STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING _____ B. WING _____	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE FOUNTAINS	**595 COUNTY AVENUE SECAUCUS, NJ 07094**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00148396, NJ00148644 NJ00148865, NJ00148892 Census: 263 Sample Size: 4 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		7/19/22

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

Electronically Signed | 07/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALARIS HEALTH AT THE FOUNTAINS	**595 COUNTY AVENUE SECAUCUS, NJ 07094**

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F 609	Continued From page 1 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00148396 Based on interviews and record review, as well as review of pertinent facility documents on 6/13/22 and 6/15/22, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) a resident to resident allegation of abuse and follow the facility policy "Abuse Prevention Program" for 1 of 3 residents (Resident #1) reviewed for incident and accident. This deficient practice is evidenced by the following: During the tour with the Assistant Director of Nursing (ADON #1) on 6/13/22 at 10:35 am, he stated that Resident #1 was interviewable. During an interview with Resident #1 on 6/13/22 at 11:16 am, Resident #1 revealed that Resident #4 entered his/her room and [redacted] Resident #1 who was unable to recall time and date to the surveyor. Resident #1 further revealed that Resident #4 [redacted] Resident #1's [redacted]. Resident #1 stated that she/he called the police because the Resident was [redacted] and could not [redacted] due to his/her health condition. Resident #1 explained that he/she did not give Resident #4 consent to come into the	F 609	1) An investigation was conducted, resident #1 was found to not have been affected by the deficient practice. 2) All residents have the potential to be affected by the deficient practice: injuries or any allegation of abuse will be reported in accordance with the facilities abuse policy. 3) All staff will be educated on prompt reporting to any suspected behavior of abuse. 4) An audit tool was created to monitor that staff is reporting allegations of abuse in a timely manner. The audit will be done weekly for three months. Also, an in-service regarding responding to any suspect behavior of abuse will be provided for all staff. The results of this audit will be reviewed at QAPI meeting. 5) The Director of Nursing is responsible for this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING _____ B. WING _____	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE FOUNTAINS	**595 COUNTY AVENUE SECAUCUS, NJ 07094**

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F 609	Continued From page 2 room and [redacted] Resident #1. Resident #1 further stated that this incident was reported to the nurses. According to the "ADMISSION RECORD (AR)" form, Resident #1 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted]. The Minimum Data Set (MDS), an assessment tool dated [redacted], showed that Resident #1's [redacted] required [redacted] from staff in Activities of Daily Living (ADL). The Progress note (PN) dated 3/29/22 at 2:00 pm, documented by Licensed Practical Nurse (LPN #1) the assigned nurse to Resident #1 during 7:00 am to 3:00 pm shift. The PN documentation indicated that Resident #1 was screaming, yelling, and calling the police when LPN #1 entered Resident #1's room. The PN further indicated that Resident #1 stated to LPN #1 that he/she was [redacted] by "another" Resident. The PN dated 3/29/22 at 7:30 pm, indicated that LPN #2 the assigned nurse during 3:00-11:00 pm shift documented that at 1:45 pm Resident #1 reported that a [redacted] (did not identify the resident) came into the room and [redacted] her/his [redacted] The "CONCERN INVESTIGATION (CI)", dated 3/30/22, and concluded on 3/30/22, by the Assistant Director of Nursing (ADON #2), documented the aforementioned incident. The CI further showed that when the time the allegation	F 609		

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ALARIS HEALTH AT THE FOUNTAINS	**595 COUNTY AVENUE SECAUCUS, NJ 07094**

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F 609	Continued From page 3	F 609		

occurred, Resident #4 was being monitored at the nurses station.

The Medical record (MR) and the CI showed no documented evidence to indicate that the aforementioned incident was reported to the NJDOH.

LPN #1 was interviewed on 6/15/22 at 10:25 am, she confirmed the aforementioned incident, an allegation of EX Order 26.4B1 involving Resident #1. LPN #1 stated that she reported the incident to ADON #1 on EX Order 26.4B1 at approximately 2:00 pm.

ADON #1 was interviewed on 6/15/22 at 11:35 am, he stated that the aforementioned incident was not reported to the NJDOH. The ADON further stated that any allegation of abuse should be investigated and reported to the NJDOH immediately.

The facility's policy titled "Resident Rights", undated, showed "...Be free from mistreatment, neglect, exploitation and verbal, sexual, mental or physical abuse..."

The facility's policy titled "Abuse Prevention Program", dated 2/18/21 "...This facility prohibits abuse, neglect, involuntary seclusion, and misappropriation of property from residents and will utilize the abuse prevention program to effectively prevent occurrences, screen and train staff, identify, investigate, report, and respond to any occurrence...When an incident is reported to the supervisor, the supervisor is responsible for ensuring that the resident is safe and will notify the administrator as well as the DON, or their

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ALARIS HEALTH AT THE FOUNTAINS	**595 COUNTY AVENUE SECAUCUS, NJ 07094**

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F 609	Continued From page 4 designees. The administrator and DON will initiate the investigation of the potential abuse incident, determine the necessary response, and report to the office of the Ombudsman and Department of Health and Senior Service as Necessary. Alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not lot later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The results of the investigation are reported within 5 working days of the incident..." NJAC 8:27.1(b) NJAC 8:39-9.4 (e)(3)(i)	F 609		
F 837 SS=D	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the	F 837		7/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALARIS HEALTH AT THE FOUNTAINS	**595 COUNTY AVENUE SECAUCUS, NJ 07094**

