of a total sample of 26. This failure placed the resident at risk for NJ Exec Order 26.4b1 and the inability to monitor for signs and symptoms of NJ Exec Order 26.4b1. Findings include: Review of R105's "Comprehensive Care Plan," located in the electronic medical record (EMR) under the "Care Plan" tab, revealed R105 was	F 656	F656: Resident #105 Care Plan was immediately updated to include the use of NJ Exec Order 26.4b1 medication. All residents on anticoagulants have the potential to be affected. An audit for residents using anticoagulant medications was immediately conducted by the Director of Nursing. Unit managers were in-serviced by the Director of Nursing on ensuring that the care plan for anticoagulants is implemented for residents in real time. All care plans will be updated in real time by the facility Unit Managers for new admissions or upon the	

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F 656	Continued From page 8 admitted to the facility on [redacted] with diagnoses that included [redacted]. Review of R105's "Medication Administration Record (MAR)," dated [redacted] and located under the "Orders" tab of the EMR, revealed R105 received [redacted] (an [redacted] used in the treatment of [redacted]) [redacted] milligrams (mg) twice daily. Review of R105's "Comprehensive Care Plan," did not show a focus, measurable goals, or interventions for the use of the [redacted] medication. During an interview with the [redacted] on 09/27/24 at 3:45 PM, the [redacted] stated that a resident receiving any type of [redacted] should be care planned for [redacted] by the clinical staff. Review of the facility's policy titled, "Interdisciplinary Plan of Care Policy," revealed, ". . . This facility shall provide an individualized, interdisciplinary plan of care for all residents that shall be appropriate to the resident's needs, strengths and goals . . . A comprehensive person-centered care plan for each resident shall be developed and implemented that includes measurable objectives and timeframes to meet a resident's medical, nursing . . . needs . . ." NJAC 8:39-11.2 NJAC 8:39-27.1(a)	F 656	adjustment of orders for residents. Weekly audits of residents on anticoagulants will be conducted on each floor by the unit manager identifying residents' medication/dose, diagnosis and if care plan is active. Results of these audits will be submitted to the administrator on a weekly basis. Results of these audits will be reported by the Director of Nursing and reviewed by the QAPI committee for the next two quarters.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		10/22/24

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F 677	Continued From page 9 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide assistance with NJ Exec Order 26.4b1 for one of three residents (Resident (R) 14) reviewed for activities of daily living (ADLs) out of a total sample of 26. This failure increased the potential for R14 to have NJ Exec Order 26.4b1. Findings include: Review of the facility's policy titled, "Shower Sheets," approved 02/14/24, revealed, "To ensure accurate documentation of resident showers. This policy applies to all nursing staff providing shower assistance with showers. After assisting with or observing a resident's shower, staff will complete the Shower Sheet for that day. The following information must be included: Date of the shower . . . Observations of the resident's skin condition . . . Residents will be offered showers on their assigned days. If a resident requests a shower on a non-shower day, it will be accommodated. If a resident refuses a shower, this must be noted on the Shower Sheet . . ." Review of the facility's policy titled, "ADL [activities of daily living] Documentation Flow Sheet," last revised 07/16/24, revealed, "The ADL performance level will be documented daily utilizing the ADL documentation flow sheet in the Point of Care (POC) kiosks. The flow sheet will reflect the ADL performance of a resident in a 24 hour period including . . . Bathing/Showering . . .	F 677	F677: Resident #14 was given a NJ Exec Order 26 by Certified Nursing Aide. All residents have the potential to be affected. Nurses and Certified Nursing Aides were educated by the Director of Nursing to properly document if a resident refuses shower, re-offering a shower to residents if they refuse and when bed baths are provided to residents. The Director of Nursing also educated Nurses to inform family members and primary care providers if a resident is consistently refusing showers. Unit managers will conduct weekly audits of four residents on the shower logs and care plan updates for those sampled residents who are refusing showers. Results will be submitted to the Administrator weekly. The Director of Nursing will report on the results of the audits, and they will be reviewed by the QAPI committee for two quarters.	

