

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

PRINTED: 11/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT HAMILTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D 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 Survey Date: 3/14/23 Census: 135 Sample: 31 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000			
F 637 SS=D	Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS), an assessment tool used to facilitate the management of care for 1 of 27 residents reviewed, Resident #63, as evidenced by the following:	F 637	Corrective action for the residents affected by the alleged deficient practice: The IDT completed a Significant Change in Status Assessment (SCSA) for resident #63. No negative outcomes were identified by the alleged deficient practice. All residents have the potential to be	4/4/23	

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

TITLE

(X6) DATE

Electronically Signed

03/30/2023

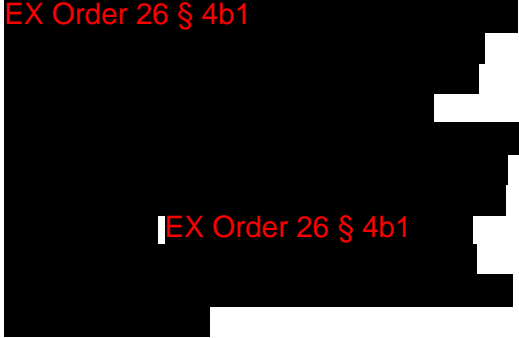

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

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F 637	<p>Continued From page 1</p> <p>The MDS is a comprehensive federal mandated process for clinical assessment of all residents that should reflect the health status of each resident to provide the best quality of care.</p> <p>On 3/2/23 at 12:07 PM, the surveyor observed Resident #63 in bed, with eyes closed. The surveyor also observed that Resident #63 was using a EX Order 26 § 4b1 [REDACTED]</p> <p>On 3/2/23 at 12:24 PM, the surveyor reviewed the hybrid medical records of Resident #63. The resident was admitted to the facility on [REDACTED] and readmitted on [REDACTED] with diagnosis that included but not limited to EX Order 26 § 4b1 [REDACTED].</p> <p>Review of the 12/18/22 Quarterly MDS indicated that Resident #63 had 3 different sites with EX Order 26 § 4b1 [REDACTED]</p> <p>Review of the 1/28/23 Medicare 5 Day MDS indicated that Resident #63 had 1 site with a EX Order 26 § 4b1 [REDACTED]</p> <p>On 3/10/23 at 12:17 PM, the surveyor interviewed</p>	F 637	<p>affected.</p> <p>Measures/Systemic changes put in place to ensure the alleged deficient practice does not re occur: DON re-educated IDT Team on the RAI Manual 3.0 guidelines for SCSA. The DON/ADON will review 5 MDS assessments a every Wednesday for 30 days to determine need for SCSA. Then every other Wednesday for 30 days; then monthly for 6 months on the 1st Wednesday of the month.</p> <p>Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review.</p>	

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F 637	Continued From page 2 the facility's MDS Coordinator who was responsible in completing MDS assessments via a phone call. During the interview, the MDS Coordinator verified that Resident #63 developed more pressure ulcers after 12/18/22 MDS assessments. The MDS Coordinator further stated that a SCSA should have been completed. According to the latest version of the Center for Medicare/Medicaid Services (CMS)- Resident Assessment Instrument (RAI) 3.0 Manual updated October 2019, page 2-22, "A "significant change" is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions" Under page 2-26, "SCSA is required to be performed Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status On 3/10/23 at 1:20 PM, the surveyor met with the facility's Licensed Nursing Home Administrator, Director of Nursing and Regional Registered Nurse who did not provide any further information related to this matter.	F 637			
F 641 SS=D	NJAC 8:39-11.2(i) 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	F 641		4/4/23	

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F 641	<p>Continued From page 3</p> <p>by: Based on observation, interview, and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for 2 of 31 residents (Resident #147, Resident #63) reviewed.</p> <p>The deficient practice was evidenced by the following:</p> <p>The MDS is a comprehensive federal mandated process for clinical assessment of all residents that should reflect the health status of each resident to provide the best quality of care.</p> <p>1. On 3/13/23 at 11:04 AM, the surveyor reviewed the discharged medical records for Resident #147. The resident was admitted to the facility on [REDACTED] with diagnosis that included but was not limited to EX Order 26 § 4b1 [REDACTED]</p> <p>A review of discharge summary dated [REDACTED] documented that the resident was discharged to home.</p> <p>The surveyor reviewed the MDS 3.0 assessments, including all the completed MDS's for Resident #147. The [REDACTED] Discharge Return Not Anticipated MDS indicated that the resident was discharged to an [REDACTED] EX Order 26 § 4b1.</p> <p>On 3/13/23 at 10:30 AM, the Licensed Nursing Home Administrator (LNHA) confirmed that Resident #147 was discharged to home on [REDACTED], during an interview with the surveyor.</p>	F 641	<p>The IDT completed a Significant Change in Status Assessment (SCSA) for resident #63 to ensure that all skin impairments were correctly coded. The MDS assessment for Resident #147 modified to reflect that he was discharged home. No negative outcomes were identified by the alleged deficient practice.</p> <p>All residents with have the potential to be affected.</p> <p>Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: DON re-educated IDT Team on regarding accuracy of MDS coding. The DON or ADON will review 5 MDS assessments every Tuesday for four weeks to ensure accuracy. Then every other Tuesday for for 30 days; then every 1st Tuesday of the month for 6 months.</p> <p>Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review</p>		

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F 641	<p>Continued From page 4</p> <p>2. On 3/2/23 at 12:07 PM, the surveyor observed the resident in bed, with eyes closed. The surveyor also observed that Resident #63 was using a EX Order 26 § 4b1 [REDACTED]</p> <p>On 3/2/23 at 12:24 PM, the surveyor reviewed the hybrid medical records of Resident #63. The resident was admitted to the facility on [REDACTED] and readmitted on [REDACTED] with diagnosis that included but was not limited to EX Order 26 § 4b1 [REDACTED]</p> <p>Review of the 1/28/23 Medicare 5 Day MDS indicated that Resident #63 had EX Order 26 § 4b1 [REDACTED]</p> <p>The facility's Director of Nursing (DON) provided the surveyor a copy of the residents active pressure ulcers which revealed that Resident #63 currently had EX Order 26 § 4b1 [REDACTED]</p> <p>On 3/10/23 at 12:17 PM, the surveyor interviewed the facility's MDS Coordinator who was responsible in completing the MDS assessments via a phone call. During the interview, the MDS Coordinator stated in reference to the 1/28/23 Medicare 5 Day MDS that the following EX Order 26 § 4b1 [REDACTED]</p>	F 641		

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F 641	Continued From page 5 EX Order 26 § 4b1  EX Order 26 § 4b1	F 641			
F 658 SS=D	NJAC 8:39-11.2(e)1 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow professional standards of practice by not administering a current Physician's Order (PO) for 1 of 5 residents reviewed (Resident #109). This deficient practice was evidenced by the following:	F 658	Corrective action for the residents affected by the alleged deficient practice: Resident #109 was seen by EX Order 26 § 4b1  . Trazodone order was discontinued per psych recommendation. No negative outcomes were identified by the alleged deficient practice.	4/4/23	

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F 658	<p>Continued From page 6</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: EX Order 26 § 4b1</p> <p>[REDACTED]</p> <p>On 2/28/23 at 12:27 PM, the surveyor interviewed Resident #109 in the room. The resident verbalized episodes of [REDACTED].</p> <p>According to the admission record, Resident #109 was admitted to the facility on [REDACTED] with diagnoses that included but were not limited to EX Order 26 § 4b1.</p> <p>Review of the most recent Significant Change Minimum Data Set, an assessment tool used to facilitate the management of care, dated [REDACTED], identified that Resident #109 had a Brief Interview for Mental Status (BIMS) of [REDACTED] out of [REDACTED] indicating that the resident was EX Order 26 § 4b1.</p> <p>On 3/9/23 at 9:14 AM the surveyor reviewed Resident #109's hybrid medical record which revealed a form titled, [REDACTED] Associates Follow Up Note" dated [REDACTED] and was completed by the Advanced Practice Registered Nurse (APRN). The APRN wrote a recommendation to start, EX Order 26 § 4b1</p> <p>[REDACTED]</p>	F 658	<p>All resident have the potential to be affected.</p> <p>The DON and ADON in-serviced all nurses on protocol for transcribing physicians orders. The DON/ADON will review 5 written POS and EMRs every Thursday for four weeks to ensure all orders were accurately transcribed. Then every other Thursday for 30 days; then every 1st Thursday of the month for 6 months.</p> <p>Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review.</p>	

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F 658	<p>Continued From page 7</p> <p>EX Order 26 § 4b1 ."</p> <p>On 3/9/23 at 10:00 AM, the surveyor reviewed Resident #109's paper chart which revealed a written PO by the APRN dated [REDACTED] with an initial by the Licensed Practical Nurse indicating "[REDACTED] noted".</p> <p>On 3/9/23 at 10:17 AM, the surveyor interviewed the Registered Nurse (RN) who stated, "The MD will write their order on paper which is the yellow sheet titled Physician's Orders, then the order will be transferred to the electronic medical record under physician the orders section and once the order is saved, it is sent to the pharmacy."</p> <p>On 3/9/23 at 10:40 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM). The RN/UM in the presence of the surveyor reviewed the electronic Medication Administration Record (eMAR) from January 2023 through March 2023. The RN/UM verified that there was no PO for [REDACTED] that was not entered/transcribed in the eMAR as ordered by the APRN from [REDACTED]. The RN/UM confirmed that the resident was not able to take the medication since it was not in the eMAR.</p> <p>A review of the facility's policy titled, "Transcribing Physician Orders" indicated under Policy and Procedure "#2. Orders are transcribed to the electronic medical record, reviewed, acknowledged and saved by the transcriber (licensed nurse) and automatically generates an electronic POS (Physician Order Sheet) and MAR (Medication Administration Record) and TAR (Treatment Administration Record), if applicable" and "#4. All orders shall be reviewed by a</p>	F 658			

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F 658	Continued From page 8 licensed nurse every 24 hours to ensure accuracy and that all orders have been carried out." On 3/13/23 at 1:52 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing and Regional Nurse to discuss the above concern. There was no further information provided.	F 658			
F 756 SS=D	NJAC 8:39-19.4 (a) (1) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756		4/4/23	

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F 756	<p>Continued From page 9</p> <p>action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that the Consultant Pharmacist (CRPh) failed to identify and/or report medication irregularities, which resulted in the administration of EX Order 26 § 4b1 [REDACTED]</p> <p>[REDACTED] (Resident #81) reviewed during medication administration observation.</p> <p>This was evidenced by the following:</p> <p>On 3/6/23 at 8:56 AM, the surveyor observed the Licensed Practical Nurse (LPN) crush medications in preparation for administration to Resident #81 that included EX Order 26 § 4b1 with directions EX Order 26 § 4b1 two times a day.</p> <p>On 3/6/23 at 9:06 AM, the LPN explained the Resident had special instructions documented on the electronic Medication Administration Record (eMAR) which reflected "Medications taken crushed with apple sauce". The LPN stated that is why she crushed Resident #81's medication</p>	F 756	<p>Corrective action for the residents affected by the alleged deficient practice: Regarding Resident #81, the order for EX Order 26 § 4b1 [REDACTED] No negative outcomes were identified by the alleged deficient practice.</p> <p>All residents with orders to crush medications have the potential to be affected.</p> <p>Measures/Systemic changes put in place to assure the alleged deficient practice does not re-occur: DON and Administrator met with CPhR to review expectations of DRR for residents with crush orders. The DON/ADON re-inserviced all nurses to ensure medications can be crushed prior to administering and to read all medication labels. The DON/ADON will review 5 resident charts and DRRs for residents with crush orders Monday for four weeks to ensure crush order compliance. Then every other Monday for 30 days; then monthly every 1st Monday</p>		

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F 756	<p>Continued From page 10 prior to administration.</p> <p>On 3/6/23 at 9:07 AM, the LPN confirmed she was ready to administer the crushed medications to Resident #81. The surveyor interrupted the LPN and asked to review the resident's medication documented in the eMAR.</p> <p>On 3/6/23 at 9:08 AM, the LPN explained that she was not aware that EX Order 26 § 4b1, which should not be crushed. The LPN stated that she did not observe any cautionary on the eMAR for EX Order 26 § 4b1.</p> <p>At that time, the surveyor and the LPN inspected Resident #81's EX Order 26 § 4b1. The bingo card had an affixed cautionary that reflected EX Order 26 § 4b1."</p> <p>During an interview with the LPN, at that time, the LPN stated she should not have crushed the EX Order 26 § 4b1. The LPN indicated that she should have read the cautionary on the bingo card.</p> <p>The surveyor reviewed the medical record for Resident #81.</p> <p>A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in August 2022 with diagnoses which included but was not limited to EX Order 26 § 4b1.</p> <p>A review of the quarterly Minimum Data Set</p>	F 756	<p>of the Month for 6 Months.</p> <p>Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review.</p>		

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F 756	<p>Continued From page 11</p> <p>(MDS; an assessment tool) for the management of care dated [REDACTED] revealed Resident #81 had a Brief Interview for Mental Status (BIMS) score of [REDACTED] out of [REDACTED], which indicated a [REDACTED] [EX Order 26 § 4b1]</p> <p>A review of the Order Review Report (ORR) from admission included</p> <p>A physician's order dated [REDACTED] "May crush crushable medications as necessary if not contraindicated by manufacturer."</p> <p>A review of the corresponding December 2022, January 2023, February 2023, and March 2023 electronic Medication Administration Record (eMAR) revealed [REDACTED] [EX Order 26 § 4b1] were both administered twice a day. This was not in accordance with manufacturer's recommendations to administer the medications whole.</p> <p>A review of the Consultant Pharmacist's (CRPh) Recommendations monthly reports from [REDACTED] through [REDACTED] did not reflect a recommendation to swallow whole, not cut or crush [REDACTED] [EX Order 26 § 4b1]</p> <p>On 3/6/23 at 10:35 AM, the surveyor interviewed the CRPh who verified that he was not the regularly assigned CRPh assigned to the facility but was familiar with the process. The CRPh established that the medication regimen reviews were conducted monthly. The CRPh revealed that he was not aware that the manufacturer of [REDACTED] [EX Order 26 § 4b1] recommended that this medications should be swallowed whole.</p> <p>A review of the manufacturer's specifications for [REDACTED] [EX Order 26 § 4b1]</p>	F 756			

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NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT HAMILTON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302		
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F 756	<p>Continued From page 12</p> <p>titled, Administration Instructions for ^{EX Order 26 § 4b1} and ^{EX Order 26 § 4b1} and EX Order 26 § 4b1</p> <p>The surveyor and [REDACTED] (SP) reviewed the [REDACTED] Therapy report dated [REDACTED], which revealed under section 10a. Consistency of pills/medications: crushed. Further review of the most recent [REDACTED] screen dated [REDACTED] revealed under section 10a. Consistency of pills/medications: crushed.</p> <p>On 3/7/23 at 11:36 AM, the surveyor interviewed the SP who stated that Resident #81's medications were crushed based on the resident's preference. The SP clarified that Resident #81 was not diagnosed with ^{EX Order 26 § 4b1}</p> <p>On 3/8/23 at 10:28 AM, the surveyor interviewed the Director of Nursing (DON) who stated that when a medication cannot be crushed, a cautionary was affixed on the medication packaging by the Provider Pharmacy which was available for the administering nurse to review.</p> <p>The DON explained that the CRPh conducted a medication regimen review on admission, followed by monthly reviews thereafter. The recommendations made by the CRPh were faxed to the facility and reviewed by nursing. The DON reviewed the CRPh reports and verified that she had not received a recommendation from the ^{EX Order 26 § 4b1} to be swallowed whole, not to be crushed.</p> <p>On 3/8/23 at 12:16 PM, the surveyor interviewed</p>	F 756		

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F 756	Continued From page 13 the pharmacy provider representative who stated that cautionary labels were affixed to a medication package based on manufacturer's recommendation. Review of the facility provided "Consultant Pharmacist Reports Policy" revised 2/22/23 by the facility included Procedure, "3. The Consultant Pharmacist will perform monthly drug regimen review on each resident." and "4. Any medication irregularities identified will be documented on a separate, written report and notification to the attending physician, and director of nursing, listing the resident name, relevant drug and irregularity that was identified with the resolution noted by the physician." Review of the agreement between the facility and CRPh dated from January 2017 included under section 2, "a. Review the drug regimen of each resident in Home at least once each month and report in writing any irregularity to Home's Administrator, Director of Nursing Services, and where appropriate, the individual resident's physician;" On 3/8/23 at 1:47 PM, the concern regarding the CP's failure to identify and report the manufacturer specification for [REDACTED] was discussed with the DON, Licensed Nursing Home Administrator (LNHA) and Regional Registered Nurse. No further information was provided.	F 756			
F 842 SS=D	NJAC 8:39-29.3(a)(1)(6) Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		4/4/23	

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F 842	<p>Continued From page 14</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p>	F 842			

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F 842	<p>Continued From page 15</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for 1 of 2 hospice residents reviewed, Resident #100, and was evidenced by the following:</p> <p>On 2/28/23 at 12:48 PM, the Licensed Practical Nurse assigned to the resident informed the surveyor that Resident #100 was on [REDACTED].</p>	F 842	<p>Corrective action for the residents affected by the alleged deficient practice: All hospice notes were obtained and made available in resident #100's chart. No negative outcomes were identified by the alleged deficient practice.</p> <p>All resident on hospice have the potential to be affected.</p> <p>Administrator met with hospice nurse to review requirements of providing facility</p>		

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F 842	<p>Continued From page 16</p> <p>On 3/6/23 at 12:29 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) to determine how often the hospice nurse visits the resident. The RN/UM responded, "it varies". The RN/UM showed the surveyor the area in the resident's physical chart where the [REDACTED] visiting notes were located.</p> <p>On 3/6/23 at 1:16 PM, the surveyor reviewed the hybrid medical records for Resident #100. The resident was admitted to the facility on [REDACTED] with diagnoses that included but not limited to EX Order 26 § 4b1 [REDACTED].</p> <p>A review of the Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate care management dated [REDACTED], indicated a Brief Interview for Mental Status score of [REDACTED] out of [REDACTED] indicating that the resident had EX Order 26 § 4b1 [REDACTED]. The Q/MDS further indicated that the resident was on [REDACTED].</p> <p>A review of Resident #100's physical chart included a form titled, "Communication/Continuation Note" which the RN/UM described as the [REDACTED] care visiting notes. The notes were dated as follows, [REDACTED]. The RN/UM informed the surveyor that the [REDACTED] nurse used their own tablet for their notes when they complete their documentation. The RN/UM indicated that she would check with [REDACTED] if there are any other visiting notes.</p> <p>On 3/10/23 at 11:15 AM, the RN/UM explained that the hospice company was faxing all the documentation from previous hospice visits.</p>	F 842	<p>with complete hospice medical records. DON re-educated all nurses to ensure that all hospice medical records are available in resident charts. The DON/ADON will review the medical records of 3 residents on hospice every Monday for four weeks to ensure medical record compliance. Then every other Monday for 30 days; then every 1st Monday of the month for 6 months.</p> <p>Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review.</p>	

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F 842	Continued From page 17 On 3/13/23 at 12:04 PM, the surveyor interviewed the [REDACTED] nurse assigned to Resident #100 via a phone call. The [REDACTED] nurse revealed "we use our own tablet for our documentation. If the facility calls our office requesting the information, we fax it to the facility." The [REDACTED] nurse explained that notes are left in the chart only when there is communication or orders for Resident #100. On 3/13/23 at 1:52 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing and Regional Nurse to discuss the above concerns. The LNHA acknowledged that hospice visit notes should be kept in the medical records as part of the resident's chart. No further information was provided	F 842			
F 880 SS=D	NJAC 8:39-35.2 (d)(5) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		4/30/23	

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F 880	<p>Continued From page 18</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents</p>	F 880			