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F 837	Continued From page 5 governing body. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 148892 Based on interviews, and record review, as well as review of pertinent facility documentation on 6/13/22 and 6/15/22, it was determined that the facility failed to consistently implement their policy on Charting and Documentation for 2 of 3 residents (Resident #2 and #3) reviewed for documentation. This deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD (AR)", Resident #2 was admitted to the facility on [NJAC 8:43E-2.1 an], with diagnosis that included but was not limited to: [NJAC 8:43E-2.1 and Exec Order 26,4]. The Minimum Data Set (MDS) an assessment tool dated [EX Order 26.4B1], Resident #2's [EX Order 26.4B1] [EX Order 26.4B1] and required [NJ Exec. Order 26:4.b.1] from staff with Activities of Daily Living (ADLs). The Care Plan (CP) dated 6/12/20, showed that Resident #2 had the potential for [NJAC 8:43E-2.1 and Exec Order 26, 4.b] [redacted]. The "Documentation Survey Report v 2 (DSR)" for the month of 9/20/21, 5/2022, and 6/2022 and the progress notes (PN) indicated no documented evidence by staff was completed about Resident #2 was provided assistance with ADLs on the following dates and shifts which was not according to their policy:	F 837	1) An investigation was conducted, residents #2 and #3 were not found to be affected by the deficient practice. 2) All residents have the potential to be affected by the deficient practice: all ADLs will be documented in PCC. C.N.A Accountability record shall be reviewed for all residents to identify failure to document since 6/15/22. 3) All ADLs will be documented on each resident every shift. 4) An audit tool was created to monitor that all ADLS were documented in PCC. This audit will be done weekly for three months. The results of this audit will be reviewed at QAPI meeting. 5) The Director of Nursing is responsible for this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 837	Continued From page 6 On [redacted] During 7:00 am-3:00 pm shift on 9/17/21, 5/3/22, 5/4/22, 5/10/22, 5/12/22, and 6/9/22 were blank. During 11:00 pm-7:00 am shift on 9/7/21, 9/9/21, 9/12/21, 9/13/21, 9/18/21, 5/2/22, and 5/8/22 were blank. 2. According to the AR, Resident #3 was admitted to the facility on [redacted], with diagnoses that included but were not limited to: [redacted]. The MDS dated 3/29/22, Resident #3's cognition was [redacted] and required [redacted] from staff with ADLs. The CP dated 3/30/22, showed that Resident #3 had the potential for [redacted]. The DSR and the PNs for the month of 9/2021, 5/2022, and 6/2022 showed no documented evidence completed by the staff about Resident #3 was provided assistance with ADL on the following dates and shifts which was not according to their policy. On [redacted] Use: During 7:00 am - 3:00 pm shift on 9/2/21, 9/9/21, 9/17/21, 5/20/22, and 6/2/22 were blank. During 3:00 pm-11:00 pm shift on 9/4/21, 9/7/21, 9/9/21, 9/18/21 through 9/20/21, 9/24/21, 9/26/21, 5/1/22, 5/4/22, 5/20/22, 5/26/22, and 6/5/22 were blank. During 11:00 pm-7:00 am shift on 9/1/21, 9/2/21, 9/4/21 through 9/7/21, 9/9/21, 9/10/21, 9/14/21 through 9/17/21, 9/20/21. 9/21/21, 9/25/21,	F 837		

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F 837	Continued From page 7 9/26/21, 9/28/21 through 9/30/21, 5/10/22, 5/13/22, 5/20/22, 5/27/22 through 5/30/22, 6/4/22, and 6/5/22 were blank. The surveyor conducted an interview with Certified Nursing Assistant (CNA #1) on 6/15/22 at 2:50 pm. The CNA stated that CNAs should document the care provided to the Resident to indicate that it was done. The surveyor conducted an interview with the Unit Managers (UM #1) and Assistant of Director of Nursing (ADON #2) on 6/15/22 from 9:05 am to 2:55 pm. The UM #1 and ADON #2 stated that CNAs should document, and the UMs should ensure that they document to indicate that the care was provided to the residents. The Job Description for UM, undated, showed "To function at a professional nursing level using both administrative leadership and clinical expertise in order to assure the comprehensive care and treatment is rendered to resident population, collaborates with the interdisciplinary team in the design, implementation and evaluation of various programs within the unit. Twenty-four hour responsibility for the continuity of nursing care and the management of the resident welfare...Encourages nursing staff to perform their jobs to the fullest of their potential; 7 Provides professional guidance and supervision to both professional and nonprofessional unit staff.." The facility's policy titled "Charting and Documentation" dated on 11/2/21, showed "All services provided to the resident, or any changes in the resident's medical or mental condition,	F 837		

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F 837	Continued From page 8 shall be documented in the resident's medical record...Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care..." NJAC 8:39-27.1(b)	F 837		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315476	A. Building B. Wing	7/20/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT THE FOUNTAINS	595 COUNTY AVENUE SECAUCUS, NJ 07094

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 F0609 Reg. # 483.12(c)(1)(4) LSC	Correction Completed 07/19/2022	ID Prefix F0837 Reg. # 483.70(d)(1)(2) LSC	Correction Completed 07/19/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
6/15/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO