STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	**40 RIVERSIDE AVENUE RED BANK, NJ 07701**

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F 000	INITIAL COMMENTS Complaint NJ#: 176512 Survey Date: 09/19/24 Census: 36 Sample: 13 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. A complaint investigation was also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		10/18/24

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

Electronically Signed | 10/10/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to a.) maintain the dignity of an unsampled resident. This deficient practice was found with 1 of 2 Certified Nursing Aides (CNA) observed during a dining observation on the third floor, and b.) place a NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) in a NJ Ex Order 26.4(b)(1) to ensure a resident's dignity for 1 of 2 residents (Resident #26) reviewed for NJ Exec Order 26.4b1. The deficient practice was evidenced by the following: a.) On 9/17/24 at 12:40 PM, during a lunch meal dining observation on the 3rd floor in the main dining room, an unsampled resident asked the surveyor a question regarding wanting pineapple chunks with their meal. The CNA was next to the	F 550	1. Resident #26 was offered the meal and dessert options and preferences for service. 2. All residents in the community are at risk for not being treated with respect and dignity according to their resident rights and Springpoint Policy and Procedures. 3. Any observed or suspected violation of resident rights is to be reported immediately to the DON/designee for investigation. All staff were in-serviced on Resident Rights, Abuse Policy and Procedure and the importance of providing residents with options for their meal preferences. Staff are to be in-serviced on Resident Rights and Abuse Policy and Procedures upon hire and yearly. Resident rights are reviewed at	

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F 550	Continued From page 2 resident when the request was made, and the CNA did not say anything. The surveyor asked the CNA if she could help the resident with their request. The CNA looked at the surveyor and said, "the resident knows that the dessert is not given until after the meal is served." The surveyor asked the CNA if she could speak directly to the resident about the concern. The CNA said, "I am not telling the resident, the resident knows this." At that time, the CNA walked away from the resident and went to the other side of the dining room without speaking to the resident and without addressing the residents' request. On 9/17/24 at 1:20 PM, the above concerns were discussed with the U.S. FOIA (b)(6), who stated that this kind of interaction is unacceptable, and she will investigate the situation. A review of the Quality of Life- Dignity policy and procedure, dated 1/24/24, which revealed "Residents shall be always treated with dignity and respect." and "Staff shall always speak respectfully to residents...." b.) On 09/17/24 at 7:41 AM, Surveyor #2 observed Resident #26 lying in bed with an uncovered NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) lying in direct contact with the floor and was visible from the hallway through the open door. The resident had a roommate, and the privacy curtain was not closed which allowed the roommate visualization of the NJ Exec Order 26.4b1 On 09/17/24 at 10:41 AM, Surveyor #2 observed Resident #26 sitting in a NJ Ex Order 26.4(b)(1) wheelchair in	F 550	Resident Council meetings monthly. Charge Nurse/designee to monitor interactions between staff and residents during mealtime. 4. All investigations will be reported appropriately and brought to QAPI meeting monthly x 3 months. Director of activities will audit the presentation of resident rights at each Resident council meeting. Results will be presented to QAPI monthly x 3 months. HR will audit that all new hires receive Resident Right and Abuse training upon hire and yearly. Results will be reported to QAPI monthly x 3 months. 1. Resident #26 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 was covered by a NJ Ex Order 26.4 2. Any residents with urinary catheter collection bags are at risk for violation of Resident Rights. 3. All staff were educated on the use of urinary privacy bags and proper placement of drainage bags to ensure Resident Rights and privacy. DON/Designee will conduct daily audits that all urinary drainage bags are properly covered with a privacy bag and properly hung to ensure Resident Rights weekly x 4 weeks and monthly x 2 months. 4.Compliance/Noncompliance results of audit of privacy bag usage and urinary bag placement will be reported by the DON/designee at monthly QAPI meeting x 3 months.	

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F 550	Continued From page 3 the [redacted] activity day room. Resident #26 was with other residents and was participating in an exercise activity. Surveyor #2 was able to observe the NJ Exec Order 26.4b1 [redacted] only partially covered and in direct contact with the floor under the wheelchair. A review of the Resident #26's medical record revealed: The Face Sheet with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate resident care dated NJ Exec Order 26.4b1, included but was not limited to; a Brief Interview for Mental Status of NJ Ex [redacted] out of 15 indicating U.S. FOIA (b)(6) [redacted]. At the time of the MDS, Resident #26 did not have a U.S. FOIA (b)(6) [redacted]. A review of the Physician's Order Sheet documented an order dated NJ Exec Order 26.4b1, for a [name redacted] NJ Exec Order 26.4b1 NJ Exec Order 26.4b - indicating the size) NJ Exec Order 26.4b1) to NJ Ex Order 26.4(b) NJ Exec Order 26.4b1 bag. A review of the resident-centered ongoing care plan included but was not limited to; a focus area of NJ Ex Order 26.4(b)(1) [redacted] due to NJ Exec Order 26.4b1 inserted NJ Exec Order 26.4b1 with a goal of no cross-contamination. On 09/17/24 at 10:44 AM, the direct care U.S. FOIA (b)(6) [redacted] stated she had cared for the resident that morning. The U.S. FOIA [redacted] further stated that she has cared for the resident before, and that the NJ Exec Order 26.4b1 [redacted] must be below the level of the NJ Exec Order 26.4b and covered with a NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) [redacted] further stated it was important in order to prevent contamination and for dignity of the resident. On 09/17/24 at 11:03 AM, the US FOIA (b)(6) [redacted]	F 550		

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F 550	Continued From page 4 US FOIA (b)(6) stated a NJ Exec Order 26.4b1 needed to be kept off the floor to prevent infection and in a privacy bag for resident rights. A review of the facility provided policy, "Quality of Life - Dignity" revised 01/24/24, included but was not limited to; "Policy: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality." ... "11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered."	F 550		
F 607 SS=D	NJAC 8:39-4.1(a)12, 12; 27.1 (a) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care	F 607		10/14/24

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F 607	Continued From page 5 facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interviews, review of facility policy, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy to ensure a criminal background checks were completed prior to the start date of employment. This deficient practice was identified for 1 of 10 employee files reviewed (Employee #7) and was evidenced by the following: The surveyor reviewed ten employee files who had been hired since the last standard survey conducted on 7/7/23, which revealed the following incomplete pre-employment screening documents: Employee #7, Activities Aide, hired [NJ Exec Order 26.4]. The background check revealed a report date of [NJ Exec Order 26.4b] A review of the employee's position description, signed on [NJ Exec Order 26.4], revealed a job summary to provide therapeutic activity programs to the residents. "Essential Functions", as follows but not limited to; assist in organizing, developing, and directing therapeutic activities for groups or	F 607	1. Employee # 7, US FOIA (b)(6), hired [NJ Ex Order 26.4b]. The background check revealed a report date of [NJ Exec Order 26.4]. 2. All residents and employees are at risk if a background check is not completed before first hire day. 3. The U.S. FOIA (b) (6) was educated on the abuse policy to ensure that background checks are completed prior to start of employment. Upon acceptance of employment, the HR representative will initiate a background check. Once the background report is received, the HR representative will present to Administrator for review. Once approved by Administrator, HR representative can initiate onboarding process. HR representative will maintain an employee list of completed background check dates and new hire dates and submit and review with the Executive Director monthly x 3 months. 4. HR representative will review results of employee list with background report dates and new hire dates at monthly QAPI meeting x 3 months.	