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F 880	<p>Continued From page 19 identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to adhere to accepted standards of infection control practices for the proper storage of a [REDACTED] for Resident #116. This deficient practice was identified for 1 of 2 residents who were reviewed for infection control practices.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 2/28/23 at 11:18 AM, the surveyor observed Resident #116 in bed with eyes closed. The surveyor also observed that the resident had a [REDACTED] ([REDACTED]) with a [REDACTED] evident on the side of the bed. The [REDACTED] was in a [REDACTED] that was on the floor.</p> <p>The surveyor reviewed Resident #116's Electronic Medical Record:</p> <p>The Admission record revealed that the resident was admitted to the facility with diagnoses which included but were not limited to [REDACTED] <small>EX Order 28 § 4b1</small></p>	F 880	<p>Corrective action for the residents affected by the alleged deficient practice: The [REDACTED] for resident #116 was removed from the floor and hung securely from the side of his bed.</p> <p>All residents with urinary catheter tubes have the potential to be affected. The facility completed a Directed Plan of Correction: A Root Cause Analysis of the alleged deficient practice was conducted. The IP in-serviced all nurses and C.N.A.s on proper infection control protocols related to urinary catheter tubes based on the findings of the RCA. The facility conducted infection prevention in-services for front line and topline staff as directed by the NJDOH. The IP will conduct weekly audits/observations of 5 residents with urinary catheter tubes. Then every other week for 30 days; then monthly for 6 months.</p> <p>Results of all audits will be discussed at</p>		

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F 880	<p>Continued From page 20</p> <p>EX Order 26 § 4b1</p> <p>Review of the 1/27/23 Re-admission Minimum Data Sheet (MDS) revealed that Resident #116 had a BIMS score of [redacted] of [redacted] which indicated that the resident's cognition was EX Order 26 § 4b1.</p> <p>Review of the March Physician's Order Summary Report revealed that Resident #116 had an active physician order (PO) for a EX Order 26 § 4b1, dated [redacted].</p> <p>On 3/1/23 at 9:40 AM, the surveyor observed Resident #116 lying in bed with their EX Order 26 § 4b1.</p> <p>On 3/1/23 at 9:45 AM, the surveyor interviewed the Registered Nurse (RN). The RN stated the EX Order 26 § 4b1. The RN did not recall if the EX Order 26 § 4b1 bag was connected to the bed when she saw the resident earlier.</p> <p>On 3/2/23 at 1:33 PM, the surveyor expressed their concerns to the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and the Regional Director of Nursing (RDON). The RDON stated that she expected that EX Order 26 § 4b1 of the resident's bed, inside of the EX Order 26 § 4b1, and that they should not be touching the floor. No further information was provided.</p> <p>Review of the facility policy, "Catheter Care,</p>	F 880	the facility's QA Committee quarterly meetings for review.	

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F 880	Continued From page 21 Urinary" with a facility revision date of 12/22 indicated under the Procedure section, "7. Be sure the catheter tubing and drainage bag are kept off the floor." NJAC 8:39-19.4 (a)	F 880			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060906	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2023
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NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT HAMILTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302
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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing	S 560	The Director of Nursing will review staffing daily for following day with the Staffing Coordinator to ensure compliance with regulated staffing ratios. Time off requests will be reviewed by the Director of Nursing and approved or denied based on facility needs to meet staffing ratios. Multiple staff will not be approved to be off on the same day, same shift based on the facility need. The facility is actively recruiting staff, and providing recruiting and sign on bonus. Facility job postings were updated. The facility began using a third agency. The facility has collaborated with a C.N.A course to host the clinical rotations at the facility.	4/10/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/30/23

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060906	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2023
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S 560	<p>Continued From page 1</p> <p>requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:</p> <p>(1) one certified nurse aide to every eight residents for the day shift;</p> <p>(2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and</p> <p>(3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties</p> <p>b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.</p> <p>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.</p> <p>(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.</p> <p>(3) All computations shall be based on the midnight census for the day in which the shift begins.</p> <p>d. Nothing in this section shall be construed to</p>	S 560	<p>All residents have the potential to be affected.</p> <p>The Staffing Coordinator was in-serviced by the Director of Nursing on the minimum staffing ratio requirement. Director of Nursing or ADON will review staffing daily for the following day to assure staffing ratios are met. Facility will continue recruitment with ads placed to hire new Certified Nursing Assistants. A second staffing agency was added to supplement staffing levels.</p> <p>The Director of Nursing will provide weekly staffing ratio reports to the administrator. The Director of Nursing will report staffing ratios to the QA Committee for the next 6 months</p>	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060906	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/14/2023
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NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT HAMILTON PARK	STREET ADDRESS CITY STATE ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	<p>Continued From page 2</p> <p>affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...</p> <p>A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 2/12/23 to 2/18/23 and ending 2/19/23 to 2/25/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total staff on 12 of 14 day shifts as follows:</p> <p>The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows:</p> <ul style="list-style-type: none"> -02/12/23 had 13 CNAs for 147 residents on the day shift, required 18 CNAs. -02/13/23 had 15 CNAs for 145 residents on the day shift, required 18 CNAs. -02/15/23 had 16 CNAs for 145 residents on the day shift, required 18 CNAs. -02/16/23 had 15 CNAs for 144 residents on the day shift, required 18 CNAs. -02/17/23 had 16 CNAs for 144 residents on the day shift, required 18 CNAs. -02/18/23 had 16 CNAs for 143 residents on the day shift, required 18 CNAs. -02/19/23 had 15 CNAs for 142 residents on the day shift, required 18 CNAs. -02/20/23 had 13 CNAs for 142 residents on the day shift, required 18 CNAs. -02/21/23 had 16 CNAs for 141 residents on the day shift, required 18 CNAs. -02/23/23 had 15 CNAs for 141 residents on the day shift, required 18 CNAs. 	S 560		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060906	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/14/2023
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NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT HAMILTON PARK	STREET ADDRESS CITY STATE ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302
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S 560	<p>Continued From page 3</p> <p>-02/24/23 had 16 CNAs for 141 residents on the day shift, required 18 CNAs. -02/25/23 had 11 CNAs for 140 residents on the day shift, required 17 CNAs.</p> <p>The facility's Licensed Nursing Home Administrator, Director of Nursing and Regional Registered Nurse was informed of their deficient practice on 3/2/23 at 1:33 PM.</p>	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315300	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 5/3/2023	Y3
NAME OF FACILITY ALARIS HEALTH AT HAMILTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302		

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 F0637	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	04/04/2023	LSC	04/04/2023	LSC	04/04/2023
ID Prefix F0756	Correction	ID Prefix F0842	Correction	ID Prefix F0880	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/04/2023	LSC	04/04/2023	LSC	04/30/2023
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	

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 3/14/2023		<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		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060906	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/3/2023
Y1	Y2	Y3
NAME OF FACILITY ALARIS HEALTH AT HAMILTON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	04/10/2023	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 _____	
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 3/14/2023
 CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
 YES NO

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

PRINTED: 11/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315300	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT HAMILTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 03/02/23. 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 on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/02/23 and was found not to be in compliance with 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 Hamilton Park is a five-story building constructed in 1980. Residents occupy the fifth floor, third and second floors. The fourth floor is unoccupied at this time. The first floor is office space and dialysis space. The facility has concrete flooring, concrete steel frame roofing and block bearing walls and brick façade exterior. Alaris Health at Hamilton Park is noted to be a type II (222) noncombustible construction with complete sprinkler system and smoke detection in all corridors. The facility has a 125 KW (kilowatt) generator. The facility is without documentation of the percentage of load when tested. The facility has 135 occupied beds. The facility has 12 smoke zones.	K 000		

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

TITLE

(X6) DATE

Electronically Signed

03/30/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315300	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2023
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K 000	Continued From page 1	K 000			
K 211 SS=F	<p>Means of Egress - General CFR(s): NFPA 101</p> <p>Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interview, the facility failed to ensure four of four exit stairways for five floors were provided with special signage within the enclosure at each floor landing in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.2.5.4.1 (A) through (M). This deficient practice had the potential to affect all 135 residents.</p> <p>Findings include:</p> <p>An observation of stairway F-1 on 03/01/23 at 1:50 PM revealed the entire staircase from the fifth to the first floor on each landing was lacking special signage.</p> <p>An observation of stairway F-9 on 03/01/23 at 2:00 PM revealed the entire staircase from the fifth to the first floor on each landing was lacking special signage.</p> <p>An observation of stairway T-29 on 03/01/23 at 2:05 PM revealed the entire staircase from the</p>	K 211	<p>Corrective action for the residents affected by the alleged deficient practice: The facility contracted with a sign vendor to fabricate NFPA compliant stairwell signage. The signs will be installed on all floors on each of the four stairways. No negative outcomes were identified by the alleged deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>Administrator re-educated the maintenance director on regulations of stairwell signage. The maintenance director will observe all stairwells weekly to ensure signage is properly maintained. Then every other week for 30 days; then monthly for 6 months.</p> <p>Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review.</p>	4/30/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315300	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2023
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K 211	Continued From page 2 fifth to the first floor was lacking special signage. An observation of stairway at the dialysis center on 03/01/23 at 2:10 PM revealed the entire staircase from the fifth to the first floor was lacking special signage. An interview with the Regional Maintenance Director and Maintenance Director on 03/02/23 at 2:15 PM verified the landings in each stairway were lacking stairway identification. NJAC 8:39-31.1(c), 31.2(e) .	K 211			
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6.19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure that one of four stairways had a two hour fire rating accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.6 to 8.5 to 8.5.4.4. to 7.1. to 7.1.3.2.1.(3). This deficient practice had the potential to affect 32	K 311	Corrective action for the residents affected by the alleged deficient practice: The stairway door near room [REDACTED] was replaced with a new door labeled with a two-hour fire resistance rating. No negative outcomes were identified by the alleged deficient practice.	4/30/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315300	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2023
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K 311	Continued From page 3 residents. Findings include: An observation of the stairway door on the second floor, located near bedroom [REDACTED] on 03/02/23 at 1:40 PM, revealed the door lacked a fire rating. There was no evidence of a tag on the side or top of the door and no evidence a tag had been removed or painted over indicating the door provided a two hour fire resistance rating. The stairway door communicated as an exit stairway with all five floors. The fourth floor was unoccupied. An interview with the Regional Maintenance Director and facility Maintenance Director at the time of the observation verified the lack of fire rating on the stairway door and said the door had been in place for years. NJAC 8:39-31.1(c), 31.2(e)	K 311	All residents have the potential to be affected. Regional Maintenance Director re-educated the maintenance director on requirements of fire doors. The maintenance director will observe all stairwell doors weekly to ensure fire-resistance rating labels are properly maintained. Then every other week for 30 days; then monthly for 6 months. Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review.		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission	K 341		4/30/23	

