

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

PRINTED: 05/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 06/26/23 to 06/29/23 Survey Census: 81 Sample Size:18 Supplemental Residents: 0 Intake NJ00156906: Unsubstantiated with no cites. Intake NJ00157718: Unsubstantiated with no cites. Intake NJ00159722: Unsubstantiated with no cites. Intake NJ00160113: Substantiated with a deficiency at F760. Intake NJ00163066: Unsubstantiated with no cites.	F 000			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately code the "Minimum Data Set (MDS)" assessment for one (Resident (R) 58) of 18 residents reviewed for "MDSs" in a total sample of 18 residents. This deficient practice increased the potential for missed opportunities	F 641	MDS for resident #58 was corrected and resubmitted. Accepted by CMS ON 7/6/23. All residents have the potential to be affected.		7/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/18/2023

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.

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

PRINTED: 05/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 641	<p>Continued From page 1 of care or services.</p> <p>Findings include:</p> <p>Review of R58's "Admission Record," undated and located in the electronic medical record (EMR) under the "Profile" tab, indicated an admission date of Ex Order 26.4B1 and diagnoses of Ex Order 26.4B1).</p> <p>Review of R58's MDS with an Assessment Reference Date (ARD) of Ex Order 26.4B1, located in the EMR, under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of Ex Order 26.4B1 out of 15, which indicated R58 was Ex Order 26.4B1.</p> <p>Review of R58's MDS with an ARD of Ex Order 26.4B1 revealed R58 was coded Ex Order 26.4B1 with a diagnosis of Ex Order 26.4B1.</p> <p>Additional review of R58's MDSs revealed an MDS with ARD of Ex Order 26.4B1 was coded as "Yes" for Ex Order 26.4B1 an MDS with ARD of Ex Order 26.4B1 was coded as "Yes" for Ex Order 26.4B1, MDS with an ARD of Ex Order 26.4B1 was coded as "Yes" for Ex Order 26.4B1 and an MDS with an ARD of Ex Order 26.4B1 was coded as "No" for Ex Order 26.4B1.</p> <p>Review of R58's EMR revealed a "History and Physical" completed by R58's primary care physician on Ex Order 26.4B1 and did not list Ex Order 26.4B1 as a diagnosis. Further review of R58's EMR revealed that R58 was seen by the facility Ex Order 26.4B1 on Ex Order 26.4B1 and Ex Order 26.4B1 and had a diagnosis of Ex Order 26.4B1 with Ex Order 26.4B1. The Ex Order 26.4B1 noted no adjustments to R58's</p>	F 641	<p>Certified Reimbursement Specialist will re-Inservice US FOIA (b)(6) on accurate coding of the MDS for documented diagnosis.</p> <p>Certified Reimbursement Specialist in-serviced US FOIA (b)(6) to thoroughly audit hospital records to capture accurate psychiatric diagnosis prior to coding and submission of MDS.</p> <p>Certified Reimbursement Specialist will audit MDS coding on 5 residents weekly for monthly for 3 months to verify accurate MDS coding.</p> <p>Certified Reimbursement Specialist will audit MDS coding on 5 residents weekly for monthly for 3 months. Results of these audits will be discussed with MDS Coordinator and DON on a monthly basis for any corrective action.</p> <p>All findings will be reported and reviewed monthly and reported quarterly during the QAPI meeting for the next 2 quarters by MDS Coordinator or designee to the QAPI committee. Evaluation by the committee to determine continuing frequency of audits.</p>		