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F 607	Continued From page 6 individuals to meet the needs of the residents. A review of "Employee Acknowledgement Form" was a signed document acknowledging receipt of employee badge to begin work, signed by Employee # 7, and the U.S. FOIA (b) (6) . It was dated on NJ Ex Order 26.4(b)(1) A review of Employee # 7's timecard dated NJ Ex Order 26.4(b)(1), revealed the following hours that the employee worked prior to the completion of the background check: - 32 hours of paid work on NJ Ex Order 26.4b - 2.0 hours - NJ Ex Order 26.4b - 7.5 hours; - NJ Ex Order 26.4b - 7.5 hours; - NJ Ex Order 26.4b - 7.5 hours; - NJ Ex Order 26.4b - 7.5 hours; On 09/18/24 at 10:48 AM, the surveyor reviewed the employee files with the Human Resource and Information System (HRIS) home office staff who acknowledged the missing documents. The HRIS stated, that the previous U.S. FOIA (b)(6) at that time should have ensured the background check was completed prior to the employees being hired. On 09/18/24 at 11:21 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated, "Human resources provides an email to the hiring department when the employee is "all cleared" and can start their employment. This email is sent once references, health check and background check are completed." Upon surveyor inquiry, the U.S. FO was unable to provide the email regarding the "all clear" for employment.	F 607		

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F 607	Continued From page 7 On 09/18/24 at 11:38 AM, the surveyor interviewed the U.S. FOIA (b)(6)) on the hiring process. The U.S. FOIA (b) stated, "interview, prospect sent to U.S. FOIA (b)(6)) for contingency review on references, health evaluation, and background check. Once the prospect is cleared for all of that then the on-boarding starts." The U.S. FOIA (b) stated, an email would go out from U.S. FO to the hiring supervisor informing that the prospect is "good to go". The U.S. FOIA (b) stated "if the background check was not completed the prospect should not have been in the building or working." On 09/18/24 at 01:10 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated, "background check should be done prior to hire." A review of the facility's undated "Skilled Nursing Policy and Procedures, Title: Abuse (Elder Abuse)" with an effective date 2/15/01, revised dates 10/12/2020, revealed: Policy: Employees have a unique position of trust with vulnerable elders. Their access to private information, as well as having elevated status and special relationships with elders, makes ethical and professional behavior essential. Springpoint is committed to ensuring that elders remain free from abuse. This includes, but not limited to facility staff. Procedures: The policies and procedures regarding abuse prevention addresses one of the seven key areas: the manner in which a prospective employee are screened. 1) New employee screening, E) New Jersey- as a condition of employment for the following job	F 607		

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F 607	Continued From page 8 categories is a statewide criminal history check to be performed ... Aide-Non-Certified and /or Activity department personnel. A review of the "Hiring Policy: Employment Application and Pre-Employment Checks," dated 04/29/24 included, all offers of employment are contingent on satisfactory references and the candidate passing the mandatory drug screen and Criminal background check. NJAC 8:39-4.1(a)5	F 607		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain an Automated External Defibrillator (AED-equipment used for the purposes of immediate response for cardiac arrest) and other emergency items prior to their expiration date. This deficient practice was identified for 2 of 2 expired AED kits located on 2 of 2 resident units (2nd and 3rd floor), which contained expired defibrillator pads dated 4/8/23, and was evidenced by the following: On 9/17/24 at 11:01 AM, in the presence of the U.S. FOIA (b)(6)), the surveyor observed an AED emergency response kit,	F 678	1. The AED pads were replaced immediately and all items on the emergency cart was checked and replaced as needed. 2. All residents in the community are at risk for equipment failure during an emergency. 3. AED pads were replaced immediately with a second set of backup pads placed in the AED machine's case. All nursing staff/supervisors/managers were educated and disciplined accordingly due to failure to check/replace emergency equipment appropriately. DON/Designee will audit emergency cart weekly x 4	10/14/24

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F 678	Continued From page 9 mounted on the wall of the AED room on the Third floor. The surveyor observed the [redacted] remove the AED kit from the wall mounting, opened it, and observed one defibrillator pad (AED electrode pad, an essential component of an AED to treat a sudden cardiac arrest emergency) attached to the AED machine, that expired on 4/8/23. No other AED pads were observed inside the AED kit. The [redacted] searched for another AED pad and acknowledged that the AED pad in the machine should not have been expired in the event of an emergency. The [redacted] confirmed that was the only AED machine located on the third floor. At that time, the surveyor and the [redacted] reviewed the Emergency Cart Daily Check List for September 2024. The checklist included "AED" and was initialed and marked checked, daily until 9/16/24, except for: Oxygen was not marked as checked on 9/1/24 which revealed all items including the AED were checked and initialed on 9/9/24. The [redacted] stated that the 11-7 shift nurse was responsible for checking and ensuring the emergency supplies were available and were not expired. A further review of the AED machine reflected a sticker "Approved for use by the Biomedical Engineering Department" and was inspected on 9/5/24. Further review of the emergency kit located inside the AED room revealed the following: - one sealed Ultra Trak test strips quantity of 50, that expired on 8/31/23. - one Insta glucose that expired on 8/2023. - two Adult manual pulmonary resuscitator bag that expired on 5/2020. At that time, the [redacted] confirmed observing the	F 678	weeks and monthly x 2 months to ensure that all equipment was checked for expiration and replaced according to needs. In addition, a new column was added to the daily emergency checklist to provide expiration dates on all equipment within the emergency cart and AED machine. 4. The DON/designee will report findings of weekly audits of emergency cart and AED machine to monthly QAPI meeting x 3 months.	

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F 678	Continued From page 10 same expired items within the AED room. On 9/17/24 at 11:26 AM, in the presence of LPN #1 and the U.S. FOIA (b)(6)), the surveyor discussed the concerns regarding the equipment for the purposes of immediate response to potential life-threatening, cardiac emergencies and the associated supply in the AED room. The U.S. FOIA (b)(6) stated she would inform the U.S. FOIA (b)(6) , remove, and replace the expired items immediately. On 9/17/24 at 11:30 AM, the surveyor and the U.S. FOIA (b)(6)) began the inspection of the AED room located on the Second Floor. The AED machine had an AED pad that expired on 4/8/23. The U.S. FOIA (b)(6) looked through the kit and could not provide another AED pad from the AED kit. At that time, the U.S. FOIA (b)(6) stated that the AED pads should have not been expired "because the AED machine won't work properly with an expired AED pad." At that time, the surveyor and the U.S. FOIA (b)(6) reviewed the Emergency Cart Daily Checklist dated September 2024. The checklist reflected that it was checked daily, until 9/16/24. The U.S. FOIA (b)(6) stated that the 11-7 PM shift nurse checked the list that included the AED. The U.S. FOIA (b)(6) informed the surveyor that the check list was to ensure all the items on the list were in the emergency kit and were not expired. At that time, the surveyor discussed the concern the expired AED pads with the U.S. FOIA (b)(6) who oversaw both floors. The U.S. FOIA (b)(6) stated she would inform the U.S. FOIA (b), remove, and replace the expired items.	F 678		

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F 678	Continued From page 11 On 9/17/24 at 12:15 PM, in the presence of the survey team, the U.S. FOIA (b)(6) [redacted] stated that the AED pads were not part of the check list and was uncertain if the nurses checked the dating on the AED pads. On 9/17/24 at 12:19 PM, the regional nurse and the surveyor re-inspected the AED machines on the second and third floor. The U.S. FOIA (b)(6) confirmed that, after surveyor inquiry, the AED pads were replaced with an in-date AED pad paired with a back-up AED pad that was also not expired. The U.S. FOIA (b)(6) confirmed picking-up the pads from a separate entity other than the facility, and also provided a copy of a purchase order for the new AED pads. A review of the facility provided policy, Automatic External Defibrillation (AED) Program dated/revised on 1/24/23, under Maintaining AED Unit in a State of Readiness included the following: Monthly check of an AED unit will be conducted by authorized U.S. FOIA (b)(6) [redacted] to Community to include: 3. Completion of the maintenance check list including the pad expiration date.	F 678		
F 690 SS=D	NJAC 8:39-23.3(a) (b)1 Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		10/18/24

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	315515	A. BUILDING _____ B. WING _____	C 09/19/2024

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F 690	Continued From page 12 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure a NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) were not in direct contact with the floor to prevent potential contamination. This deficient practice was identified for 1 of 2 residents (Resident #26) reviewed for NJ Ex Order 26.4(b)(1) use	F 690	1. Resident #26 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 were replaced and the new tubing and bag properly hung with a NJ Ex Order 26.4(b)(1). 2. All residents with indwelling catheters are at risk for infection due to failure to protect urinary drainage tubing and urinary drainage bag from coming in contact with	

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F 690	Continued From page 13 and was evidenced by the following: A review of the facility provided policy, "Indwelling Urinary Catheter Insertion/Maintenance (Male/Female)" revised 01/29/24, included but was not limited to; 5. ... "Both the drainage tubing and bag must be kept from touching the floor." On 09/17/2024 at 7:41 AM, the surveyor observed Resident #26 lying in bed with part of the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 lying in direct contact with the floor. On 09/17/2024 at 10:41 AM, the surveyor observed Resident #26 in a high-backed wheelchair in the third-floor activity day room. The surveyor observed part of the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 lying directly on the floor under the wheelchair. Resident #26 was participating in exercise and as their NJ Exec Orde NJ Ex the over bed table, the activity staff moved the table and the NJ Exec Order 26.4b1 on floor was even more obvious. A review of Resident #26's medical record revealed: A Face Sheet with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 . A review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate resident care dated NJ Exec Order 26.4b1, included but was not limited to; a Brief Interview for mental status (BIMS) of NJ Ex out of 15 indicating NJ Exec Order 26.4b1 . Section H: NJ Ex Order 26.4(b)(1) documented no NJ Exec Order 26.4b1 at that time. A review of the Physician Order Sheet included an order dated NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 to straight NJ Exec Order 26.4b1 bag. A review of the assessment note	F 690	contaminated surface. 3. All nursing staff were educated on indwelling catheter care Policy and procedures including proper urinary catheter care, urinary drainage tubing and urinary bag placement to prevent contamination and recognition of contamination risks. All nursing staff were educated on providing dignity with privacy bag for all urinary drainage bags. The Unit Manager/Designee will conduct weekly audits x 4 weeks and monthly x 2 months to ensure that drainage bags are secured off the floor and covered with privacy bags. 4. DON/Designee will audit daily to ensure that all Urinary Catheter policies are followed. Findings will be reported at monthly QAPI meeting x 3 months.	

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F 690	Continued From page 14	F 690		

dated 07/12/2024, revealed the resident had a NJ Exec Order 26.4b1 insertion completed. A review of the resident-centered on-going care plan included but was not limited to; a goal of "there will be no cross contamination due to my U.S. FOIA (b)(6) with myself or staff for my length of stay."

On 09/17/24 at 10:44 AM, the direct care U.S. FOIA (b) (6)) stated she cares for Resident #24 including NJ Ex Order 26.4(b)(1) care. The U.S. FOIA stated that the NJ Exec Order 26.4b1 bag must be placed below the NJ Exec Order 26.4b1 and covered by a NJ Exec Order 26.4b1. The U.S. FOIA (b) stated she checked the NJ Ex Order 26.4b1 at 9:30 AM. The U.S. FOIA was informed about the observation of the NJ Exec Ord and NJ Ex Order 26 on the floor and was then shown the U.S. FOIA (b)(6) and NJ Exec Order 26 that was lying on the floor. The U.S. FOIA went into the activity room and acknowledged. The U.S. FOIA asked the U.S. FOIA (b)(6) to bring the resident to their room to correctly place the NJ Exec Ord

On 09/17/24 at 10:52 AM, the U.S. FOIA (b) stated she was responsible to NJ Ex Order and keep the NJ Exec Ord clean. She stated the U.S. FOIA (b) should be hooked on the side and off the floor because of "contamination". The U.S. FOIA (b) stated she was off the floor that morning and someone else must have cared for Resident #24.

On 09/17/24 at 11:03 AM, the U.S. FOIA (b)(6) was asked about the observations of the NJ Exec Order 26.4b1 and tubing. The U.S. FOIA (b)(6) stated that the NJ Exec Order 26.4b1 and NJ Ex Order 26 must be off the floor to prevent infection.

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F 690	Continued From page 15 NJAC 8:39-19.4 (a)5; 27.1 (a)	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure a resident who received NJ Ex Order 26.4(b)(1): a.) had a comprehensive patient-centered care plan for NJ Ex Order and b.) the NJ Ex Order 26.4(b)(1) physician recommendation was acted upon in a timely manner. This deficient practice was identified for 1 of 1 resident, reviewed for NJ Exec Order 26.4b1 (Resident #15) and was evidenced by the following: On 9/17/24 at 7:43 AM, a surveyor observed Resident #15 in bed who NJ Exec Order 26.4b1. The resident stated that the NJ Exec O medication would be administered after breakfast. On 9/17/24 at 11:11 AM, a surveyor observed the resident in the rehabilitation room. At that time, during an interview with the surveyor, the U.S. FOIA (b)(6) stated that they would provide a hot pad for the resident's NJ Exec Order 26.4b1. The surveyor then interviewed the U.S. FOIA (b)(6) who informed the surveyor that they charted the resident's NJ Exec O by exception (documenting only when NJ Exec O was reported or observed).	F 697	1. Resident #15 was assessed by the nurse to determine the resident's NJ Exec O and how to manage NJ Exec O. The recommendations were addressed and the care plan was updated 2. All resident in the community are at risk for not having pain addressed in a timely manner. 3.A comprehensive NJ Exec O assessment was completed for resident #15 and address the resident's NJ Exec O. Nursing staff was trained and educated on pain policy and procedure, pain management, care planning and timely implementation of pain management interventions. The Unit Manager/designee will assess 5 residents weekly x 4 weeks and then monthly x 2 months for adequate pain control and management based on the resident's plan of care. 4. The results of the audits will be forwarded to the QAPI committee by the DON. The DON will report the findings monthly for the next 3 months.	10/18/24

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On 9/18/24 at 10:47 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) stated the resident had a NJ Exec Order 26.4b1 while NJ Exec Order 26.4b1.

The surveyor reviewed the hybrid (electronic and paper) medical record for Resident #15.

According to the Face Sheet, Resident #15 was admitted to the facility with diagnoses that included unspecified NJ Exec Order 26.4b1

Review of the Quarterly Minimum Data Set (qMDS), an assessment tool dated NJ Exec Order 26.4b reflected a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated that the resident had NJ Exec Order 26.4b1.

Further review of the qMDS dated NJ Exec Order 26.4b under section J. NJ Ex Order 26.4(b)(1) indicated the resident received PRN (as needed) NJ Exec Ord medication, a NJ Ex Ord assessment interview should be conducted, and that the resident had not experienced NJ Ex Order 26.4(b)(1) in the last five (5) days.

A review of the NJ Ex Order 26.4(b)(1) Physician Order (PO) sheet included the following orders:

(2) NJ Exec Order 2 every NJ Ex hours as needed for NJ Exec Order 26.4b1 (NJ Exec Order 26.4b1). The order was started on NJ Exec Order 26.4.

NJ Exec Order 26.4b1 tablet every NJ Ex hours as

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F 697	Continued From page 17 needed for NJ Exec Order 26.4b1 (scale of [redacted]. The order was started on [redacted] NJ Exec Order 26.4b1 to the [redacted] times daily for NJ Exec Order 26.4b1. The order was started on [redacted]. [redacted], apply a small amount [redacted] to [redacted] every [redacted] hours as needed for [redacted] 1. A review of the resident's comprehensive person -centered care plan dated [redacted] reflected that there was no goal or interventions to monitor or manage [redacted] including the resident's preferences for management of their [redacted] triggers, medications, and any non-pharmacological interventions. On 9/18/24 at 11:15 PM, during an interview with the surveyor, the [redacted] stated that the standard of practice was when a resident had [redacted], the resident would request for the PRN (as needed) pain medication or was offered and declined. The surveyor then asked the [redacted] what should have been the standard of practice of Resident #15's comprehensive person-centered care plan, a resident who had unspecified [redacted], with a documented NJ Exec Order 26.4b1 during admission assessment of NJ Exec Order 26.4b1 with admitted [redacted] when NJ Ex Order 26.4(b)(1). At that time, the [redacted] confirmed that the patient should have had a care plan for [redacted] A review of the admission assessment for [redacted] dated [redacted], included that at the time of the interview Resident had not reported [redacted] at admission, was able to report [redacted] and had been	F 697		

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F 697	Continued From page 18	F 697		

treated for [redacted] in the past. During assessment, the nurse documented that the resident was observed [redacted] when [redacted] with [redacted] for care and was unable to rate their [redacted] scale.

On 9/18/24 at 10:58 AM, the surveyor and the [redacted] reviewed the [redacted] electronic Administration Record (eMAR) and the electronic Treatment Administration Record (eTAR) together. The eMAR and the eTAR did not reveal a shift-to-shift [redacted] monitoring for Resident #15. At that time, the [redacted] stated that the shift-to-shift [redacted] assessment was on the eMAR/eTAR from [redacted] prior to the addition of [redacted]. The surveyor asked how Resident #15's [redacted] was monitored without a care plan and a shift-to-shift monitoring of [redacted] The [redacted] stated that the shift-to shift [redacted] assessment continued to be documented until [redacted] and was stopped, based on the [redacted]) recommendation to discontinue, the [redacted] scale on [redacted]. The [redacted] also stated that monitoring a resident's [redacted] included patient's self-reporting of [redacted] and observations of the resident's [redacted] which was monitored by staff but did not mention the resident's [redacted] and the non-pharmacological interventions used to address the resident's [redacted]

At that time, the [redacted] who did not carry out the order to discontinue the shift-shift [redacted] assessment stated that discontinuation of the shift-to-shift [redacted] assessment was inappropriate, and the failure to develop a care plan for [redacted] was improper because Resident #15 might not have received enough [redacted] medication, ensuring

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F 697	Continued From page 19 that Resident #15 was living their best life and the resident's [NJ Exec O] was well managed. On 9/18/24 at 11:37 AM, during an interview with the surveyor, the [U.S. FOIA (b)(6)] stated she was familiar with Resident #15 and was assigned to the resident that day. The [U.S. FOIA (b)] stated she monitored the resident for [NJ Exec O], although the resident was able to do things by them self. The [U.S. FOIA (b)] stated, "no, I don't monitor [gender redacted] for [NJ Exec Orde]. On 9/18/24 at 11:39 AM, during an interview with the surveyor, the [U.S. FOIA (b)(6)]) stated that Resident #15 was asked every shift about their [NJ Exec Orde] when the resident was having [NJ Exec O], it followed with a discussion with the physician to see if a routine medication would be needed, or an adjustment of medication, and a consult for the resident may be ordered. The [U.S. FOIA] also stated that a family meeting was also completed along with a care plan for [NJ Exec Orde] At that time, there was no evidence a care plan for [NJ Exec O] existed for Resident #15. 2. A review of the the [NJ Exec O] Management Consultant report dated [NJ Exec Order 26], included the following: "Consider adjusting [NJ Exec O] medication for better [NJ Exec O] control". On 9/18/24 at 11:15 AM, during an interview with the surveyor, the [U.S. FOIA (b)(6)] stated the consult for adjusting [NJ Exec O] medication for better [NJ Exec O] control should have been acted upon within 24 hours of the recommendation. The [U.S. FOIA (b)(6)] could not explain how the consult was missed and was unsure if the attending physician was notified. At that time, after surveyor inquiry, the [U.S. FOIA (b)(6)]	F 697		

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F 697	Continued From page 20 stated she would contact the physician, conduct a pain assessment, and inform the [redacted] On 9/18/24 at 11:59 PM, in the presence of the survey team, the [redacted] and the [redacted], the surveyor discussed the concerns regarding Resident #15's comprehensive patient centered care plan failed to include a focus on [redacted] the [redacted] assessment/ monitoring that was discontinued on [redacted], and the inaction with the [redacted] management physician's recommendation to adjust the resident's [redacted] medication for better [redacted] control. On 9/19/24 at 10:14 AM, during a telephonic interview with the surveyor, the CP clarified that the discontinuation of vitals and [redacted] scale was only to remove the documentation from the eMAR and/or the eTAR, and not to discontinue the [redacted] assessment altogether. On 9/19/24 at 10:58 AM, during a meeting with the survey team, and the [redacted] the [redacted] stated that Resident #15 complained of [redacted] more consistently and was sent to a [redacted] management physician. At that time, the [redacted] acknowledged that the [redacted] management physician's consult from [redacted], should have been followed. At that time, the [redacted] stated that the facility policy was to monitor a resident when they had [redacted] and thought it was appropriate to remove the shift-to-shift [redacted] monitoring on the eMAR/eTAR because the resident was able to self-report. A review of the provided facility policy for Pain Management dated/revised 6/13/23 included the following:	F 697		

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F 697	Continued From page 21 It is the policy of [facility name redacted] to ensure that the care planning process is systematic, comprehensive, interdisciplinary, and timely and directed toward achieving and maintaining each resident's optimal physical, psychosocial, and functional status. Procedure: 4. Pain Monitoring and evaluation will be specific to each resident based on the outcome of the pain assessment. 5. The pain management program will be addressed on the Resident Care Plan. It will include the medical/pathological basis of pain, triggers of pain, medications, modalities, non-pharmacological interventions, and how to evaluate the resident's response. Resident Care Plans will be specific, tailored to their individual needs and responses. A review of the provided facility policy for Resident Care Plan dated/revised 6/29/23, included It is the policy of [facility name redacted] to ensure that the care planning process is systematic, comprehensive, interdisciplinary, and timely and directed toward achieving and maintaining each resident's optimal physical, psychosocial, and functional status.	F 697		
F 757 SS=D	NJAC 8:39-27.1(a) Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		10/18/24

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F 757	Continued From page 22 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to appropriately administer medications used to manage NJ Ex Order 26.4(b)(1) in accordance with physician orders. The deficient practice was identified for one (1) of five (5) residents reviewed for unnecessary medications (Resident #15) and was evidenced by the following: On 9/17/24 at 7:43 AM, a surveyor observed Resident #15 in bed who complained of NJ Exec C. The resident stated that the NJ Exec Orde medication would be administered after breakfast. On 9/17/24 at 11:11 AM, a surveyor observed the resident in the rehabilitation room. At that time, during an interview with the surveyor, the US FOIA (b)(6) . The surveyor then interviewed the NJ Exec Order 26.4b1 who informed the surveyor that they charted the resident's NJ Exec Orde	F 757	1. Resident #15 NJ Ex Order 26.4b1 is obtained prior to administration of NJ Exec Order 26.4b1 at 9am, 1pm and 5pm. The parameter orders are to hold NJ Ex Order 26.4(NJ Exec Order 26.4b1 orders were reviewed by the physician. The medication and parameters were discontinued. 2. All residents with medication parameters including NJ Exec Order 26.4b1 are at risk. 3. The DON/designee and pharmacy consultant educated nursing staff regarding medication administration protocols, and proper medication administration of NJ Exec Order 26.4b1 and medications with blood pressure parameters. The Pharmacy Consultant audited all medications , auditing compliance of prescribed blood pressure	

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	315515	A. BUILDING _____ B. WING _____	C 09/19/2024

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F 757	Continued From page 23 by exception. On 9/18/24 at 10:47 AM, during an interview with the surveyor, the U.S. FOIA (b) (6) U.S. FOIA) stated the resident had a on NJ Ex Order 26.4 while going to the bathroom and a NJ Ex O assessment was conducted. The surveyor reviewed the hybrid medical record for Resident #15. According to the Face Sheet, Resident #15 was admitted to the facility with diagnoses that included unspecified NJ Exec Order 26.4b1 Review of the Quarterly Minimum Data Set (qMDS), an assessment tool dated NJ Ex Order 26.4(b), reflected a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated that the resident had NJ Exec Order 26.4b1. A review of the NJ Ex Order 26.4(b)(1), Physician Order (PO) sheet included the following orders: NJ Exec Order 26.4b1, scheduled for administration at NJ Exec Order 26.4b1 Under notes, included parameters that reflected, hold for NJ Ex Order 26.4(b)(1) greater than (>) NJ Exec O. The order date was started on U.S. FOIA (b)(6). NJ Exec Order 26.4b1, schedule for administration at NJ Exec Order 26.4b1 Under notes, incorporated parameters that reflected hold for NJ Ex Order 26.4(b)(1)	F 757	parameters for NJ Exec Order 26.4b1 and any other medications with blood pressure parameters. The DON/designee will monitor 5 random medication orders with prescribed parameters weekly x 4 weeks and monthly x 2 months to ensure that medications are appropriately transcribed with parameters and nurses are following parameters during medication administration. 4. The DON/designee will report findings of audits of administration of medications with parameters to the monthly QAPI committee x 3 month. The Pharmacy Consultant will present his findings to the DON monthly and will report audit results at Quarterly QAPI meeting x 2 quarters.	

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F 757	Continued From page 24	F 757		

NJ Ex Order 26.4(b)(1)) greater than (>) NJ Ex Ord The order date was started on NJ Exec Order 26.4b

A review of the NJ Ex Order 26.4(b)(1) electronic Medication Administration Record (eMAR) revealed NJ Exec Order 26.4b1 was administered to Resident #15 outside the hold parameters on the following:

NJ Exec Order 26.4b1

A review of the NJ Ex Order 26.4(b)(1) electronic Medication Administration Record (eMAR) revealed NJ Exec Order 26.4b1 following:

NJ Exec Order 26.4b1

A review of the resident's individualized comprehensive care plan dated NJ Ex Order 26.4(, reflected that there was no intervention to monitor the NJ Ex Order 26.4(b)(1).

On 9/19/24 at 10:14 AM, during an interview with the surveyor, the U.S. FOIA (b) (6) admitted to missing the NJ Exec Order 26.4b1 that occurred in NJ Ex Order 26.4(b)(1) for the administration of NJ Exec Order 26.4b1 outside the hold parameter. In missing the irregularity, a recommendation to the facility was not made.

On 9/19/24 at 10:58 AM, in the presence of the survey team, the U.S. FOIA (b)(6) the surveyor discussed the concern regarding the administration of NJ Exec Order 26.4b1 outside

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F 757	Continued From page 25 the parameters for [redacted], and [redacted]. The [redacted] stated that she would educate the nurses on administration of [redacted] and its parameters. The [redacted] stated that the facility had no policy on administration of medication with parameters. A review of the facility provided medication administration pass observation for the five (5) nurses that administered the [redacted] outside of the prescribed parameters revealed only two (2) of the (3) nurses received a graded medication pass observation. No further information was provided. NJAC 8:39-27.1(a), 29.2(d)	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		10/7/24

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F 812	Continued From page 26 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store food in a manner to prevent food-borne illness and, b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: 1. On 09/17/24 at 7:30 AM, an initial brief tour of the kitchen was conducted in the presence of the U.S. FOIA (b) (6)), and the surveyor observed the following: - The large commercial food processor was stored on the metal table with the lid, and when the U.S. FOIA lifted the lid the inside was wet. The U.S. FOIA stated it should not have been left wet. - Various crumb type debris was observed on the bins which stored bulk flour and sugar. - The base of the can opener, affixed to the stainless steal table debris on the base and around - A large meat slicer was observed on the corner of the metal steam table, covered in plastic, and was identified as clean by the U.S. FOIA (b The U.S. FOIA removed the cover and there was various debris by the slicer blade, on the base of the slicer, and a blue handled food scoop was stored on the base of the slicer. 2. A follow up observation in the kitchen at 9:25 AM, in the presence of the U.S. FOIA (b the surveyor observed the following:	F 812	1. The large commercial food processor's lid was washed and dried prior to storage. The crumbs and debris found on the bulk flour and sugar bins were cleared and cleaned. The base of the can opener affixed to the stainless steel table was cleaned. Debris found on slicer blade was cleaned.The blue handle scoop was removed, cleaned and stored in drawer. The dried substances found on the soda dispensing tubes and drink dispenser boxes were cleaned. The brown substance beneath the 4 drink dispenser boxes was cleaned. The open ice cream containers were discarded and replaced with new products. The Dietary director/designee provided inservice to dietary staff on cleanliness and sanitation procedures. The Dietary director/designee provided inservice to dietary staff on proper storage of foods. The Dietary director/designee provided inservice to dietary staff on the policy and procedures for maintaining a sanitary kitchen equipment to prevent microbial growth. Staff education was provided on Equipment cleaning, cleaning vs. sanitizing, Sanitizer buckets, food storage Infection Prevention Control, Wet nesting and Can opener cleaning. 2. All residents have the potential to be affected by these practices. 3. The Dietary Director/designee utilize a daily opening and closing checklist to monitor floor cleanliness and safety as well as, all kitchen equipment cleaning,	

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F 812	Continued From page 27 In the server kitchen area, the surveyor observed the following: - A dried brown substance on 2 of the 4 dispensing tubes which came from the soda drink dispensers. - A brown substance on the floor beneath the 4 drink dispenser boxes. - Inside the box ice cream freezer, the surveyor observed 6 of 10 lids on the ice cream containers opened. The [redacted] stated that the server kitchen area should be clean and the ice cream lids should have been closed. NJAC 8:39-17.2(g)	F 812	storage, and sanitation. Opening and closing checklists are completed daily and reviewed by the Dining Director/designee daily to ensure compliance is met. Monthly sanitation audits are completed by the dietician and Dining director. 4. Daily audits and monthly sanitation reports will be reviewed and presented by the Dietary Director/designee at the monthly QAPI meetings for the next 2 quarter.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		10/2/24

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F 883	Continued From page 28 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and review of other pertinent facility documentation, it was determined the facility failed to consistently offer residents a NJ Exec Order 26.4b1. The	F 883	1. Resident #2 and #18 were offered the appropriate NJ Exec Order 26.4b1 and documented. 2. All residents who are not up to date	

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F 883	Continued From page 29 deficient practice was identified for 2 of 5 residents (#2, #18) reviewed for immunizations and was evidenced by the following. Reference: A review of the CDC's Advisory Committee on NJ Ex Order 26.4(b)(1) Practices (NJ Ex Order 26 for U.S. FOIA (b)(6) Recommendations dated/last reviewed on 2/13/23, included the following. The CDC recommends routine administration of NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1)) for all adults 65 years or older who have never received any NJ Exec Order 26.4b1 or whose previous NJ Ex Order 26.4(b)(1) history is unknown ... 1. The surveyor reviewed Resident #12's immunization history on the hybrid (paper and electronic) medical record on 9/18/24. Documentation supporting the administration of NJ Exec Order 26.4b1 could not be located on the paper or electronic sections of the record. In an interview with the unit U.S. FOIA (b)(6) on 9/18/24, the U.S. FOIA indicated all immunization documentation should be located on the electronic medical record. A review of Section NJ E of the NJ Ex Order 26 Comprehensive Minimum Data Set (MDS) assessment tool revealed the resident's NJ Exec Order 26.4b1 was not up to date. Additionally, no reason was indicated of why the NJ Ex Order 26.4(b)(1) was not given. On 9/19/24 at 11:11 AM the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) stated they could not provide evidence of U.S. FOIA (b)(6) for Resident #12.	F 883	receiving their pneumococcal immunization has the potential to be affected by these practices. 3. Resident #2 and #18 medical record was reviewed. The residents were offered the NJ Exec Order 26.4b1 . Residents received and was documented in medical record. All resident medical records were reviewed for immunization documentation. Any residents who are not up to date are offered pneumococcal immunization. All nursing staff was in-serviced on documentation of offering, receiving or declination of pneumococcal immunization. MDS coordinator also interviewed resident and reviewed immunization documentation prior to completion of MDS. The Infection Preventionist/designee will monitor all new admissions weekly x 4 and monthly x 2 for documentation of pneumococcal offering or declination. 4. The DON/designee will report audit findings at monthly QAPI meeting x3 months.	

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F 883	Continued From page 30 2. On 9/18/24 at 9:28 AM, a surveyor observed the Resident #18 sleeping in bed; the head of the bed was elevated. The resident was wearing a NJ Exec Order 26.4b1 . . The surveyor reviewed the hybrid medical record for Resident #18. According to the Face Sheet (an admission record), Resident #18 was admitted to the facility with diagnoses which included NJ Exec Order 26.4b1 Further review of the Face Sheet, under notes, reflected Resident #18's immunization record, that did not include information about the resident's NJ Exec Order 26.4b1 . Review of the Quarterly Minimum Data Set (qMDS), an assessment tool dated NJ Exec Order 26, reflected a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated that the resident was NJ Exec Order 26.4b1. Further review of the qMDS dated NJ Exec Order 26. under section NJ Ex Order 26.4(b)(1) Was the resident's NJ Exec Order 26.4b1 to date? The response was marked one (1), which indicated Yes. Section B. If NJ Exec Order 26.4b1 not received, and the reason was blank. A review of the admission assessment dated NJ Exec Order 26.4, indicated the resident received the NJ Exec Order 26.4b1 and the date was unknown.	F 883		

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F 883	Continued From page 31 On 9/18/24 at 10:27 AM, during an interview with the surveyor, the U.S. FOIA (b)(6)) stated that during admission the resident was asked if, or when they received the NJ Exec Order 26.4b1. At the time of admission NJ Ex Order 26.4b1 ago, Resident #18 was NJ Exec Order 26.4b1 and was able to inform the facility staff of having received the NJ Exec Order 26.4b1 but could not recall which type and when. At that time, in the presence of the surveyor and the U.S. FOIA (b)(6)) was asked about the qMDS information that reflected the resident's NJ Exec Order 26.4b1 was up to date. The U.S. FOIA (b)(6) stated that she received the information from the nurses during her interview with them for the qMDS dated NJ Exec Order 2. On 9/18/23 at 12:43 PM, during an interview with the surveyor, the U.S. FOIA (b)(6)) stated she did not have documentation that showed the resident was offered or declined the NJ Exec Order 26.4b1 and was not able to provide proof that an education was provided. At that time, the U.S. FOIA (b)(6) acknowledged that based on the missing consent, declination, education, the historical data provided by the resident, and a review of the hybrid medical record, Resident #18's NJ Ex Order 26.4(b)(1) status was not up to date. At that time, the U.S. FOIA (b)(6) was asked how the inaccuracy of the qMDS occurred. The U.S. FOIA (b)(6) stated she could not answer for the U.S. FOIA (b)(6) who conducted the resident's assessments for the NJ Exec Order 26.4b1.	F 883		

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F 883	Continued From page 32	F 883		

At that time, the U.S. FOIA (b)(6) stated that in the spring of 2024, she began to update the NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) surveillance for the long-term care residents to determine who was current against who was not. The U.S. FOIA (b)(6) also stated that moving forward the documentation of when a NJ Ex Order 26.4(b)(1) was received, offered, declined, and when the resident was educated would be documented.

On 9/18/24 at 12:24 PM, in the presence of the survey team, the U.S. FOIA (b)(6) , and the U.S. FOIA (b)(6) , the surveyor discussed the concerns regarding Resident #18's qMDS that reflected the resident had a current NJ Exec Order 26.4b1 while the hybrid medical record did not reflect the resident was offered, or declined and was educated on the NJ Exec Order 26.4b1 .

On 9/19/24 at 9:00 AM, the surveyor reviewed the facility's response to the concern that revealed, after surveyor inquiry, the resident's family member was contacted by the facility, then asked for a consent to administer the NJ Exec Order 26.4b1 to Resident #18. A verbal consent was given by the family member, and was informed that the administration would occur when the physician advised.

A review of the provided facility policy, Pneumonia Prevention and Control dated 9/18/24, under Procedure included the following:

1. Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has

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F 883	Continued From page 33 already been vaccinated. 5. The resident or the resident's legal representative may refuse vaccination for any reason. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the Pneumococcal vaccination. 7. Initiation of the Pneumococcal vaccine or revaccinations will be made in accordance with current Center for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. NJAC 8:39-19.4 (i)	F 883		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315515 Y1	A. Building B. Wing Y2	11/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

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 F0550	Correction	ID Prefix F0607	Correction	ID Prefix F0678	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.24(a)(3)	Completed
LSC	10/18/2024	LSC	10/14/2024	LSC	10/14/2024
ID Prefix F0690	Correction	ID Prefix F0697	Correction	ID Prefix F0757	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(k)	Completed	Reg. # 483.45(d)(1)-(6)	Completed
LSC	10/18/2024	LSC	10/18/2024	LSC	10/18/2024
ID Prefix F0812	Correction	ID Prefix F0883	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(d)(1)(2)	Completed	Reg. #	Completed
LSC	10/07/2024	LSC	10/02/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/19/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. BUILDING **01** B. WING _____	**09/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	**40 RIVERSIDE AVENUE** **RED BANK, NJ 07701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The Atrium at Navesink Harbor was not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's	E 009		11/4/24

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

Electronically Signed | 10/10/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 009	Continued From page 1 needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 09/19/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that a copy of the facility's Emergency Preparedness Plan and Program (EPP) was sent to the local and county Office of Emergency Management (OEM) for annual review in accordance with the Code of Federal Regulations (CFR) 483.73 LTC facilities. This deficient practice had the potential to affect 36 residents and was evidenced by: Record review on 09/19/24 between 9:30 AM and 2:30 PM, revealed the last documented communication with county OEM was for a forum the county had conducted on July 10, 2019. There was no document of communication with the local township OEM. There was no documentation of the emergency preparedness plan annual review including the local or county OEM. No further documentation was provided. In an interview at the time, the U.S. FOIA (b)(6) stated that they did not review the emergency preparedness plan with the local and county OEM and had no record of the annual review being done with OEM in the last 12 months. The U.S. FOIA (b)(6) were informed of the findings at the EPP exit conference at 2:35 PM. NJAC 8:39-31.2(e), 31.6(f), 31.6(h), 31.6(i)1.	E 009	1. The community failed to ensure that a copy of the facility's Emergency Preparedness Plan and Program (EPP) was sent to the local and county Office of Emergency Management (OEM) for annual review. (See attached email) 2. All residents residing in the community are at risk due to this deficient practice. 3. The community met with NJ Ex Order 26.4(d) [redacted], U.S. FOIA (b) (6), and provided a copy of the facility's Emergency Preparedness Plan and Program for annual review. The manual was reviewed by the OEM Coordinator of Red Bank and was approved. The Director of Facilities will schedule the following year's annual review for Nov. 4, 2025 and place on the Facility calendar to ensure compliance. The Administrative Assistant will provide meeting reminder and monitor compliance with meeting. The Director of Facilities will monitor time compliance and will communicate to local and county OEM 1 month prior to schedule meeting date. 4. Director of Facilities will report to monthly QAPI meeting the scheduled review of Emergency Preparedness Plan, meeting date, and communications until annual review is completed.	
E 039 SS=F	EP Testing Requirements	E 039		11/8/24

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E 039	Continued From page 2 CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 3 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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E 039	Continued From page 4 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.	E 039		

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E 039	Continued From page 5 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.	E 039		

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E 039	Continued From page 6 *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):]	E 039		

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E 039	Continued From page 7 (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:	E 039		

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E 039	Continued From page 8 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years;	E 039		

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E 039	Continued From page 9 or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem	E 039		

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E 039	Continued From page 10 statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 09/19/24 in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that a full scale community based or if community based was not available, individual facility based exercise was conducted annually with the local, county, and state, Offices of Emergency	E 039	1. The facility failed to ensure that a full scale community based or individual facility based exercise was conducted annually with invitation to the local, county and state Offices of Emergency Preparedness Plan. (See attached email, disaster drill summary, attendance sheet and photos) 2. All residents residing in the community are at risk due to this deficient practice.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 11 Management (OEM) invited to attend in accordance with Title 42 Code of Federal Regulations (CFR) at 483.73 LTC facilities. This deficient practice had the potential to affect 36 residents and was evidenced by the following: Record review of the facility's Emergency Preparedness Plan and Program (EPP)between 9:30 AM and 2:30 PM, revealed the last 2 emergency preparedness exercises performed on 06/13/24 and 12/13/23 were table top exercises conducted by a contracted service and no OEM officials were included. There were no other emergency preparedness drills or exercises provided. In an interview at the time, the [redacted] and [redacted] stated the previous [redacted] handled the emergency preparedness and he left in [redacted]. They also that they did not have any document of a community or facility based full scale exercise with the local, county and state OEM invited in the past 12 months. The [redacted] and [redacted] were informed of the findings at the EPP exit conference at 2:35 PM. NJAC 8:39-31.2(e), 8:39-31.6(f), 31.6(o)	E 039	3. The facility conducted a disaster and evacuation exercise and invited the Red Bank OEM, Monmouth County OEM and NJ OEM. Director of Facilities observed and documented the achievements and areas of opportunity of the disaster and evacuation drill along with the team in post analysis. 4. The Director of Facilities has reported the scheduled disaster drills for 2024/2025 at the monthly QAPI meeting. The Director of Facilities will audit results of disaster drills and review at corresponding monthly QAPI meeting x 1 year.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/18/2024 and The Atrium at Navesink Harbor was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. BUILDING **01** B. WING _____	**09/19/2024**

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ATRIUM AT NAVESINK HARBOR, THE	**40 RIVERSIDE AVENUE** **RED BANK, NJ 07701**

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K 000	Continued From page 12 (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. The Atrium at Navesink Harbor is a 12-story building that was built in 1965. Skilled Nursing is located on the second and third floors of the building. It is composed of Type II protected construction. The facility is divided into four - smoke zones. The generator does approximately 50% of the building as per the Maintenance Director. The current occupied beds are 36 out of 43.	K 000		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 09/18/2024 in the presence of facility management, it was determined that the facility failed to ensure that 3 of 6 stairwell exit access (leading into stairwells) doors latched into the frames to maintain the 1-1/2 hour fire rated	K 223	The facility failed to ensure that 3 of 6 stairwell exit access doors latched into the frames to maintain the 1-1/2 hour fire rated construction.(see attached document) 2. This deficient practice had the potential	10/7/24

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	315515	A. BUILDING 01 B. WING _____	09/19/2024

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ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

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K 223	Continued From page 13 construction in accordance with NFPA 101:2012 Edition. This deficient practice had the potential to affect all 36 residents and was evidenced by the following, A review of the facility provided lay-out on 09/18/2024, revealed the facility was a twelve-story building with the nursing facility resident sleeping rooms located on the second and third floors. There were two (2) exit stairwells in the facility that residents, visitors and staff could use in the event of an emergency. Observations in the presence of the U.S. FOIA (b)(6) [redacted]), revealed the following stairwell exit access doors (illuminated exit signs above the doors) that during closure tests, failed to positive latch into their frames: 1. At approximately 10:23 AM, on the 3rd. floor, the stairwell #3 door that leads to the Independent Living section of the facility did not close and positive latch into its frame. 2. At approximately 12:40 PM, on level 1, the stairwell #3 door did not close and positive latch into its frame. 3. At approximately 12:43 PM, on level R-1 (by the kitchen), the stairwell #2 door did not close and positive latch into its frame. The [redacted] confirmed the findings at the time of observations. The U.S. FOIA (b)(6) [redacted] were informed of the deficient practice during the Life Safety Code survey exit on 079/18/2024 at approximately 2:10 PM.	K 223	to affect all 36 residents. 3. The Director of Facilities/designee will monitor exit stairwells daily to check positive door latching. Checklist sheet will be completed daily during audit to ensure all exit doors are checked. 4. Director of Facilities/designee will report findings of daily audit to QAPI meeting for the next two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. BUILDING **01** B. WING _____	**09/19/2024**

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ATRIUM AT NAVESINK HARBOR, THE	**40 RIVERSIDE AVENUE** **RED BANK, NJ 07701**

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K 223	Continued From page 14 NJAC 8:39- 31.2(e)	K 223		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation on 09/18/2024 in the presence of facility management, it was determined that the facility failed to provide one (1) illuminated exit sign to clearly identify the exit access path to reach an exit discharge door in accordance with NFPA 101:2012, Sections 7.7 and 19.2. This deficient practice had the potential to affect all 38 residents and was evidenced by the following: Observations on 09/18/2024 at approximately 9:49 AM in the presence of the U.S. FOIA (b) (6) [redacted]), revealed the Physical Therapy area a door had a sign that read, "Push door will open in 15 seconds". There was no illuminated exit sign provided above the exit. The U.S. FOIA [redacted] confirmed the findings at the time of observations.	K 293	1. The facility failed to provide an illuminated exit sign to clearly identify the exit access path to reach an exit discharge door.(See attached document and pictures) 2. This deficient practice had the potential to affect all residents. 3. The Director of Facilities contracted an electrician, who installed illuminated exit sign at identified exit door.(see invoice and picture) The director of facilities will audit all egress doors for exit signs. 4. The Directors of Facilities provided documentation of exit sign installation to the monthly QAPI meeting following installation x 1 month. The Director of facilities will provide audit of egress doors for exit signs x 3 months then x one quarter.	10/2/24

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	315515	A. BUILDING **01** B. WING _____	**09/19/2024**

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K 293	Continued From page 15 The U.S. FOIA (b) (6) were informed of the deficient practice during the Life Safety Code survey exit on 09/18/2024 at approximately 2:10 PM. NJAC 8:39-31.1 (c), 31.2(e)	K 293		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315515 Y1	A. Building 01 - MAIN (2ND AND 3RD FLOORS) B. Wing Y2	11/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

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 K0223	Correction Completed 10/07/2024	ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 10/02/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			