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K 341	<p>Continued From page 4 paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8</p> <p>This REQUIREMENT is not met as evidenced by: .</p> <p>Based on observations, record review and interview, the facility failed to ensure that two of 113 photo electric smoke detectors were greater than 36 inches from ceiling air diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 29.8.3.4.(6). This deficient practice had the potential to affect 11 residents in one smoke zone on the fifth floor.</p> <p>Findings include:</p> <p>An observation of a smoke detector in the corridor, located near the fifth floor nursing station and dayroom, on 03/01/23 at 10:40 AM revealed the smoke detector was 14 inches from a heating and cooling air diffuser as measured by the Maintenance Director.</p> <p>An observation of a smoke detector, located in the fifth floor dayroom, on 03/01/23 at 10:45 AM revealed the smoke detector was 10 inches from a heating and cooling air diffuser as measured by the Maintenance Director.</p> <p>A review of the most recent fire alarm inspection on 09/30/22 revealed the facility has 113 smoke detectors as part of the alarm system.</p> <p>An interview with the Maintenance Director at the</p>	K 341	<p>Corrective action for the residents affected by the alleged deficient practice: The smoke detectors on the 5th floor near the dayroom and nursing station were moved more than 36 inches away from the air diffusers. No negative outcomes were identified by the alleged deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>Regional Maintenance Director re-educated the maintenance director on regulations of smoke detector installation/location. The maintenance director inspected all smoke detectors in the facility to ensure that they are at least 36 inches from air diffusers. The Maintenance Director will continue to conduct monthly audits of all smoke detectors in the facility for six months.</p> <p>Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review.</p>		

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K 341	Continued From page 5 time of each observation verified the measurements of the smoke detectors to the heating and cooling air diffusers. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 341			
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to complete a smoke detection sensitivity test for all 113 photo electric smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 135 residents. Findings include: A review of fire safety records, located in an untitled white binder and at tab three, revealed the most recent fire alarm inspection on 09/30/22 and prior reports of 10/01/22, 04/02/22, and 04/01/21 did not include a smoke detection	K 345	Corrective action for the residents affected by the alleged deficient practice: The facility arranged with the fire alarm service provider to conduct a smoke detector sensitivity test. No negative outcomes were identified by the alleged deficient practice. All residents have the potential to be affected. Regional Maintenance Director re-educated the maintenance director on requirement to have annual smoke detector sensitivity tests. Facility contracted with the fire alarm service provider to ensure that sensitivity tests will be included in annual testing.	4/30/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315300	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2023
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K 345	Continued From page 6 sensitivity test. An observation on 03/01/23 from 10:15 AM to 2:00 PM revealed the facility had smoke detection in all corridors every 30 feet. The facility did not have a self-testing fire alarm system. An interview with the Regional Maintenance Director on 03/02/23 at 11:45 AM revealed the facility did not have a smoke detector sensitivity test from the past two years. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	Administrator will review the Life Safety Book quarterly to monitor when annual smoke detector sensitivity tests are due. Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		4/30/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315300	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2023
NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT HAMILTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302	
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K 351	Continued From page 7 by: . Based on observations and interview, the facility failed to ensure sprinkler coverage was provided under two of four staircase first floor landings in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition) Section 8.15.3.2.1. This deficient practice had the potential to affect all 135 residents. Findings include: An observation on 03/01/23 at 1:50 PM revealed the lower-level exit stairway landing in stairwell F-1 was lacking sprinkler protection. The nearest sprinkler was located at the landing above the lower-level landing and did not cover the lower landing or under the lower landing staircase. An observation on 03/02/23 at 2:00 PM revealed the lower-level exit stairway landing in stairwell F-9 was lacking sprinkler protection. The nearest sprinkler was located at the landing above the lower-level landing and did not cover the lower landing or under the lower landing staircase. An interview with the Regional Maintenance Director and Maintenance Director on 03/01/23 at 2:00 verified the lack of sprinkler coverage on the landings of the two exit stairways. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25 .	K 351	Corrective action for the residents affected by the alleged deficient practice: New sprinkler heads were installed in stairwells F-1 and F-9. No negative outcomes were identified by the alleged deficient practice. All residents have the potential to be affected. Regional Maintenance director re-educated the maintenance director on sprinkler location regulations. Maintenance director will conduct weekly audits all stairwells for 1 month to ensure proper sprinkler coverage in stairwells. Then every other week for 30 days; then monthly for 6 months. Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations	K 741		4/30/23

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K 741	<p>Continued From page 8</p> <p>Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(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.</p> <p>(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.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(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.</p> <p>18.7.4, 19.7.4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on observation, interview and record review, the facility failed to ensure a metal container with a self-closing cover device was provided and smoking regulations were enforced in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.7.4. This deficient practice had the potential to affect eight smokers.</p> <p>Findings include:</p>	K 741	<p>Corrective action for the residents affected by the alleged deficient practice: The facility updated its smoking policy to include protocols for use of ash trays, extinguishing cigarettes, and disposing of ashes and cigarettes butts. Metal containers with self-closing lids were placed in smoking areas.</p> <p>No negative outcomes were identified by the alleged deficient practice.</p>		

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NAME OF PROVIDER OR SUPPLIER ALARIS HEALTH AT HAMILTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302		
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K 741	<p>Continued From page 9</p> <p>An observation of the smoking area, located on the second-floor patio area, on 03/01/23 at 1:25 PM revealed two residents were flicking their ashes on the ground and in the air without staff present. Both residents were in wheelchairs. An ash tray was present on the patio but full of water and ten feet from their location. The area was also lacking a self-closing metal container to dump the cigarette butts into after smoking. Staff were watching or supervising through the glass door inside the building. Cigarette butts were also observed extinguished on the ground of the patio.</p> <p>A review of the facility policy dated 01/15/23 titled "Smoking Policy and Procedure" revealed the policy lacked references to safety while smoking such as safe use of ash trays at all times, extinguishing cigarettes in ash trays only, disposing of all ashes and cigarette butts when finished smoking, and how and when and where to dispose of such cigarette butts. The policy also lacked a reference to final disposal of all cigarette butts at the end of the day or smoking session.</p> <p>An interview with the Regional Operations Director at the time of the observation verified the condition of the area and residents smoking without ash trays and use of a self-closing metal can.</p> <p>NJAC 8:39-31.2(e), 31.6(e)</p>	K 741	<p>All resident who smoke have potential to be affected.</p> <p>Administrator re-in-serviced staff responsible for smoking supervision to ensure that residents safely extinguish and dispose of cigarette butts and ashes. Administrator in-serviced housekeeping staff on proper disposal of cigarette butts and ashes.</p> <p>The LNHA will observe 5 smoking sessions per week for proper extinguishing and disposal of cigarettes butt and ashes. Then every other week for 30 days; then monthly for 6 months.</p> <p>Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review.</p>		
K 918 SS=F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source</p>	K 918		4/30/23	

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K 918	<p>Continued From page 10</p> <p>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.</p> <p>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.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on observation, record review, and interview, the facility failed to ensure that the 125 KW (kilowatt) stand-by diesel generator was tested and maintained in accordance with NFPA 110 Standard for Emergency and Stand by Power</p>	K 918	<p>Corrective action for the residents affected by the alleged deficient practice: A generator load test was conducted by the facilities contracted generator service provider.</p>		

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

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FORM APPROVED
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K 918	<p>Continued From page 11</p> <p>Systems (2010 Edition) Sections 8.3.4. and 8.4.5.9.1. This deficient practice had the potential to affect all 135 residents.</p> <p>Findings include:</p> <p>An observation of the stand-by diesel generator on 03/01/23 at 1:45 PM revealed the generator was positioned outdoors above the diesel fuel tank. The generator was labeled as 125 KW.</p> <p>A review of the fire safety records from the untitled white binder revealed a load bank test was not available. The facility did not have information related to routine load testing at 30% or greater including no amperage information or total amperage under load.</p> <p>An interview with the Regional Maintenance Director on 03/02/23 at 11:45 AM verified he did not have a load bank test.</p> <p>NJAC 8:39-31.2(e) NFPA 99, 110</p>	K 918	<p>All residents have the potential to be affected.</p> <p>The Regional Maintenance director re-educated the maintenance director regarding generator load test requirements. Facility added a generator load test to the life safety inspection book checklist. Administrator will review Life Safety Book Quarterly to monitor when 3 year generator load test is due.</p> <p>Results of all audits will be discussed at the facility's QA Committee quarterly meetings for review.</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315300	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 5/3/2023	Y3
NAME OF FACILITY ALARIS HEALTH AT HAMILTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 525 MONMOUTH STREET JERSEY CITY, NJ 07302		

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # NFPA 101 LSC K0211	Correction Completed 04/30/2023	ID Prefix _____ Reg. # NFPA 101 LSC K0311	Correction Completed 04/30/2023	ID Prefix _____ Reg. # NFPA 101 LSC K0341	Correction Completed 04/30/2023
ID Prefix _____ Reg. # NFPA 101 LSC K0345	Correction Completed 04/30/2023	ID Prefix _____ Reg. # NFPA 101 LSC K0351	Correction Completed 04/30/2023	ID Prefix _____ Reg. # NFPA 101 LSC K0741	Correction Completed 04/30/2023
ID Prefix _____ Reg. # NFPA 101 LSC K0918	Correction Completed 04/30/2023	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

REVIEWED BY STATE AGENCY <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 3/14/2023		<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		