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F 677	Continued From page 10	F 677		

The flow sheet is to be completed by the CNA (certified nursing assistant) assigned . . . The flow sheet identifies three shifts: 7-3, 3-11, and 11-7 for each ADL tasks . . . The Nurse Aide will document the resident's performance in each specific ADL before the end of the shift worked. At the end of the week, all sheets will be reviewed for completeness . . ."

Review of R14's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R14 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1

Review of R14's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b and located under the "MDS" tab of the EMR, revealed R14 had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order which indicated R14 had NJ Exec Order 26.4b1 . It was recorded R14 required NJ Exec Order 26.4b1 , with helper doing NJ Exec Order 26.4b1 the effort. R14 was recorded to have an NJ Exec Order 26.4b1 and was always NJ Exec Order 26.4b1 . The resident was documented to not NJ Exec Orde care.

Review of R14's "Care Plan," located in the EMR under the "Care Plan" tab, dated NJ Exec Order 26.4b1 revealed R14 had an ADL NJ Exec Order 26.4b1 related to medical diagnoses of NJ Exec Order 26.4b1 and required NJ Exec Order 26.4b1 with most ADLS. Interventions included to NJ Exec Order 26.4b1 to the fullest extent possible with

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F 677	Continued From page 11 each interaction. Review of R14's "Care Plan," located in the EMR, revealed no recorded concerns with NJ Exec Order 26.4b of care related to ADLs, including NJ Exec Order 26.4b1 nor that the resident NJ Exec Order 26.4b1 to questions in the NJ Exec Order 26.4b1 Review of R14's "Weekly NJ Exec Order 26.4b1 Assessment" sheets, provided by the facility, documented: NJ Exec Order 26.4b1 Review of NJ Exec Order 26.4b1 revealed NJ Exec opportunities for NJ Exec Order 26.4b1 on R14's scheduled NJ Exec Order 26.4b1 NJ Exec Order 26 days. Out of NJ Exec opportunities, the resident received NJ Exec O NJ Exec Order 26.4b1 NJ Exec NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. There was no documentation that indicated the resident was NJ Exec Order 26.4b1. Record review of R14's "Progress Notes," under the "Progress Notes" tab of the EMR, revealed no	F 677		

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	315192	A. BUILDING _____ B. WING _____	C 09/27/2024

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ALARIS HEALTH AT KEARNY	206 BERGEN AVE KEARNY, NJ 07032

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F 677	Continued From page 12 nursing documentation of the resident [redacted]. "Progress Notes" also failed to document that the resident stated [redacted] when asked questions. Record review of R14's "Point of Care (kiosks)" under the "Task" tab of the EMR and dated [redacted] revealed under "[redacted] 7-3 shift," there was no documentation of "[redacted] Self Performance (how resident takes [redacted] for the 30 day look back period. Record review of R14's "Point of Care (kiosks)" under the "Task" tab of the EMR and dated [redacted] revealed under "[redacted] 7-3 shift," there was no documentation of "[redacted] Support Provided (how resident takes [redacted]" for the 30 day look back period. Record review of R14's "Point of Care (kiosks)" under the "Task" tab and dated [redacted] revealed under [redacted]," there was no documentation of "[redacted] Self Performance (how resident takes [redacted]" for the 30 day look back period. Record review of R14's "Point of Care (kiosks)" under the "Task" tab and dated [redacted], revealed under [redacted]," there was no documentation of "[redacted] Support Provided (how resident takes [redacted]"	F 677		