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

PRINTED: 05/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 641	<p>Continued From page 2</p> <p>medication since R58 was NJ Ex Order 26.4b1 and needed time to adjust. Additional review of R58's hospital documentation revealed no documentation of a Ex Order 26.4B1 diagnosis.</p> <p>During an interview on 06/28/23 at 3:00 PM, the US FOIA (b)(6) stated R58 was being "... treated for Ex Order 26.4B1 Ex Order 26.4b1 was in process ..." and "the MDS is coded for what is being treated." The US FOIA (b)(6) was unable to state during the interview where the diagnosis was found for them to code on the MDS. According to the "current" diagnoses for R58, Ex Order 26.4B1 was not listed.</p> <p>During the same interview on 06/28/23 at 3:00 PM the US FOIA (b)(6) stated the Ex Order 26.4B1 diagnosis "... had been resolved and was no longer current ..." The US FOIA (b)(6) showed this surveyor the "... resolved ..." medical diagnoses, in the EMR, for R58 and Ex Order 26.4B1 was listed as resolved as of Ex Order 26.4B1 However, the US FOIA (b)(6) was unable to provide any documentation that reflected the Ex Order 26.4B1 diagnosis was resolved.</p> <p>Review R58's Ex Order 26.4B1 progress notes, located in the EMR, under the "Miscellaneous" tab, revealed a note dated Ex Order 26.4B1 with details for a Ex Order 26.4B1 of and a diagnosis of "... Ex Order 26.4B1 Ex Order 26.4B1 ..."</p> <p>During an interview on 06/29/23 at 11:10 AM, the US FOIA (b)(6), they confirmed that R58 should have been coded on each MDS as "Yes" for Ex Order 26.4B1 as there was no related documentation from the physician or Ex Order 26.4B1 that stated R58 did not</p>	F 641			

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

PRINTED: 05/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 641	Continued From page 3 have Ex Order 26.4B1 symptoms. The TS FOUR also stated the facility did not have a specific policy related to MDS coding, but that the MDS nurses follow the RAI manual.	F 641			
F 760 SS=D	NJAC 8:39-11.1(e)1,2 Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Complaint # NJ 160113 Based on interview, record review and facility policy review, the facility failed to ensure one (Resident (R)186) of six residents for medication services received their prescribed medication. This deficient practice could allow residents to have NJ Exec Order 26.4b1 or put them at NJ Exec Order 26.4b1 Ex Order 26.4B1 Findings include: During an interview on 06/27/23 at 11:39 AM, R186 stated NJ EX was discharged on Ex Order 26.4B1 R186 stated that NJ EX was supposed NJ Ex Order 26.4b1 a couple of days prior. While he remained in the facility R186 stated NJ EX did not receive NJ EX Ex Order 26.4 Ex Order 26.4B1 medication or NJ EX Ex Order 26.4B1 Review of R186's electronic medical record (EMR) revealed an undated "Admission Record" located under the "Profile" tab with an admission on Ex Order 26.4B1 and a discharge on Ex Order 26.4B1 R186	F 760	No corrective measure was done for resident #186 as resident has been discharged home. All residents receiving medication could have the potential to be affected. In-service for nurses conducted by Director of Nursing or designee on medication administration and proper documentation. Nurses in-serviced by Director of Nursing to review EMAR prior to shift ending to capture any missed documentation and correct immediately. Daily audits by UM or supervisor & that would be the review on the dashboard to look for reds for missed signatures prior to shift ending and/or to review the past 24 hours.		7/31/23

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

PRINTED: 05/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 760	<p>Continued From page 4</p> <p>was admitted with diagnoses of Ex Order 26.4B1</p> <p>Ex Order 26.4B1</p> <p>Review of R186's EMR revealed an admission "Minimum Data Set (MDS)" assessment, located under the "MDS" tab with an Assessment Reference Date (ARD) of Ex Order 26.4B1. A Brief Interview of Mental Status (BIMS) revealed a score of Ex Order 26.4B1 out of 15, indicating Ex Order 26.4B1</p> <p>Review of R186's EMR revealed physician orders, located under the "Order" tab, indicated orders for the following medications:</p> <p>Ex Order 26.4B1 Ex Order 26.4B1]</p> <p>Give Ex Order 26.4B1 by mouth one time a day for Ex Order 26.4B1 ."</p> <p>Ex Order 26.4B1 Ex Order 26.4B1 Give Ex Order 26.4B1 tablet by mouth Ex Order 26.4B1 times a day for Ex Order 26.4B1</p> <p>Ex Order 26.4B1 Ex Order 26.4B1 Give Ex Order 26.4B1 tablet by mouth two times a day for Ex Order 26.4B1"</p> <p>Review of R186's "Medication Administration Record (MAR)," dated Ex Order 26.4B1, located under the "Orders" tab in the EMR, revealed the Ex Order 26.4B1 were not given on the evening of Ex Order 26.4B1</p> <p>During an interview on 06/28/23 at 11:36 AM, Licensed Practical Nurse (LPN)1 was asked to review R186's MAR for Ex Order 26.4B1. LPN1 reviewed and was asked about the blank spaces on Ex Order 26.4B1 for the medications. LPN1 indicated there should not be any blank spaces on the MAR. LPN1 stated, "There should be notes written if the resident refused the medication or why it was not given." LPN1 reviewed the notes and stated, "I cannot find any notes as to why the medication was not given."</p>	F 760	<p>Director of Nursing or designee will review 5 resident medical record for missing documentation weekly for 3 months then monthly.</p> <p>All findings will be reported and reviewed monthly and reported quarterly during the QAPI meeting for the next 2 quarters by DON or designee to the QAPI committee. Evaluation by the committee to determine continuing frequency of audits.</p>		

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

PRINTED: 05/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 760	<p>Continued From page 5</p> <p>During an interview on 06/29/22 at 10:45 AM, Unit Manager (UN)1 was asked about the medication and blank spaces on the MAR. UN1 stated there should be a note as to why the medication was not given. UN1 stated, "UN1 should have gotten the medications on that shift."</p> <p>During an interview on 06/29/23 at 11:44 AM, the US FOIA (b)(6) was asked to review the MAR and the notes. She confirmed the blanks for the evening of NJ EXES 01067 2540 and stated, "There should not be any delay in receiving medications. They should have been given."</p> <p>Review of the facility policy titled, "Missed Medication," with a review date of 09/2022, revealed, "Policy: to provide guidelines for handling missed medications administrations to ensure patient safety and effective medication management. . ."</p> <p>NJAC 8:39-29.2(d)</p>	F 760			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315366	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 7/31/2023
NAME OF FACILITY ALARIS HEALTH AT BELGROVE	STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 F0641	Correction	ID Prefix F0760	Correction	ID Prefix	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.45(f)(2)	Completed	Reg. #	Completed
LSC	07/31/2023	LSC	07/31/2023	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/29/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

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

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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	E 000			
K 000	<p>An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 06/28/2023. The facility was found to be in compliance with 42 CFR 483.73.</p> <p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/28/23 and was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.</p> <p>Alaris Health at Belgrove is a five story building built in 1927. It is composed of Type II protected construction. The facility is divided into nine smoke zones. The generator does approximately 40 percent of the building as per the ^{US FOIA (b)(6)} [REDACTED]. The current occupied beds are 81 out of 118.</p>	K 000			
K 351 SS=F	<p>Sprinkler System - Installation CFR(s): NFPA 101</p> <p>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</p>	K 351			7/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/21/2023

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.

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

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 351	Continued From page 1 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, the facility failed to ensure the facility was protected throughout by an approved automatic sprinkler system in accordance with NFPA 13 (Standard for the Installation of Sprinkler Systems) 2010 Edition, Section 8.15.10.1. This deficient practice had the potential to affect 81 residents. Findings include: An observation on 06/28/23 at 2:46 PM revealed the electrical closet, located on the Main Level and adjacent to the kitchen, measured four inches by six feet, contained an electrical panel and was not equipped with a sprinkler head. During an interview at the time of the observation, the Regional Maintenance Director 1 confirmed a sprinkler head was not in the electrical closet and stated he thought the room was small enough to not have a sprinkler head. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25 Portable Fire Extinguishers	K 351	Vendor scheduled to install new sprinkler head. All residents have the potential to be affected. The Maintenance Director will make monthly rounds to ensure all sprinkle heads are in place for the next 6 months. The Maintenance Director will report the results of these audits to the Administrator on a monthly basis. The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the 2 quarters.		
K 355 SS=F		K 355			7/21/23

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

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 355	<p>Continued From page 2 CFR(s): NFPA 101</p> <p>Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire extinguishers were provided for the protection of both the building structure and the occupancy hazards regardless of the presence of any fixed fire suppression systems in accordance with NFPA 10 Section (Standard for Portable Fire Extinguishers) 2010 Edition, Section 5.4.2. This deficient practice had the potential to affect 83 residents.</p> <p>Findings include:</p> <p>An observation at 2:35 PM on 06/28/23 revealed the laundry contained two residential washing machines, two clothes dryers, and clothing. The laundry did not have a portable fire extinguisher.</p> <p>During an interview at the time of the observation, the Regional Maintenance Director 1 confirmed the laundry did not have a portable fire extinguisher and stated he did not think the laundry needed one since the washing machines were residential type.</p> <p>NJAC 8:39-31.1(c), 31.2(e) NFPA 10</p>	K 355	<p>Vendor installed new fire extinguisher in laundry room.</p> <p>All residents have the potential to be affected.</p> <p>The Maintenance Director will make monthly rounds to ensure all portable fire extinguishers are working properly for the next 6 months</p> <p>The Maintenance Director will report the results of these audits to the Administrator on a monthly basis. The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2 quarters</p>		
K 741 SS=E	<p>Smoking Regulations CFR(s): NFPA 101</p>	K 741			7/24/23

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

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 741	<p>Continued From page 3</p> <p>Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a metal container with a self-closing cover device into which an ashtray could be emptied was readily available to the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4(6). This deficient practice had the potential to affect five residents who utilized the smoking area.</p>	K 741	<p>New compliant ashtray ordered and will replace existing ashtray in smoking area.</p> <p>All residents who smoke have the potential to be affected.</p> <p>Director of Maintenance will audit appropriate ashtray are available monthly</p>		

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

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 741	Continued From page 4 Findings include: An observation on 06/28/23 at 3:00 PM revealed the smoking area had two NJ Ex Order 26.4b1 listed freestanding cigarette butt receptacles but did not have a metal container with a self-closing cover device. During an interview at the time of the observation, the Regional Maintenance Director 1 confirmed there was no metal container with a self-closing cover device. He stated he considered the freestanding receptacle to meet both requirements of an ashtray and self-closing container.	K 741	over the next 2 quarters The Maintenance Director will report the results of these audits to the Administrator on a monthly basis. The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2 quarters		
K 911 SS=F	NJAC 8:39-31.2(e) Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure junction boxes were provided with a cover compatible with the box and suitable for the condition of use in accordance with NFPA 70 (2011 Edition) section 314.28(C). This deficient practice had the potential to affect 50 residents.	K 911	Appropriate Covers were placed on Junction boxes located adjacent to room 301, adjacent to second floor electrical room and adjacent to Therapy gym and adjacent to room 102. All residents have the potential to be affected.		7/21/23

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

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 911	Continued From page 5 Findings include: An observation on 06/28/23 at 1:36 PM revealed a junction box, located above the ceiling tile adjacent to Room 301, contained low voltage wiring and did not have a cover compatible with the box. An observation on 06/28/23 at 1:59 PM revealed a junction box, located above the ceiling tile adjacent to the second floor Electrical Room, contained low voltage wiring and did not have a cover compatible with the box. An observation on 06/28/23 at 2:14 PM revealed two junction boxes, located above the ceiling tile adjacent to Therapy, contained low voltage wiring and did not have covers compatible with the box. An observation on 06/28/23 at 2:23 PM revealed a junction box, located above the ceiling tile adjacent to Room 102, contained low voltage wiring and did not have a cover compatible with the box. During an interview at the time of the observations, the Regional Maintenance Director 2 confirmed the junction boxes did not have covers.	K 911	Director of Maintenance will audit Junction Box monthly to ensure all are covered appropriately with no exposure of wiring for the next 2 quarters The Maintenance Director will report the results of these audits to the Administrator on a monthly basis. The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2 quarters		
K 917 SS=F	NJAC 8:39-31.2(e) Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a	K 917			7/21/23

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

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 917	<p>Continued From page 6</p> <p>distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure cover plates for the electrical receptacles or the electrical receptacles themselves supplied from the life safety and critical branches had a distinctive color or marking to be readily identifiable in accordance with NFPA 99 (Health Care Facilities Code) 2012 Edition, Section 6.6.2.2.3.2. This deficient practice had the potential to affect 83 residents.</p> <p>Findings include:</p> <p>An observation at 1:56 PM on 06/28/23 revealed the electrical receptacle, located on the third floor medication room, was supplied from the critical branch, and did not have a distinctive color or marking.</p> <p>An observation at 2:32 PM on 06/28/23 revealed the electrical receptacle, located on the first floor medication room, was supplied from the critical branch, and did not have a distinctive color or marking.</p> <p>During an interview at the time of the observations, the Regional Maintenance Director 1 confirmed the electrical receptacles were supplied from emergency power and stated since the electrical outlet was dedicated to the medication refrigerator it did not need to be marked.</p> <p>NJAC 8:39-31.2(e) NFPA 99</p>	K 917	<p>Outlet covers have been replaced to distinctive color (red) in the 1st and 3rd floor medication rooms.</p> <p>All residents have the potential to be affected.</p> <p>Director of Maintenance will audit monthly the emergency power outlets to ensure the 1st and 3rd floor medication rooms are connected to red emergency outlets for the next 2 quarters</p> <p>The Maintenance Director will report the results of these audits to the Administrator on a monthly basis.</p> <p>The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2 quarters</p>		

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

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 918 K 918 SS=F	Continued From page 7 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 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:	K 918 K 918			7/21/23

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

PRINTED: 07/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT BELGROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 918	<p>Continued From page 8</p> <p>Based on observation and interview, the facility failed to ensure disconnecting means were legibly marked to indicate its purpose for the Life Safety Code Branch of the Emergency Electrical System (EES) in accordance with NFPA 70 (National Electrical Code) 2011 Edition, Article 110.22. This deficient practice had the potential to affect 83 residents.</p> <p>Findings include:</p> <p>An observation at 4:00 PM on 06/28/23 revealed the disconnecting means for the Life Safety Code Branch of the EES was not marked to indicate its purpose.</p> <p>During an interview at the time of the observation, the Regional Maintenance Director 1 confirmed the Life Safety Code Branch was not labeled correctly and he did not know why they had not been labeled.</p> <p>NJAC 8:39-31.2(e) NFPA 70</p>	K 918	<p>The EES Panel; LS-Panel and EM-Panel has been properly labeled</p> <p>All residents have the potential to be affected.</p> <p>The Maintenance Director will make monthly rounds to ensure to ensure compliance for the next 2 quarters</p> <p>The Maintenance Director will report the results of these audits to the Administrator on a monthly basis.</p> <p>The Maintenance Director will review the findings of the monthly audits at the Quarterly QAPI Meeting for the next 2 quarters</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315366	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 7/31/2023
NAME OF FACILITY ALARIS HEALTH AT BELGROVE	STREET ADDRESS, CITY, STATE, ZIP CODE 195 BELGROVE DRIVE 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 K0351	07/31/2023	LSC K0355	07/21/2023	LSC K0741	07/24/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0911	07/21/2023	LSC K0917	07/21/2023	LSC K0918	07/21/2023
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/29/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			