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F 677	Continued From page 13 for the 30 day look back period. During an observation and interview on 09/24/24 at 2:10 PM, R14 was observed in [NJ Exec O] room and in [NJ Exec] bed. Her [NJ Exec] was noted to be [NJ Exec Order 26.] [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4b1] were observed on the [NJ Exec Order 26.4b1]. [NJ Exec O] stated that [NJ Exec O] did not choose when [NJ Exec O] had [NJ Exec] [NJ Exec Order 26.4b] and could not recall how often [NJ Exec O] was getting them or when [NJ Exec O] had [NJ Exec] last one. [NJ Exec Order 26.] sheet documentation revealed that the resident had received a [NJ Exec Order 26.4b1] During an observation and interview on 09/25/24 at 11:33 AM, R14 was observed in [NJ Exec O] room watching television from [NJ Exec O] wheelchair. Her [NJ Exec O] was again observed to be [NJ Exec Order 26.4b1], and with [NJ Exec Order 26.4b1] . When asked if [NJ Exec O] had received a recent [NJ Exec Order 26.4b] she shook her head and said "no." During an observation and interview on 09/26/24 at 1:30 PM, the [U.S. FOIA (b)(6)] and Certified Nursing Assistant (CNA) 2 entered R14's room and asked the resident if [NJ Exec O] had been [NJ Exec Order 26.4b1] recently. R14 shook [NJ Exec O] head "no." The resident's [NJ Exec O] was again observed to be [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4b1] were observed on the [NJ Exec Order 26.4b1]. The [U.S. FOIA (b)] and CNA2 said that R14 had been getting [NJ Exec O] During an interview on 09/26/24 at 2:40 PM, CNA2 stated that she used a [NJ Exec Order 26.4b1] [] on R14 on the [NJ Exec Order 26.4b1] days. She said that when she [NJ Exec Order 26.4] out R14's [NJ Exec Order 26.4] continued to have [NJ Exec Order] even after [NJ Exec Order 26.4b1] . CNA2 said that R14 would [NJ Exec Order 26.4b1] when asked questions on a regular basis, even if	F 677		

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F 677	Continued From page 14 care had been provided. During an interview on 09/27/24 at 8:54 AM, the U.S. FOIA (b) said that the facility was going to purchase a NJ Exec Order 26.4b1 for R14 to NJ Exec Order 26.4b1, instead of what they were currently using on NJ Exec NJ Exec O The U.S. FOIA (b) said that R14 NJ Exec Order 26.4b1 even when NJ Exec O was receiving NJ Exec Order 26.4b1 During a follow-up interview on 09/27/24 at 10:35 AM, CNA2 said that R14 NJ Exec Order 26.4b1 She stated that she wrote down the NJ Exec Order 26.4b that were given on the NJ Exec Order 26 sheets and in the computer kiosk. She said that she would document on the days the resident received a NJ Exec Order 26.4 but not when a NJ Exec Order 26.4b1 . CNA2 stated that if a resident refused a NJ Exec Order 26.4 she would let the nurse know so they could document in the resident's record. She confirmed R14 was scheduled to receive NJ Exec Order 26.4 on NJ Exec Order 26.4b1 , and if the resident refused a NJ Exec Order 26.4 she would not ask again until their next scheduled NJ Exec Order 26 day. During an interview on 09/27/24 at 10:42 AM, CNA1 said that aides used shower sheets to document NJ Exec Order 26.4b given on scheduled days. She said if the resident refused a NJ Exec Order 26.4 the aide would go back and try again later. If the resident continued to say "no," they would tell the nurse. CNA1 said that the aides would also chart NJ Exec Order 26.4b in the kiosk system. During an interview on 09/27/24 at 6:10 PM, Registered Nurse (RN) 1 said that if a resident refused a NJ Exec Order 26.4 the CNAs would document the refusal on the NJ Exec Order 26 sheets and then tell the nurse. RN1 said that the nurse would then document the refusal in a progress note, and	F 677		

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F 677	Continued From page 15 then contact the family. She said that the CNA would next offer a [NJ Exec Order 26] on the next scheduled [NJ Exec Order 26] day. NJAC8:39-4.1(a) NJAC 8:39-27.2	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure one of one resident (Resident (R) 51) reviewed for [NJ Exec Order 26] out of a total sample of 26 was offered a snack and/or fluids on [NJ Exec Order 26.4] days when away from the facility during mealtimes and failed to	F 692	F692: Resident #51 was offered a snack immediately upon identification by the surveyor. Residents receiving Dialysis services have the potential to be affected.	10/22/24

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F 692	Continued From page 16 accurately document the resident's NJ Exec Order 26.4b1 . This had the potential to cause NJ Exec Order 26.4b1 incidents and provided inaccurate data for the resident's NJ Exec Order 26.4b1 assessments. Findings include: Review of the facility's policy titled, "Dialysis," dated 05/11/10, revealed, ". . . The nurse admitting the resident will verify the center/clinic, the schedule and transportation arrangement made for the resident. If no transportation arrangement has been made, the nurse will then call and make the transportation arrangement from the resident. The dietary department will be notified of the resident's admission. Type of diet ordered and provided resident with a brown bag (snack) if applicable, on days of dialysis schedule, if Dialysis Center permits. It will be noted on the dietary slip that will be submitted to the dietary department on the day of admission . . ." Review of R51's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R51 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1 . Review of R51's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b and located under the "MDS" tab of the EMR, revealed R51 had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1 which indicated R51 was NJ Exec Order 26.4b1 . It was recorded that the resident received NJ Exec Order 26 while a resident at the facility.	F 692	Dialysis communication form was updated to reflect that a snack will be offered to residents prior to leaving the facility for dialysis services. The administrator informed dietary staff to prepare snacks in a paper bag for dialysis residents with resident's name labeled, and to give the bag to the nurse on duty date of dialysis. Clinical staff were in-serviced by the Director of Nursing to ensure residents receive their snacks bags prior to going to dialysis. A weekly audit by the unit managers to make sure residents receive snacks bags prior to going to dialysis. Results of these audits will be submitted to the administrator on a weekly basis. Results of these audits will be presented by the Director of Nursing and reviewed by the QAPI committee for the next two quarters.	

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F 692	Continued From page 17 Review of R51's "Care Plan," located in the EMR under the "Care Plan" tab and dated [redacted], revealed R51 needed [redacted] related to [redacted]. Interventions included to encourage the resident to go for the scheduled [redacted] appointments. Pick up time was [redacted]. The Care Plan intervention identified a [redacted] center location that was no longer used after a physician order change on [redacted] Review of R51's "Care Plan," located in the EMR under the "Care Plan" tab, last revised [redacted], revealed R51 was at nutritional risk related to ". . . [redacted] on [redacted] . . ." Interventions included to encourage [redacted] and to maintain communication with the [redacted] center related to [redacted] of care. Review of R51's EMR under the "Orders" tab revealed an order, dated [redacted], for the resident to go to [redacted] at a different location than identified in the [redacted] care plan. During an observation and interview on 09/24/24 at 3:36 PM, R51 said [redacted] went to [redacted]. [redacted] said [redacted] leaves the facility at [redacted] and gets back about this time [redacted] stated [redacted] had just returned from [redacted] and that the facility did not send [redacted] with any food. [redacted] said [redacted] used to go out with food on [redacted] days, with a sandwich and juice. R51 showed a bag with some [redacted] inside and stated that [redacted] would sometimes bring [redacted] the [redacted] so [redacted] would have something to eat.	F 692		

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F 692	Continued From page 18	F 692		

[redacted] confirmed that [redacted] ate breakfast at approximately 8:00 AM, and then did not eat again until [redacted] returned from [redacted]. [redacted] stated [redacted] was [redacted] At this time, Registered Nurse (RN) 1 brought a food tray to the resident and said [redacted] had reheated [redacted] lunch tray. R51 said that this was a problem, because [redacted] now had lunch brought to [redacted] so late, they would be bringing dinner soon, too.

During an interview on 09/26/24 at 9:15 AM, R51 said [redacted] was preparing to go out to [redacted] but had run out of the [redacted] had provided.

During an interview on 09/26/24 at 9:30 AM, RN1 said that it was [redacted] understanding that the resident was not sent out to [redacted] with anything to eat or snack on because of infection control concerns.

During a subsequent interview on 09/26/24 at 9:40 AM, RN1 said that the facility would be sending the resident with a snack since [redacted] "is complaining of being [redacted] when [redacted] is gone." RN1 confirmed that because the resident was also [redacted] NJ Exec Order 26.4b1

During an interview on 09/26/24 at 10:50 AM, the [redacted] US FOIA (b) (6)) said that she believed the resident was not supposed to take anything to eat or drink because the [redacted] center was concerned about infection control during the procedure. She stated she was not sure if this was identified in a [redacted] contract or if there was any documented communication with the [redacted] center stating this to the facility staff.

On 09/26/24, the [redacted] provided a document

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F 692	Continued From page 19	F 692		

titled, "Patient's Acknowledgement of Risks for Eating and Drinking Hot Liquids on [NJ Exec Order 26.4b1]. This form recorded, ". . . strongly recommends that I do not eat food or drink hot liquids while I am on the[NJ Exec Order 26.4b1] . . ." The form was signed on [NJ Exec Order 26.4b], prior to the admission to the facility, or to the new [NJ Exec Order 26] location ordered on [NJ Exec Order 26.4b].

During an interview on 09/27/24 at 10:35 AM, Certified Nursing Assistant (CNA) 2 said that when a resident ate their meals, the aides documented the meal percentages in the Point of Care (POC) kiosk system. She said she worked during the breakfast and lunch meal service, and she would capture the intake percentages at the end of her shift.

Record review of R51's "Point of Care (kiosks)" under the "Task" tab for "Eating Percentage," documented that the resident had eaten [NJ Exec] lunch on NJ Exec Order 26.4b1 when the resident was not present at the facility. Meal intake in the 30 day look back period regularly documented the resident meal intakes for breakfast and lunch at similar times, when the resident was at [NJ Exec Order 26] or revealed a delay in meal intake of six to eight hours.

During a phone interview on 09/27/24 at 11:37 AM, the current [NJ Exec Order 26] center that R51 attended was contacted. The U.S. FOIA (b)(6) stated that the resident would not be allowed to eat while on the [NJ Exec Order 26] system, but residents were not prevented from bringing or eating a drink and snack prior or after the procedure. She stated that it would be important to provide these items, especially if they were [NJ Exec Order 26.] and had to manage their[NJ Exec Order 2] . She said residents often brought these items because they were "on the side of

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F 692	Continued From page 20 humanity." During an interview on 09/27/24 at 6:10 PM, RN1 said that the CNAs should capture meal intakes within an hour or two after meals were served, or at the end of the day when their shifts were over. She stated that the aides knew their residents, so they could remember how much they ate during the multiple meal services and document it accurately in the kiosk system. NJAC 8:39-17.1, 17.2	F 692		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced	F 757		10/22/24

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F 757	Continued From page 21 by: Based on record review, staff interview, and policy review, the facility failed to ensure staff followed physician ordered parameters for NJ Exec Order 2 [redacted] medications for one of five residents (Resident (R) 105) reviewed for unnecessary medications. R105 received NJ Exec Order 26.4b1 medications when the NJ Exec Order 26 [redacted] was NJ Exec Order [redacted] the parameters set by the attending physician. This had the potential to cause NJ Exec Order 26.4b1 for the resident. Findings include: Review of R105's "Comprehensive Care Plan," located under the "Care Plan" tab of the electronic medical record (EMR), revealed R105 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1 [redacted]. Review of R105's "Medication Administration Record (MAR)," located under the "Orders" tab of the EMR and dated NJ Exec Order 26.4b1 revealed R105 was to receive NJ Exec Order 26.4b1 [redacted], NJ Exec Order 26.4b1 [redacted] times daily. Instructions were to hold both medications if NJ Exec Order 26.4b1 [redacted]. Further review of R105's "MAR" revealed: NJ Exec Order 26.4b1 [redacted]. It was recorded R105 received both the NJ Exec Order 26.4b	F 757	F757: Resident #105's vital signs were assessed, and the Primary Care Doctor was notified following a medication error. The nurse involved was disciplined and re-educated. All residents have the potential to be affected. All staff nurses were immediately educated by the Director of Nursing on following proper medication parameters, as outlined in physician orders, and on avoiding unnecessary drug regimen. The Director of Nursing immediately conducted an audit on Hypertension/Hypotension medication with parameters. Unit managers will conduct weekly audits on five residents to ensure that the nurses are consistently following up on the prescribed parameters. In case of any errors, staff will receive an in-service by the Director of Nursing and report the medication errors to the Director of Nursing and the Primary Care Doctor immediately. Results of these audits will be submitted to the administrator on a weekly basis. Results of these audits will be reported by the Director of Nursing and reviewed by the QAPI committee for the next two quarters.	

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F 757	Continued From page 22 NJ Exec Order 26.4b1 at these times even though the NJ Exec Order 26.4b1 was below the physician ordered parameter NJ Exec Order 26.4b1 On 09/27/24 at 4:10 PM, Registered Nurse (RN) 3, who administered R105's medications on the above referenced dates and times, stated, "I'm aware of the NJ Exec Order 26.4b1 parameters and do not give either of the NJ Exec Order 26.4b1 medications if the NJ Exec Order 26.4b1 RN3 confirmed the MAR recorded the medications were administered on the above referenced dates and times. She stated, "Yes. It shows that I gave the medication but I'm sure that I didn't give it." RN3 was asked if there was documentation the medications were held. She stated, "No, it shows I gave the meds." Review of the facility's policy titled, " Medication Administration," revised 01/20/24, revealed, ". . . Medications shall be administered in a safe and timely manner, and as prescribed. 7. The following information must be check/verified for each resident prior to administering Medications . . . Vital signs, if necessary . . ."	F 757		
F 909 SS=D	NJAC 8:39-27.1(a) Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed	F 909		10/22/24

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

(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 909	Continued From page 23 frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to conduct regular inspections of all bed frames, mattresses, and [NJ Exec Order 26.4b1] as part of a regular maintenance program to identify areas of possible [NJ Exec Order 26.4b1] for one of 26residents (Resident (R) 63) whose beds were observed for [NJ Exec Order 26] safety out of a total sample of 26. The facility failed to ensure R63's [NJ Exec Order 26.4b] were identified and [NJ Exec Order 26.4b] timely when [NJ Exec Order 26.4] which had the potential to cause [NJ Exec Orde] to the resident. Findings include: Review of the facility's policy titled, "Side Rail Policy," last reviewed 07/23/24, revealed, "The purpose of these guidelines is to ensure the safe use of side rails . . . Side rails may be appropriate when used to assist with mobility and transfer and to maintain safety related to the resident's medical condition . . . When side rail usage is appropriate, the facility maintenance department will ensure that side rails are secure and in proper working order. " Review of R63's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR), revealed R63 was admitted to the facility on [NJ Exec Order 26.4b] with diagnoses which included [NJ Exec Order] . Review of R63's "Physician Orders," located in the EMR under the "Order" tab, revealed a physician order on [NJ Exec Order 26.4b] for, "May have [NJ Exec] while in bed every shift."	F 909	F909: Resident #63's [NJ Exec Order 26] was [NJ Exec Order 26.4b] by maintenance following identification by the state surveyor. All residents with side rails have the potential to be affected. Maintenance updated their audit forms to include bed rail functionality. A bed rail functionality order was also added for the nursing department in Point Click Care and for the Certified Nursing Assistants in Point of Care. All staff were in-serviced on identifying defective side rails by the Administrator. Unit managers and supervisors will conduct weekly audits for six months of bed rail functionality in four rooms per floor, per shift. Results will be submitted weekly to the Administrator. The Administrator will report on the findings and they will also be reviewed by the QAPI committee for the next two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING _____ B. WING _____	C 09/27/2024

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 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 909	Continued From page 24 Review of R63's "Care Plan," located in the EMR under the "Care Plan" tab and dated [redacted], revealed R63 had [redacted] on the bed due to [redacted] in bed to [redacted] secondary to [redacted] and [redacted]. Interventions included that the resident and staff were educated on the safe use of [redacted] to assist in [redacted] in bed without the [redacted] and use as an [redacted] to obtain a physician order, and to review [redacted] quarterly. Record review of R63's "Quarterly [redacted] Assessment," dated [redacted], revealed that [redacted] were indicated at the present time to use as an [redacted] and [redacted] Review of R63's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted] and located under the "RAI (Resident Assessment Instrument)" tab, showed a "Brief Interview for Mental Status (BIMS)" score of [redacted], indicating [redacted]. R63 was assessed to have [redacted] on [redacted] and required [redacted] and [redacted] and to go from [redacted] of bed. During an observation on 09/24/24 at 12:34 PM, R63's [redacted] were observed in place on [redacted] of the resident's bed. The [redacted] was observed to be [redacted]. There was an approximate [redacted] between the [redacted] and the mattress.	F 909		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING _____ B. WING _____	C 09/27/2024

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 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 909	Continued From page 25 During an observation on 09/25/24 at 12:30 PM, the NJ Exec Order 26.4b1 on R63's bed was again noted to be NJ Exec Order 26.4b1 [redacted] During an interview on 09/26/24 at 9:15 AM, Registered Nurse (RN) 1 said that nurses would do an initial assessment if they believed a resident would benefit from positioning bed rails, and then therapy would look at the resident. She said that nurses would monitor the bed rails on the Treatment Administration Record (TAR) and check to ensure the bed rails were in place. RN1 confirmed that maintenance would be responsible for ensuring the bed rails were placed and maintained properly. During an observation and interview on 09/26/24 at 9:30 AM, the U.S. FOIA (b)(6) [redacted] confirmed that nurses would determine if they thought a resident might benefit from bed rails, and then therapy would do an assessment. The U.S. FOIA (b) [redacted] said that the nurses on the floor were responsible for ensuring the bed rails were present on resident beds, but they did not monitor bed rail condition or placement. Upon observing R63's NJ Exec Order 26.4b1 [redacted] She said that maintenance would NJ Ex [redacted] the NJ Exec Order 26. [redacted], and she would be educating staff to ensure that they not only documented that the NJ Exec Order 26.4b [redacted] were in place on resident beds, but also that they were in safe working condition. During an interview on 09/27/24 at 8:54 AM, RN1 said that nursing staff had a communication book at the nurse station where they could write down repair needs for the maintenance department. Upon review, she confirmed that R63's NJ Exec Order 26. [redacted]	F 909		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING _____ B. WING _____	C 09/27/2024

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 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 909	Continued From page 26 had not been identified as needing [NJ Exec Order 2] During an interview on 09/27/24 at 9:40 AM, the [U.S. FOIA (b)(6)] stated that nurses used a written log at the nurse station to let maintenance know of needed repairs. He said that the nurses did not always document things that needed to be fixed. He confirmed that the process was not very effective in showing what work had been completed and that the maintenance department needed to do a better job of reviewing bed rails to make sure they were not broken and in need of repair. NJAC 8:39-27.1(a)	F 909		

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	11/1/2024 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 F0561	Correction	ID Prefix F0656	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(f)(1)-(3)(8)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	10/22/2024	LSC	10/22/2024	LSC	10/22/2024
ID Prefix F0677	Correction	ID Prefix F0692	Correction	ID Prefix F0757	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.45(d)(1)-(6)	Completed
LSC	10/22/2024	LSC	10/22/2024	LSC	10/22/2024
ID Prefix F0909	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(d)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/22/2024	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	
9/27/2024	☐ 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
	315192	A. BUILDING **01** B. WING _____	**09/27/2024**

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 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
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) on 09/26/24. 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 09/26/24 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 Kearny is a four-story building with a basement built in 1930 with an addition in 1985. It is composed of Type I protected construction. The facility is divided into 12 - smoke zones. The generator does approximately 100 % of the building per[US FOIA (b) (6)]. The current occupied beds are 105 of 119.	K 000		
K 300 SS=F	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 300		10/22/24

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

Electronically Signed | 10/17/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING **01** B. WING _____	**09/27/2024**

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 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 300	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the fire pump was tested with the generator in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) Section 8.3.4.1. This deficient practice had the potential to affect all 105 residents who resided at the facility. Findings include: A review of the facility's untitled fire pump inspection report dated 06/13/24 indicated the fire pump could not be tested with the generator because no one from the generator company was present at the time of testing. During an interview at on 09/26/24 at 12:25 PM, the U.S. FOIA (b)(6) confirmed the fire pump was not tested with the generator. The U.S. FOIA (b)(6) stated he did not read the report. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K 300	K300- The fire pump was tested with the generator in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection System (2011 Edition) Section 8.3.4.1 The Fire Pump Inspection report indicates this testing was completed. The original report had to be revised due to a clerical error. All residents in the facility are potentially affected. Annual fire pump inspections with facility generator will be conducted by the buildings generator and fire alarm company. Director of Maintenance will complete an annual audit on coordinating fire pump testing with facilities generator, with the buildings generator and fire alarm companies. Results of this audit will be presented by the Director of Maintenance and reviewed at the buildings quarterly QAPI Committee meetings.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to	K 761		10/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING 01 B. WING _____	09/27/2024

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 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 761	Continued From page 2 patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure fire doors in the horizontal exit were inspected by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 105 residents who resided at the facility. Findings include: Observations on 09/26/24 from 11:55 AM to 1:25 PM revealed the fire doors in the Endover House were not being inspected annually. A horizontal exit went through the Endover House which had access to three exit stairwells. The fire door rating was painted over in stairwell one, the door was equipped with panic hardware and not the required fire exit hardware, and the door had four holes in the face of the door. Additionally, the fire door rating was painted over in stairwell two. During an interview at the time of each observation, the U.S. FOIA (b)(6) confirmed the fire doors were not inspected in the Endover House, and he would get with the owner of the	K 761	K761- The US FOIA (b) (6) and the building maintenance team were immediately inserviced by the Regional Director of Maintenance on the the facilities horizontal exits. The Director of Maintenance and building maintenance team conducted an immediate audit of all fire doors in the building□s horizontal exits. Building owners were notified that fire doors in the Endeavor House side needed to be inspected annually. The fire door paintings that were obscured were removed or replaced on all of the building□s horizontal exits. Fire exit hardware was immediately purchased and placed on the building□s horizontal exits, replacing the previously used panic hardware. The doors holes on the face of the horizontal exit leading to Endeavor House were repaired. All residents residing in the facility are potentially affected. Director of Maintenance and Building maintenance team will audit all fire doors in the building□s horizontal exits weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. BUILDING **01** B. WING _____	**09/27/2024**

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 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 761	Continued From page 3 facility and advise them that the doors would have to be inspected annually. NJAC 8:39-31.2(e) NFPA 80	K 761	for the next six months to ensure compliance and provide a copy of the audit to the Administrator. Results of these audits will be presented by the Maintenance Director and reviewed at the QAPI committee meetings for the next two quarters.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315192	A. Building 01 - MAIN BUILDING 01 B. Wing	11/1/2024

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0300	Correction Completed 10/22/2024	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 10/22/2024	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
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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	
9/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO