

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

PRINTED: 07/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). Complaint #: NJ162305, NJ165081, NJ173057, NJ174738, NJ179563, NJ181490, NJ181609, and NJ183067 Survey Dates: 02/18/25 to 02/21/25 Survey Census: 144 Sample Size: 37 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000			
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		3/31/25	

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

TITLE

(X6) DATE

Electronically Signed

03/12/2025

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 640	Continued From page 1 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to complete a discharge "Minimum Data Set (MDS)" tracking form within 14 days of a resident's discharge and	F 640	F640 - Encoding / Transmitting Resident Assessments 1. The following corrective actions have been accomplished for the identified		

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F 640	<p>Continued From page 2</p> <p>submit it to the Centers for Medicare and Medicaid Services (CMS) system for one resident out of 37 sampled residents (Resident (R) 7) reviewed for MDS completion. This failure prevented the transmission and compilation of resident-specific information for payment and quality measure purposes.</p> <p>Findings include:</p> <p>Review of R7's undated "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed [redacted] was admitted to the facility on <u>NJ Ex Order 26. 4B1</u> [redacted].</p> <p>Review of R7's "Census" tab of the EMR revealed the resident <u>NJ Ex Order 26. 4B1</u> [redacted].</p> <p>Review of a "Social Service" note, dated <u>NJ Ex Order 26.4(b)(1)</u> [redacted] and located in the "Prog Note" tab of the EMR revealed, <u>NJ Ex Order 26. 4B1</u> [redacted].</p> <p>Review of R7's "MDS" tab of the EMR revealed the most recent assessments that had been completed and transmitted were admission and <u>NJ Ex Order 26.4(b)(1)</u> - 5 Day "MDSs" with an Assessment Reference Date (ARD) of <u>NJ Ex Order 26.4(b)(1)</u> [redacted].</p> <p>During an interview on 02/21/25 at 2:44 PM, the <u>U.S. FOIA (b) (6)</u> [redacted] stated a discharge tracking "MDS" should be opened and completed within 14 days of the resident discharging.</p> <p>During an interview on 02/21/25 at 3:41 PM, the</p>	F 640	<p>deficiency:</p> <p>-Resident # 7- The MDS Coordinator immediately reviewed the discharge tracking of the required Minimum Data Set (MDS) for accuracy of assessment and timely transmission. The MDS for <u>NJ Ex Order 26. 4B1</u> [redacted] was completed, submitted and accepted on 2/28/25. There was no identified negative outcome.</p> <p>2. All residents may be affected by this deficient practice.</p> <p>3. The following measures have been put into place to prevent the deficient practice from recurring:</p> <ul style="list-style-type: none"> - The Vice President of MDS/Reimbursement re-educated the new <u>U.S. FOIA (b) (6)</u> [redacted] on Federal Guidelines F640 related to coding and transmitting of MDS as outlined in the RAI Manual. - A new <u>U.S. FOIA (b) (6)</u> [redacted] was recently hired and started. - The MDS Coordinator set up a weekly schedule for all the discharged residents. - The MDS Coordinator will open and complete the discharge MDS within 14 days of the discharged date. <p>4. MDS Coordinator / Designee will audit 3 discharged residents weekly x 4 weeks and then monthly x 3 months to ensure appropriate tracking and MDS submission of discharged residents and will report any findings to the Administrator. The MDS Coordinator / Designee will report the results of these audits to the quarterly Quality Assurance Committee.</p>		

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F 640	Continued From page 3 U.S. FOIA (b) (6) stated she expected MDSs to be completed timely. Review of the facility's policy titled "RAI Process-MDS Completion," reviewed July 2024, revealed, "The MDSs will be filled out accurately, after proper collection of data, in a timely manner according to the RAI manual standards" and "Periodic checks will be performed to ensure the MDS is being opened, filled out and transmitted timely and accurately, according to the RAI requirements." Review of the RAI Manual," dated 10/01/24, revealed a "Discharge Assessment-Return Not Anticipated" "must be completed within 14 days after the discharge date."	F 640			
F 641 SS=E	NJAC 8:39-11.2 Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure five residents (Resident (R) 89, 138, 293, 295, and R299) out of 37 sampled residents had an accurate Minimum Data Set (MDS) assessment. This had the potential to cause the residents to have unmet care needs. Findings include:	F 641	F641 – Accuracy of Assessments 1. The following corrective actions have been accomplished for the identified deficiency: - Resident #138 - The MDS Coordinator immediately reviewed and completed the modification discharged assessment and submitted. There was no identified negative outcome. - Resident #293- The MDS Coordinator	3/31/25	

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F 641	<p>Continued From page 4</p> <p>1. Review of R138's "Admission Record," located in the resident's electronic medical record (EMR) section titled "Profile," revealed the resident was admitted to the facility on <u>NJ Ex Order 26. 4B1</u> [REDACTED].</p> <p>Review of R138's "Prog Note" tab in the EMR revealed a "Physician Note" dated <u>NJ Ex Order 26.4(b)(1)</u> [REDACTED] which stated <u>NJ Ex Order 26. 4B1</u> [REDACTED].</p> <p>" A "Nurses Notes," dated <u>NJ Ex Order 26.4(b)(1)</u> [REDACTED] stated <u>NJ Ex Order 26. 4B1</u> [REDACTED]."</p> <p>Review of the R138's discharge "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of <u>NJ Ex Order 26.4(b)(1)</u> [REDACTED] and located in the resident's EMR section titled "MDS," documented R138 <u>NJ Ex Order 26. 4B1</u> [REDACTED].</p> <p>During an interview on 02/20/25 at 2:05 PM, <u>U.S. FOIA (b) (6)</u> [REDACTED] 6 stated R138 had <u>NJ Ex Order 26. 4B1</u> [REDACTED].</p> <p>During an interview on 02/21/25 at 2:44 PM, the <u>U.S. FOIA (b) (6)</u> [REDACTED] stated if a resident returned home, their MDS should reflect <u>NJ Ex Order 26. 4B1</u> [REDACTED].</p> <p>2. Review of R293's "Admission Record," located in the resident's EMR section titled "Profile," revealed the resident was admitted to the facility on <u>NJ Ex Order 26. 4B1</u> [REDACTED].</p>	F 641	<p>immediately reviewed and completed the modification of the MDS to reflect the <u>NJ Ex Order 26. 4B1</u> [REDACTED]. The modified assessment was submitted. There was no identified negative outcome.</p> <p>- Resident #295- The MDS Coordinator immediately reviewed and completed the modification of the MDS to reflect that <u>NJ Ex Order 26. 4B1</u> [REDACTED]. The modified assessment was submitted. There was no identified negative outcome.</p> <p>- Resident #299 -The MDS Coordinator immediately reviewed and completed the modification of the MDS to reflect the <u>NJ Ex Order 26. 4B1</u> [REDACTED]. The modified assessment was submitted. There was no identified negative outcome.</p> <p>- Resident #89- The MDS Coordinator immediately reviewed and completed the modification of the MDS to reflect that the resident was not under <u>NJ Ex Order 26. 4B1</u> [REDACTED]. The modified assessment was submitted. There was no identified negative outcome.</p> <p>2.All residents have the potential to be affected deficient practice</p> <p>3.The following measures have been put into place to prevent the deficient practice from recurring:</p> <p>-The Vice President of MDS/Reimbursement re-educated the new <u>U.S. FOIA (b) (6)</u> [REDACTED] on Federal Guidelines F641 related to accuracy of the MDS as outlined in the RAI Manual.</p> <p>-The new <u>U.S. FOIA (b) (6)</u> [REDACTED] was recently</p>		

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F 641	<p>Continued From page 5</p> <p>Review of R293's "Orders" tab in the EMR revealed no orders for [redacted] NJ Ex Order 26. 4B1.</p> <p>Review of the R293's admission "MDS," with an ARD of 01/23/25 and located in the resident's EMR section titled "MDS," revealed [redacted] scored [redacted] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating [redacted] NJ Ex Order 26. 4B1. It further documented the resident used [redacted] while a resident or within the last 14 days.</p> <p>During an observation and interview on 02/18/25 at 10:12 AM, R293 had a [redacted] NJ Ex Order 26. 4B1 [redacted] and R293 reported not utilizing a [redacted] NJ Ex Order 26. 4B1 since admission or during the 14 days prior to admission.</p> <p>During an interview on 02/20/25 at 2:00 PM, [redacted] U.S. FOIA (b) (6) [redacted] 6 stated R293 did not use a [redacted] NJ Ex Order 26. 4B1, and the facility admitted no residents on [redacted] NJ Ex Order 26. 4B1.</p> <p>Review of the "Facility Assessment" dated [redacted] NJ Ex Order 26.4(b)(1) [redacted] revealed the facility did not admit residents on [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>During an interview on 02/21/25 at 2:44 PM, the [redacted] U.S. FOIA (b) (6) [redacted] stated unless a resident was on a [redacted] NJ Ex Order 26. 4B1 [redacted] should not be coded on the MDS. The [redacted] U.S. FOIA (b) (6) [redacted] was unaware of anyone in the facility who used a [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>3. Review of R295's "Admission Record," located in the resident's EMR section titled "Profile," revealed the resident was admitted to the facility on [redacted] NJ Ex Order 26. 4B1 [redacted].</p>	F 641	<p>hired and started.</p> <p>4.MDS Coordinator / Designee will audit 5 residents weekly x 4 weeks and then monthly x 3 months to ensure appropriate accuracy of the resident's status on the MDS being submitted and will report any findings to the Administrator. The MDS Coordinator / Designee will report the results of these audits to the quarterly Quality Assurance Committee.</p>	

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F 641	<p>Continued From page 6</p> <p><i>NJ Ex Order 26. 4B1</i></p> <p>Review of R295's "Care Plan" located in the "Care Plan" section of the EMR revealed the resident required a <i>NJ Ex Order 26. 4B1</i>.</p> <p>Review of the R295's admission "MDS," with an ARD of <i>NJ Ex Order 26.4(b)(1)</i> and located in the resident's EMR section titled "MDS," revealed <i>NJ Ex Or</i> scored <i>NJ Ex</i> out of 15 on the "BIMS," indicating <i>NJ Ex Order 2</i>. It further documented the resident had an <i>NJ Ex Order 26. 4B1</i>.</p> <p>During an observation and interview on 02/18/25 at 3:42 PM, R295 had a <i>NJ Ex Order 26. 4B1</i> hanging from the bed. R295 reported the <i>NJ Ex Order 26. 4B1</i> prior to <i>NJ Ex O</i> admission to the facility. R295 also reported <i>NJ Ex Order 26. 4B1</i>.</p> <p>During an interview on 02/21/25 at 2:44 PM, the <i>U.S. FOIA (b) (6)</i> stated when a resident had a <i>NJ Ex Order 26. 4</i> needed coded as <i>NJ Ex Order 26. 4B1</i>.</p> <p>4. Review of R299's "Admission Record," located in the resident's EMR section titled "Profile," revealed the resident was admitted to the facility on <i>NJ Ex Order 26. 4B1</i>.</p> <p>Review of R299's "Orders" tab in the EMR revealed no orders for <i>NJ Ex Order 26. 4B1</i>.</p> <p>Review of the R293's admission "MDS," with an ARD of <i>NJ Ex Order 26.4(b)(1)</i> and located in the resident's EMR section titled "MDS," revealed <i>NJ Ex</i> scored</p>	F 641		

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F 641	<p>Continued From page 7</p> <p>^{NJ Ex Order} out of 15 on the "BIMS," indicating ^{NJ Ex Order 26. 4B1}. It documented the resident used ^{NJ Ex Order 26. 4B1} while a resident or within the last 14 days.</p> <p>During an observation on 02/18/25 at 12:30 PM, R299 had ^{NJ Ex Order 26. 4B1}. No ^{NJ Ex Order 26. 4B1} was in use.</p> <p>During an interview on 02/20/25 at 2:00 PM, LPN6 stated the facility admitted no residents on ^{NJ Ex Order 26. 4B1}.</p> <p>Review of the "Facility Assessment" dated ^{NJ Ex Order 26.4(b)(1)} revealed the facility did not admit residents on ^{NJ Ex Order 26. 4B1}.</p> <p>During an interview on 02/21/25 at 2:44 PM, the ^{U.S. FOIA (b) (6)} stated unless a resident was on a ^{NJ Ex Order 26. 4B1} should not be coded on the MDS. The ^{U.S. FOIA (b) (6)} was unaware of anyone in the facility who used a ^{NJ Ex Order 26. 4B1}.</p> <p>During an interview on 02/21/25 at 3:41 PM, the ^{U.S. FOIA (b) (6)} stated she expected MDSs to be coded accurately. The facility's "RAI Process - MDS Completion" policy, last reviewed 07-2024, stated "The MDSs will be filled out accurately, after proper collection of date, in a timely manner according to the RAI manual standards."</p> <p>Review of the RAI Manual," dated 10/01/24, indicated, ". . . It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was</p>	F 641			

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F 641	<p>Continued From page 8 during that observation period) by the IDT completing the assessment. . ."</p> <p>5. Review of R89's "Admission Record" face sheet located in the EMR under the "Admission Record" tab revealed [redacted] was admitted to the facility [redacted] NJ Ex Order 26. 4B1</p> <p>[redacted]</p> <p>Review of R89's annual "MDS" assessment located in the "MDS" tab of the EMR with an ARD of [redacted] NJ Ex Order 26.4(b)(1), revealed R89 had a "BIMS" of [redacted] out of 15 which indicated R89 was [redacted] NJ Ex Order 26. 4B1. Review further revealed R89 had not received [redacted] NJ Ex Order 26. 4B1.</p> <p>Review of R89's quarterly MDS assessment located in the "MDS" tab of the EMR with an ARD of [redacted] NJ Ex Order 26.4(b)(1) revealed R89 received [redacted] NJ Ex Order 26. 4B1.</p> <p>Review of R89's quarterly MDS assessment located in the "MDS" tab of the EMR with an ARD of [redacted] NJ Ex Order 26.4(b)(1) revealed R89 had not received [redacted] NJ Ex Order 26. 4B1.</p> <p>During an interview on 02/21/25 at 3:49 PM with the [redacted] U.S. FOIA (b) (6) revealed R89 had never been with [redacted] NJ Ex Order 26. 4B1 and the quarterly MDS was inaccurate.</p> <p>During an interview on 02/21/25 at 4:00 PM with the [redacted] U.S. FOIA (b) (6) revealed the MDS coding should be accurate and timely.</p> <p>Review of the facility's policy titled, "RAI Process-MDS Completion," revealed it was their</p>	F 641			

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F 641	Continued From page 9 policy to follow the requirements and standards of the latest published RAI manual. The policy further revealed all disciplines would assess all aspects of the resident's care and needs accurately. The policy revealed the MDS would be filled out accurately.	F 641			
F 645 SS=D	NJAC 8:39-33.2(d) PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 645		3/12/25	

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F 645	<p>Continued From page 10</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.</p> <p>§483.20(k)(2) Exceptions. For purposes of this section-</p> <p>(i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.</p> <p>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-</p> <p>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,</p> <p>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and</p> <p>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.</p> <p>§483.20(k)(3) Definition. For purposes of this section-</p> <p>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).</p> <p>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by:</p>	F 645			

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F 645	<p>Continued From page 11</p> <p>Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to ensure one out of two resident (Resident (R)4) had an accurate Pre-Admission Screening and Resident Review (PASRR) done out of the 37 sampled residents. This failure put R4 at risk of not receiving the services needed.</p> <p>Findings include:</p> <p>Review of R4's "Admission Record" face sheet located under the "Admission Record" tab of the electronic medical record (EMR) revealed [redacted] was [redacted] NJ Ex Order 26. 4B1</p> <p>[redacted]</p> <p>Review of R4's annual "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of [redacted] revealed R4 had a Brief Interview for Mental Status (BIMS) [redacted] out of 15 which indicated [redacted].</p> <p>Review of the comprehensive care plan, located in the EMR under the "Care Plan" tab with a review date of [redacted] revealed [redacted].</p> <p>Review of the PASRR Level I screen assessment, dated [redacted], revealed a [redacted]. The screening further revealed R4 did not qualify for a [redacted].</p>	F 645	<p>F645- PASARR Screening for MD & ID</p> <p>1. The following corrective actions have been accomplished for the identified deficiency:</p> <ul style="list-style-type: none"> - Resident # 4 The U.S. FOIA (b) (6) [redacted] immediately completed the PASARR form to accurately screen the identified resident's NJ Ex Order 26. 4B1 [redacted]. <p>There was no identified negative outcome to the identified resident.</p> <p>2. All residents have the potential to be affected deficient practice</p> <p>3. The following measures have been put into place to prevent the deficient practice from recurring:</p> <ul style="list-style-type: none"> - The Administrator in-serviced the U.S. FOIA (b) (6) [redacted] on [redacted] Federal Guidelines F645 Preadmission Screening for individuals with a mental disorder and individuals with intellectual disabilities - The Social Worker will complete the audit of all the residents with a diagnosis of mental illness and intellectual disability to ensure all PASARR Screenings are accurately completed. <p>4. The Director of Social Services or designee will audit the PASARR for all new admissions daily x 4 weeks and weekly x 3 months ensure the PASARR accurately includes all diagnosis related to mental disorder or intellectual disability and will report any findings to the Administrator. The results of these audits will be reported quarterly to the QAPI committee.</p>		

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F 645	<p>Continued From page 12</p> <p>NJ Ex Order 26. 4B1.</p> <p>During an interview on 02/21/25 at 11:42 AM with the U.S. FOIA (b) (6) revealed the PASRR came with the admission packet from the hospital. The U.S. FOIA (b) (6) revealed she did not review the PASRR for accuracy.</p> <p>During an interview on 02/21/25 at 11:51 AM with the U.S. FOIA (b) (6) revealed she did not review the NJ Ex Order 26. 4B1. The U.S. FOIA (b) (6) revealed she only uploaded the PASRR into the computer system. The U.S. FOIA (b) (6) further revealed the U.S. FOIA (b) (6) would review the PASRR NJ Ex Order 26. 4B1.</p> <p>During an interview on 02/21/25 at 12:01 PM with the U.S. FOIA (b) (6) revealed she reviewed the clinical chart on admissions and she would check the PASARR if it was included in the packet. The U.S. FOIA (b) (6) confirmed the PASARR was inaccurate because R4 had a NJ Ex Order 26. 4B1. The U.S. FOIA (b) (6) revealed a PASARR NJ Ex Order 26. 4B1 would indicate if a resident needed special services that the facility would be able to offer. The U.S. FOIA (b) (6) revealed she did not know who was responsible for ensuring the PASARR NJ Ex Order 26. 4B1 were accurate.</p> <p>Review of the facility's policy titled, Preadmission Screening and Annual Resident Review (PASRR) created on 08/14 and reviewed on 08/24, revealed the PASARR process consisted of a Level I screen and a review and implementation of the Level II recommendations upon admission to the facility. The policy further revealed the PASRR process required that all applicants to the Medicaid certified Nursing Facilities be given a preliminary assessment to determine whether</p>	F 645		

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F 645	Continued From page 13 they might have a pertinent diagnosis which was called a Level I screen. The policy revealed those individuals who test positive at Level I will be evaluated in depth, which was called a PASRR Level II and a determination would be made of the need for an appropriate setting and a set of recommendations for services.	F 645			
F 656 SS=D	NJAC 8:39-5.1(a) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		3/31/25	

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F 656	<p>Continued From page 14</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure comprehensive care plans were initiated for two out of three residents (Resident (R) 63 and R128) of the 37 sampled residents. Specifically, R63 was on NJ Ex Order 26.4B1, and R128 had NJ Ex Order 26.4B1 that were not addressed in the care plan.</p> <p>Findings include:</p> <p>1. Review of R63's "Admission Record" face sheet located in the "Admission Record" tab of the electronic medical record (EMR), revealed R63 was admitted to the facility on NJ Ex Order 26.4B1</p>	F 656	<p>F656 Develop/Implement Comprehensive Care Plan</p> <p>1. The following corrective actions have been accomplished for the identified deficiency: Resident #63 The Director of Nursing immediately updated the Care Plan of the resident to reflect NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)</p> <p>Resident #128 -The resident was discharged from the facility NJ Ex Order 26.4(b)(1) and no longer a resident of the facility, therefore the Care Plan could not be updated.</p> <p>2. All residents have the potential to be affected deficient practice</p> <p>3. The following measures have been put into place to prevent the deficient practice: - The Director of Nursing and Assistant</p>		

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F 656	<p>Continued From page 15</p> <p><i>NJ Ex Order 26. 4B1</i></p> <p>Review of R63's admission "MDS" under the "MDS" tab in the EMR, with an ARD of <i>NJ Ex Order 26.4(b)(1)</i> revealed a BIMS of <i>NJ Ex Order 26.4B1</i> out of 15 which indicated his <i>NJ Ex Order 26. 4B1</i>.</p> <p>Review of the comprehensive care plan located under the "Care Plan" tab in the EMR, with a review date of <i>NJ Ex Order 26.4(b)(1)</i> revealed there was not any problem for <i>NJ Ex Order 26. 4B1</i> medication usage.</p> <p>Review of the physician orders, dated <i>NJ Ex Order 26.4(b)(1)</i> for <i>NJ Ex Order 26. 4B1</i>.</p> <p>Review of the physician orders revealed an order for a <i>NJ Ex Order 26. 4B1</i> every shift for <i>NJ Ex Order 26. 4B1</i> for one day before and after medication administration. Another physician order was for <i>NJ Ex Order 26. 4B1</i>.</p> <p>The physician orders included <i>NJ Ex Order 26. 4B1</i>.</p> <p>A physician order was obtained on <i>NJ Ex Order 26.4(b)(1)</i> for a <i>NJ Ex Order 26. 4B1</i>.</p> <p>During an observation on 02/18/25 at 10:03 AM R63 was lying in bed in his room and <i>NJ Ex Order 26. 4B1</i>.</p> <p>During an interview on 02/21/25 at 2:40 PM with LPN1 revealed there should be a care plan due to <i>NJ Ex Order 26. 4B1</i> for R63. LPN1</p>	F 656	<p>Director of Nursing in-serviced the Interdisciplinary Team on Federal Guidelines F656 Develop/Implement Comprehensive Care Plan.</p> <p>- The Nursing Director in conjunction with the Interdisciplinary team have audited all residents with religious / cultural preferences and those with a problem for hydration or interventions for IV fluid and IV medication usage to ensure comprehensive care plans are updated accurately in a timely manner</p> <p>4. The DON and/or designee will complete 3 resident care plan audits per week for 4 weeks and 10 resident's care plans monthly for 3 months to ensure the comprehensive care plan is completed for the individualized resident. The results of these audits will be reported to the quarterly QAPI committee.</p>	

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F 656	<p>Continued From page 16</p> <p>revealed, after she reviewed the care plan, there was not any care plan for the <u>NJ Ex Order 26. 4B1</u> [REDACTED] and there should be. LPN1 stated a care plan informed the staff of R63's needs.</p> <p>During an interview on 02/21/25 at 3:30 PM with the ^{U.S. FOIA (b) (6)} [REDACTED] revealed R63 should have a care plan for <u>NJ Ex Order 26. 4B1</u> [REDACTED] and after she reviewed the care plan state R63 did not have a care plan for <u>NJ Ex Order 26. 4B1</u> [REDACTED]. LPN1 revealed the purpose of the care plan was to guide the staff on R63's care. LPN1 revealed the staff that took the order should have put it on the care plan.</p> <p>During an interview on 02/21/25 at 12:30 PM with the ^{U.S. FOIA (b) (6)} [REDACTED] revealed <u>NJ Ex Order 26. 4B1</u> [REDACTED] should be included in R63's care plan.</p> <p>Record review of the facility's policy titled, "Care Plan Process," with a last reviewed and revised date of 09/24, revealed a care plan should be developed that was appropriate for each resident's needs. The policy further revealed a care plan should incorporate identified problems with appropriate interventions. The care plan policy further revealed the plan of care must describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and social well-being.</p> <p>2. Review of R128's "Admission Record," located in the resident's electronic medical record (EMR) section titled "Profile," revealed the resident was admitted to the facility on <u>NJ Ex Order 26. 4B1</u> [REDACTED]. R128's <u>NJ Ex Order 26. 4B1</u> [REDACTED].</p>	F 656			

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F 656	<p>Continued From page 17</p> <p>Review of the "Orders" tab of the EMR revealed R128 had an order on admission, NJ Ex Order 26.4B1 [REDACTED].</p> <p>Review of a NJ Ex Order 26.4 "Assessment," dated NJ Ex Order 26.4(b) and located in the resident's EMR section titled "Assmnts" revealed no response to the NJ Ex Order 26.4(b)(1) " area and "none; per nurse via phone" as the response for NJ Ex Ord Preferences/Dislikes."</p> <p>Review of the R128's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Ex Order 26.4(b) and located in the resident's EMR section titled "MDS," revealed NJ Ex Ord scored NJ Ex out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating NJ Ex Order 26.4B1.</p> <p>Review of R128's "Care Plan," located in the resident's EMR section titled "Care Plan," revealed NJ Ex Order 26.4B1 [REDACTED], revised on NJ Ex Order 26.4(b). Interventions included to monitor intakes, provide NJ Ex Ord as ordered, and obtain NJ Ex Ord preferences as needed. The "Care Plan" did not address R128's NJ Ex Order 26.4(b)(1) and corresponding NJ Ex Order 26.4 [REDACTED].</p> <p>During an interview on 02/18/25 at 1:59 PM, R128 stated due to NJ Ex Ord and NJ Ex Order 26.4 [REDACTED] NJ Ex Ord stated NJ Ex Ord had to order other foods on days there was NJ Ex Order 26.4B1 [REDACTED], and so NJ Ex Ord often ate NJ Ex Order 26.4 [REDACTED].</p> <p>During an interview on 02/19/25 at 3:55 PM, Certified Nurse Aide (CNA) 10 stated only</p>	F 656		

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F 656	<p>Continued From page 18</p> <p>females could assist R128 with ^{NJ Ex Order 26.4(b)(1)} [REDACTED]. If a ^{NJ Ex Order 26.4(b)(1)} [REDACTED] [REDACTED].</p> <p>During an interview on 02/20/25 at 4:00 PM, the ^{U.S. FOIA (b) (6)} [REDACTED] stated she had worked at the facility for one month and could not state what alternatives were offered to R128 for ^{NJ Ex Order 26.4B1} [REDACTED]. The facility had an "NJ Ex Order 26.4B1" menu.</p> <p>During an interview on 02/21/25 at 11:48 AM, the ^{U.S. FOIA (b) (6)} [REDACTED] stated she was aware of R128's ^{NJ Ex Order 26.4B1} [REDACTED] and that R128 frequently requested ^{NJ Ex Order 26.4(b)(1)} [REDACTED], and ^{NJ Ex Order 26.4(b)(1)} [REDACTED] sometimes twice for one ^{NJ Ex Order 26.4(b)(1)} [REDACTED]. The ^{U.S. FOIA (b) (6)} [REDACTED] said she was not involved in care planning.</p> <p>During an interview on 02/21/25 at 2:32 PM, ^{U.S. FOIA (b) (6)} [REDACTED] 5 stated she or the ^{U.S. FOIA (b) (6)} [REDACTED] initiated care plans for the floor. Care plans were then updated as needed through report at morning meetings and as changes occurred. Updates were completed by whoever got to them first. RN5 expected ^{NJ Ex Order 26.4(b)(1)} [REDACTED] needs and preferences to be included in the care plan.</p> <p>During an interview on 02/21/25 at 2:44 PM, the ^{U.S. FOIA (b) (6)} [REDACTED] stated nursing management initiated the care plans. The care plans were then updated quarterly with MDS assessments and as needed. The ^{U.S. FOIA (b) (6)} [REDACTED] stated it was a team effort to maintain the accuracy of the care plans. Preferences, such as ^{NJ Ex Order 26.4(b)(1)} [REDACTED], should be on the care plan.</p> <p>During an interview on 02/21/25 at 3:41 PM, the ^{U.S. FOIA (b) (6)} [REDACTED] said she expected ^{NJ Ex Order 26.4(b)(1)} [REDACTED] and ^{NJ Ex Order 26.4(b)(1)} [REDACTED] preferences to be care planned and verified that R128's were not.</p>	F 656			

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F 656	Continued From page 19 Review of the facility's "Care Plan Process" policy, reviewed 09/2024, stated, "The plan of care must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and social well-being."	F 656			
F 657 SS=D	NJAC 8:39-11.2(e)thru(i) NJAC 8:39-27.1(a) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		3/31/25	

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F 657	<p>Continued From page 20</p> <p>comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure comprehensive care plans were revised for one out of three residents (Resident (R91) of the 37 sampled residents. Specifically, R91 had a <u>NJ Ex Order 26. 4B1</u> and it was not addressed in the care plan.</p> <p>Findings include:</p> <p>Review of the "Admission Record" face sheet located in the "Admission Record" tab of the electronic medical record (EMR), revealed R91 was admitted to the facility on <u>NJ Ex Order 26. 4B1</u>.</p> <p>Review of R91's annual "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of <u>NJ Ex Order 26.4(b)</u> revealed R91 had a Brief Interview for Mental Status (BIMS) of <u>NJ Ex Order 26.4(b)</u> out of 15 which indicated R91 was <u>NJ Ex Order 26. 4B1</u>. R91 had <u>NJ Ex Order 26. 4B1</u>.</p> <p>Review of the comprehensive care plan, located in the EMR under the "Care Plan" tab with an initiated date of <u>NJ Ex Order 26.4(b)</u> and revised on <u>NJ Ex Order 26.4(b)</u> revealed <u>NJ Ex Order 26. 4B1</u>.</p>	F 657	<p>F657 Care Plan Timing & Revision</p> <p>1. The following corrective actions have been accomplished for the identified deficiency:</p> <ul style="list-style-type: none"> - Resident #91-The Director of Nursing immediately updated the care plan and interventions to include <u>NJ Ex Order 26. 4B1</u>. <p>2. All residents have the potential to be affected deficient practice.</p> <p>3. The following measures have been put into place to prevent the deficient practice:</p> <ul style="list-style-type: none"> - The Director of Nursing and the Assistant Director of Nursing will in-service the Unit Managers and the Occupational Therapist on Federal Guidelines F657 related to Care Plan Timing and Revision. - The Rehab Director audited all the resident's with <u>NJ Ex Order 26. 4B1</u> to ensure the contracture and interventions are addressed in the care plan <p>4. The Rehab Director / Designee will audit 3 care plans for residents with contractures weekly x 4 weeks and then monthly x 3 months to ensure appropriate tracking and MDS submission of discharged residents and will report any findings to the Administrator. The results of these audits will be reported Quarterly to the QAPI committee.</p>		

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F 657	Continued From page 21 NJ Ex Order 26. 4B1 was not addressed. Record review of the physician orders, dated NJ Ex Order 26.4(b)(1) located under the "Orders" tab of the EMR revealed R91 had an order for NJ Ex Order 26. 4B1 [REDACTED]. During an interview on 02/21/25 at 2:33 PM with LPN1 revealed the initial care plan was initiated by the U.S. FOIA (b) (6), nurses, dietary, rehab, and activities update the care plan. LPN1 further revealed the NJ Ex Order 26. 4B1 [REDACTED] should be addressed on the care plan and it was not addressed. During an interview on 02/21/2025 at 2:48 PM, U.S. FOIA (b) (6) revealed the managers on the unit initiated the care plan, and social services, dietary, and activities all initiated and updated care plans. The U.S. FOIA (b) (6) revealed the team all oversaw that the care plan was accurate. The MDS further revealed R91 should be care planned NJ Ex Order 26. 4B1 and she reviewed the care plan, which included NJ Ex Order 26. 4B1 [REDACTED], but was added to the care plan on NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated the U.S. FOIA (b) (6) that took the order for RNP, which included NJ Ex Order 26. 4B1 [REDACTED], should have updated the care plan.	F 657			
F 688 SS=D	NJAC 8:39-11.2(e)(h) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		3/31/25	

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F 688	<p>Continued From page 22</p> <p>resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure one out of the 37 sampled residents (Resident (R)91) who had ^{NJ Ex Order 26. 4B1} [REDACTED].</p> <p>This failure put R91 at ^{NJ Ex Order 26. 4B1} [REDACTED].</p> <p>Findings include:</p> <p>Review of the "Admission Record" face sheet located in the "Admission Record" tab of the electronic medical record (EMR), revealed R91 was admitted to the facility on ^{NJ Ex Order 26. 4B1} [REDACTED].</p> <p>Review of R91's annual "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the EMR with an Assessment Reference Date</p>	F 688	<p>F688 – Increase / Prevent Decrease in ROM / Mobility</p> <p>1. The following corrective actions have been accomplished for the identified deficiency:</p> <ul style="list-style-type: none"> - Resident #91-The Unit Manager discontinued the resident's ^{NJ Ex Order 26. 4B1} [REDACTED] since ^{NJ Ex Order 26. 4B1} [REDACTED] is currently on the ^{NJ Ex Order 26. 4B1} [REDACTED]. No identified negative outcome. 2. All residents have the potential to be affected deficient practice 3. The following measures have been put into place to prevent the deficient practice from recurring: <ul style="list-style-type: none"> - The Director of Nursing will in-service the Rehab Department, nurses, CNAs, and Restorative Aide on Federal Guidelines F688 Increase / Prevent Decrease in ROM / Mobility/ splints and orders. - All residents with contractures and 		

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F 688	<p>Continued From page 23</p> <p>(ARD) of [redacted] revealed R91 had a Brief Interview for Mental Status (BIMS) of [redacted] out of 15 which indicated R91 was [redacted] NJ Ex Order 26. 4B1 [redacted]. R91 had a [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>Review further revealed R91 had received [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>Review revealed R91 had not received any [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>Review of the comprehensive care plan, located in the EMR under the "Care Plan" tab with an initiated date of [redacted] NJ Ex Order 26.4(b)(1) [redacted] and revised on [redacted] NJ Ex Order 26.4(b)(1) [redacted] revealed [redacted] NJ Ex Order 26. 4B1 [redacted]. Interventions included [redacted] NJ Ex Order 26. 4B1 [redacted]. [redacted] was not addressed.</p> <p>Record review of the physician orders, dated [redacted] NJ Ex Order 26.4(b)(1) [redacted] located under the "Orders" tab of the EMR revealed R91 had an order for [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>During an observation on 02/19/2025 at 8:38 AM, R91 was lying in bed in [redacted] NJ Ex Order 26.4(b)(1) [redacted] room and did not have any [redacted] NJ Ex Order 26. 4B1 [redacted]. Observation further revealed a [redacted] NJ Ex Order 26. 4B1 [redacted] was not laying around in the room.</p> <p>During an observation on 02/19/25 at 2:50 PM R91 was up in [redacted] NJ Ex Order 26. 4B1 [redacted] at the nurses station and did not have a [redacted] NJ Ex Order 26. 4B1 [redacted].</p>	F 688	<p>splints were audited to ensure restorative nursing program is in place with care plan and Kardex interventions in place.</p> <p>-The Director of Nursing will in-service the therapist on how to write an order for the splints.</p> <p>4. The Director of Rehab or designee will audit 5 resident charts for those on the Nursing Restorative Program weekly x 4 weeks and then monthly x 3 months to ensure that communication in regard to residents placed on the Restorative Nursing Program is appropriately documented in the electronic medical record and plan is being appropriately followed. The findings will be reported to the quarterly QAPI committee.</p>	

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F 688	<p>Continued From page 24</p> <p>During an observation on 02/20/25 at 10:25 AM, R91 was lying in [redacted] bed in [redacted] room and the [redacted]</p> <p>During an observation on 02/20/25 at 3:57 PM, R91 was sitting in [redacted] up at the nurse's station and [redacted]</p> <p>During an interview on 02/21/25 at 8:46 AM with the [redacted] U.S. FOIA (b) (6) revealed he did not do [redacted] of R91 because it was the nurse's responsibility to apply them. The [redacted] U.S. FOIA (b) (6) revealed he did [redacted] for R91 but since [redacted] NJ Ex Order 26. 4B1, he would not be performing [redacted] NJ Ex Order 26. 4B1. The [redacted] U.S. FOIA (b) (6) revealed the nursing staff knew they were supposed to apply the [redacted] NJ Ex Order 26. 4B1 of R91.</p> <p>During an interview on 02/21/25 at 8:46 AM with the [redacted] U.S. FOIA (b) (6) revealed an [redacted] NJ Ex Order 26. 4B1 had been done on [redacted] NJ Ex Order 26.4(b)(7) and they would be working on [redacted] NJ Ex Order 26. 4B1. The [redacted] U.S. FOIA (b) (6) revealed the [redacted] NJ Ex Order 26. 4B1 should have been applied to R91's [redacted] NJ Ex Order 26. 4B1, by the nurses, up until the [redacted] NJ Ex Order 26. 4B1 was completed. The [redacted] U.S. FOIA (b) (6) revealed R91 was at risk of not maintaining [redacted] NJ Ex Order 26. 4B1.</p> <p>During an interview on 02/21/25 at 9:18 AM with Certified Nursing Assistant (CNA)9 revealed he had not applied any [redacted] NJ Ex Order 26. 4B1 to R91's [redacted] NJ Ex Order 26. 4B1 and it was not on the Kardex to apply any.</p>	F 688			

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F 688	<p>Continued From page 25</p> <p>Review of the "Kardex" as of 02/19/25 indicated the NJ Ex Order 26. 4B1 were not listed on the document.</p> <p>During an interview on 02/21/25 at 9:25 AM with Licensed Practical Nurse (LPN)² revealed R91 should have had NJ Ex Order 26. 4B1 but the NJ Ex Order 26. 4B1 was supposed to be applied by NJ Ex Order 26. 4B1.</p> <p>During an interview on 02/21/25 at 10:31 AM RN4 revealed NJ Ex Order 26. 4B1 was not done until NJ Ex Order 26. 4B1 educated the staff on how to apply the NJ Ex Order 26. 4B1 of R91 even though the physician ordered the NJ Ex Order 26. 4B1 on NJ Ex Order 26.4(b)(1) and initially on NJ Ex Order 26.4(b)(1). RN4 revealed R91 was on a trial program right now with NJ Ex Order 26. 4B1 and would not be receiving any NJ Ex Order 26. 4B1. RN4 revealed an NJ Ex Order 26. 4B1 was done on NJ Ex Order 26.4(b)(1).</p> <p>During an interview on 02/21/25 at 12:30 PM with the U.S. FOIA (b) (6) revealed when the physician ordered the NJ Ex Order 26. 4B1 on NJ Ex Order 26.4(b)(1) it should have been applied on that day to prevent any further NJ Ex Order 26. 4B1.</p> <p>During an interview on 02/21/25 at 2:48 PM, U.S. FOIA (b) (6) revealed R91 should have been care planned for NJ Ex Order 26. 4B1 and she reviewed the care plan, which included a NJ Ex Order 26. 4B1 but was added to the care plan on NJ Ex Order 26.4(b)(1).</p> <p>Review of the undated "Policy and Procedure Manual for Functional Maintenance/Restorative Nursing Program," revealed the restorative</p>	F 688			

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F 688	Continued From page 26 nursing program was developed to assist in the delivery of interventions that promote a resident's ability to function at their highest level. The policy further revealed a resident's ability to perform active or passive range of motion exercises would not diminish unless the clinical condition demonstrated that diminution was unavoidable.	F 688			
F 836 SS=C	NJAC 8:39-27.1(a) License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human	F 836		3/12/25	

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F 836	<p>Continued From page 27</p> <p>subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview, the facility failed to ensure the facility received licensure and certification approval prior to changing the name of the facility on the facility sign located outside the facility. Failure to get approval prior to changing the name of the facility on the sign had the potential to result in confusion among visitors, employees, and residents. This had the potential to affect 144 of 144 residents in the facility.</p> <p>Findings include:</p> <p>Review of the facility State license titled "New Jersey Department of Health" "Division of Certification of Need and Licensing" "License" stated the facility was licensed to operate as "Atrium Post Acute Care of Wayne" consisting of 209 Long-Term Care Beds.</p> <p>Observations upon the facility at 8:15 AM on 02/18/25, 02/29/25, 02/20/25, and 02/21/25, revealed the sign located at the driveway to the facility read "Alps at Wayne." The sign was a banner that completely covered the facility's original sign.</p> <p>Interview with the U.S. FOIA (b) (6) on 02/19/24 at 1:04 PM, revealed they were in the application process and were unable to provide approval for the name change. When asked if she had a</p>	F 836	<p>F836 - License / Comply w/ Fed / State / Locl law / Prof Std</p> <p>1. The following corrective actions have been accomplished for the identified deficiency:</p> <ul style="list-style-type: none"> - The Maintenance Director removed the temporary sign that covered the facilities original sign 2. All residents have the potential to be affected deficient practice 3. The following measures have been put into place to prevent the deficient practice from recurring: <ul style="list-style-type: none"> - The Administrator reviewed the Federal Guidelines for F836 License / Comply with Federal , State, Local laws and Professional Standards - The Maintenance Director removed the temporary sign that covered the facilities original sign 4. The Administrator will review daily the facility sign x 7 days and weekly x 2 weeks and monthly x 3 months to ensure the original sign remains visible until the License for the Change of Ownership is approved and the new name is placed on the License. The findings will be reported to the quarterly QAPI committee. 		

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F 836	<p>Continued From page 28</p> <p>CMS-855B form she stated they had not completed one because that gets completed further in the approval process. When asked about the name change and the U.S. FOIA (b) (6) stated the name change was not official, and they were in the process of getting the name changed.</p> <p>Further interview on 02/19/25 at 1:34 PM the U.S. FOIA (b) (6) provided the following documents: A letter from an attorney, dated 01/03/25, titled "Change of Information" referring to exhibits that were not attached to the letter.</p> <p>Review of a letter from an attorney, dated 01/29/25, with the "Application for a Long-Term Care Facility License" with attachments. The attachments include an "Application for a Long-Term Care Facility License", a certificate of a Merger, and an Interim Management Agreement.</p> <p>A letter from an attorney, dated 02/18/25, revealed the transfer of ownership application again referred to attachments that were not attached or provided with the information she gave me.</p> <p>Review of an undated document titled, "CHOW [Change of Ownership]" application from the New Jersey Department of Health thanking them for submitting their application.</p> <p>The facility did not provide CMS 855B or any documentation showing the name change was approved.</p> <p>On 02/20/25 at 2:00 PM, the U.S. FOIA (b) (6) verified they did not have an approval letter from the State Licensure agency approving the name</p>	F 836			

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F 836	Continued From page 29 change.	F 836			
F 880 SS=D	<p>NJAC 8:39-2.1 thru 2.7</p> <p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be</p>	F 880		3/31/25	

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F 880	<p>Continued From page 30 reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure infection control procedures were followed while lunch trays were being passed on one of the three floors. This failure puts residents at risk for infections.</p>	F 880	<p>F880 – Infection Control</p> <p>1. The following corrective actions have been accomplished for the identified deficiency:</p> <ul style="list-style-type: none"> - The Infection Preventionist Nurse (IPN) immediately in-serviced CNA2, all the 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 31</p> <p>Findings include:</p> <p>Review of the facility's policy titled, "Infection Control Transmission Precautions-Enhanced Barrier Precautions" dated 05-2024, revealed the policy was to provide guidance on when to implement enhanced barrier precautions. The policy further revealed the "facility was committed to providing a safe and healthy environment for residents to minimize or prevent the spread of disease." The policy revealed clear signage should be on the door or wall by the resident's room indicating the type of precautions.</p> <p>During an observation on 02/18/25 at 12:26 PM on the third-floor unit revealed lunch trays were being passed by staff. Certified Nursing Assistant (CNA)2 passed a tray to room [redacted] which had signage on the wall that said <u>NJ Ex Order 26. 4B1</u> [redacted] and to sanitize your hands upon entry and exit to the room. CNA2 did not sanitize his hands before going into the room and leaving the room. CNA2 continued to pass tray to room [redacted] which did not have <u>NJ Ex Order</u>, and he did not sanitize his hands. CNA2 continued to pass trays to room [redacted], which did not have any signage, and moved the bedside table, and did not sanitize his hands. CNA2 continued to pass trays to room 331 which had <u>NJ Ex Order</u> signage, and he did not sanitize his hands going into the room or exiting the room. CNA2 continued passing trays to room [redacted] and did not sanitize his hands going into the room but did use the sanitizer when he exited the room.</p> <p>Interview on 02/18/25 at 2:10 PM with CNA2 revealed he had never heard of <u>NJ Ex Order 26. 4B1</u> [redacted], but he did sanitize his hands before</p>	F 880	<p>CNAs, and nurses related to Enhanced Barrier Precaution including PPE and handwashing.</p> <ul style="list-style-type: none"> - The Infection Preventionist Nurse (IPN) completed the competency of the hand hygiene with CNA2. 2. All residents may be affected by this deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: <ul style="list-style-type: none"> - The Infection Preventionist Nurse (IPN) and the Facility Educator will in-service all the nursing staff on Federal Guidelines F880 Enhanced Barrier and transmission base precaution. 4. The Infection Preventionist Nurse / Designee (IPN) will audit 2 employees on EBP weekly x 4 weeks and then 3 employees monthly for 3 months and will audit 2 employees hand hygiene weekly and 3 employees monthly for 3 months. The IPN or designee will submit the audit reports for EBP and hand hygiene to the Quarterly Quality Assurance Committee. 		

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

PRINTED: 07/16/2025
FORM APPROVED
OMB NO. 0938-0391

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F 880	<p>Continued From page 32</p> <p>he went into a room to pass trays and after he came out. CNA2 revealed he used the sanitizers on the wall, and he kept one in his pocket, however he checked, and he did not have any in his pocket.</p> <p>During an interview on 02/20/25 at 8:38 AM with the <u>U.S. FOIA (b) (6)</u> revealed if a resident was on <u>NJ Ex Order</u> then staff should sanitize their hands before going into the room to pass a tray and then sanitize their hands when they exit, but if the resident needed assistance, then staff would have to put a gown on and gloves. The <u>U.S. F</u> further revealed if staff did not follow proper precautions, it would put the residents and staff at risk to spread an infection. The <u>U.S. F</u> further revealed the residents were already at risk for infection due to their conditions and if improper precautions were used it increased the risk. The <u>U.S. F</u> revealed staff were educated on proper personal protective equipment (PPE).</p> <p>During an interview on 02/20/25 at 3:00 PM with the <u>U.S. FOIA (b) (6)</u> revealed <u>NJ Ex Order</u> protected the residents. The <u>U.S. FOIA (b)</u> revealed before you went into a room with <u>NJ Ex Order</u> signage you should sanitize your hands, take the tray in, and sanitize your hands when you exit the room. The <u>U.S. FOIA (b)</u> further revealed when a resident was on contact precautions anytime you cross that barrier your hands should be sanitized, gloves, and gown should be worn even passing trays. The <u>U.S. FOIA (b)</u> revealed improper precautions put the residents at risk for the spread of infection. The <u>U.S. FOIA (b)</u> revealed she had been monitoring correct isolation application of PPE</p> <p>Review of the "Handwashing, PPE" in-service done on 12/23/23 revealed CNA 2 had attended</p>	F 880			

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F 880	Continued From page 33 the in-service. Review of the signage for EBP on the walls revealed EBP "everyone must clean their hands including before entering the room and when leaving the room." Review of the contact precautions signage revealed "everyone must clean their hand, including before entering the room and when leaving the room." The signage further revealed "providers and staff must also put on gloves before room entry" and "discard gloves before room exit, put on gown before room entry. Discard gown before room exit." NJAC 8:39-19.4	F 880			

New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER ATRIUM POST ACUTE CARE OF WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470
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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	S560 Mandatory Access to Care 1. The following corrective actions have been accomplished for the identified deficiency: - There was no negative outcome to residents on the day shifts identified as not meeting the NJ staffing requirements on the dates of 3/5/23-3/3/11/23, 5/29/23-6/4/23, 4/7/24-4/9/24, 4/12/24-4/15/24, 4/17/24-4/20/24, 6/9/24, 20/21/24, 10/26/24, 10/27/24, 11/1/24, 11/10/24-11/13/24, 11/16/24, 12/8/24-12/11/24, 12/13/24-12/18/24, 12/21/24-12/22/24, 12/25/24-12/28/24, 1/26/25-1/28/25, 1/30/25, 2/1/25, 2/2/25, 2/6/25, 2/8/25 -2/12/25 and 2/15/25.	3/12/25

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

TITLE

(X6) DATE

Electronically Signed

03/12/25

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S 560	<p>Continued From page 1</p> <p>nursing homes. The following ratio(s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>For the 14 weeks of AAS-11 staffing, the facility was deficient as follows:</p> <p>1. For the week of Complaint staffing from 03/05/2023 to 03/11/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:</p> <p>-03/05/23 had 11 CNAs for 151 residents on the day shift, required at least 19 CNAs. -03/06/23 had 13 CNAs for 149 residents on the day shift, required at least 19 CNAs. -03/07/23 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -03/08/23 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -03/09/23 had 16 CNAs for 149 residents on the day shift, required at least 19 CNAs. -03/10/23 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs. -03/11/23 had 15 CNAs for 150 residents on the</p>	S 560	<p>2. All residents have the potential to be affected by the deficient practice of not meeting the NJ Staffing requirement ratios.</p> <p>3. The following measures have been put into place to prevent the deficient practice from recurring:</p> <ul style="list-style-type: none"> -The Administrator will in-service the Staffing Coordinator in reference to the state guideline S 560. - The facility has posted job openings on job sites to promote CNA job openings to be filled - The staffing coordinator is offering staff the ability to pick up extra shifts for overtime, incentive bonuses are being offered as well as referral bonuses - Staffing agencies will be utilized as needed. - HR Director has reached out to CNA schools to advise we are hiring and willing to train new graduates <p>4. The Staffing Coordinator and/or designee will audit the staffing weekly for 4 weeks then monthly for 3 months. The Staffing Coordinator and DON will submit the audit report to the quarterly Quality Assurance Improvement Committee.</p>	
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S 560	<p>Continued From page 2</p> <p>day shift, required at least 19 CNAs.</p> <p>2. For the week of Complaint staffing from 05/29/2023 to 06/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:</p> <ul style="list-style-type: none"> -05/29/23 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. -05/30/23 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. -05/31/23 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs. -06/01/23 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. -06/02/23 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -06/03/23 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -06/04/23 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs. <p>3. For the 2 weeks of Complaint staffing from 04/07/2024 to 04/20/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows:</p> <ul style="list-style-type: none"> -04/07/24 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs. -04/08/24 had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs. -04/09/24 had 15 CNAs for 135 residents on the day shift, required at least 17 CNAs. -04/12/24 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs. -04/13/24 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs. -04/14/24 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs. -04/15/24 had 16 CNAs for 136 residents on the 	S 560		

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S 560	<p>Continued From page 3</p> <p>day shift, required at least 17 CNAs. -04/17/24 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. -04/18/24 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. -04/19/24 had 13 CNAs for 140 residents on the day shift, required at least 17 CNAs. -04/20/24 had 13 CNAs for 140 residents on the day shift, required at least 17 CNAs.</p> <p>4. For the week of Complaint staffing from 06/09/2024 to 06/15/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows:</p> <p>-06/09/24 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs.</p> <p>5. For the 2 weeks of Complaint staffing from 10/20/2024 to 11/02/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:</p> <p>-10/21/24 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. -10/26/24 had 13 CNAs for 139 residents on the day shift, required at least 17 CNAs. -10/27/24 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs. -11/02/24 had 16 CNAs for 136 residents on the day shift, required at least 17 CNAs.</p> <p>6. For the week of Complaint staffing from 11/10/2024 to 11/16/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:</p> <p>-11/10/24 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs. -11/11/24 had 16 CNAs for 134 residents on the</p>	S 560		

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S 560	<p>Continued From page 4</p> <p>day shift, required at least 17 CNAs. -11/12/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -11/13/24 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. -11/16/24 had 14 CNAs for 129 residents on the day shift, required at least 16 CNAs.</p> <p>7. For the 3 weeks of Complaint staffing from 12/08/2024 to 12/28/2024, the facility was deficient in CNA staffing for residents on 16 of 21 day shifts as follows:</p> <p>-12/08/24 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/09/24 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/10/24 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/11/24 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/13/24 had 15 CNAs for 130 residents on the day shift, required at least 16 CNAs. -12/14/24 had 14 CNAs for 130 residents on the day shift, required at least 16 CNAs. -12/15/24 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs. -12/16/24 had 16 CNAs for 132 residents on the day shift, required at least 16 CNAs. -12/17/24 had 15 CNAs for 130 residents on the day shift, required at least 16 CNAs. -12/18/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/21/24 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/22/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/25/24 had 15 CNAs for 135 residents on the day shift, required at least 17 CNAs. -12/26/24 had 16 CNAs for 134 residents on the</p>	S 560		

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S 560	<p>Continued From page 5</p> <p>day shift, required at least 17 CNAs. -12/27/24 had 15 CNAs for 134 residents on the day shift, required at least 17 CNAs. -12/28/24 had 14 CNAs for 134 residents on the day shift, required at least 17 CNAs.</p> <p>8. For the week of Complaint staffing from 01/26/2025 to 02/01/2025, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:</p> <p>-01/26/25 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs. -01/27/25 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. -01/28/25 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. -01/30/25 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. -02/01/25 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs.</p> <p>9. For the 2 weeks of staffing prior to survey from 02/02/2025 to 02/15/2025, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows:</p> <p>-02/02/25 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -02/06/25 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. -02/08/25 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs. -02/09/25 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs. -02/10/25 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs. -02/11/25 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. -02/12/25 had 16 CNAs for 144 residents on the</p>	S 560		

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S 560	Continued From page 6 day shift, required at least 18 CNAs. -02/15/25 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs.	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315335	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 4/15/2025	Y3
NAME OF FACILITY ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		

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 F0640 Reg. # 483.20(f)(1)-(4) LSC	Correction Completed 03/31/2025	ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 03/31/2025	ID Prefix F0645 Reg. # 483.20(k)(1)-(3) LSC	Correction Completed 03/12/2025
ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 03/31/2025	ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 03/31/2025	ID Prefix F0688 Reg. # 483.25(c)(1)-(3) LSC	Correction Completed 03/31/2025
ID Prefix F0836 Reg. # 483.70(a)-(c) LSC	Correction Completed 03/12/2025	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/31/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/25/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315335	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 4/15/2025	Y3
NAME OF FACILITY ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		

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 F0640 Reg. # 483.20(f)(1)-(4) LSC	Correction Completed 03/31/2025	ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 03/31/2025	ID Prefix F0645 Reg. # 483.20(k)(1)-(3) LSC	Correction Completed 03/12/2025
ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 03/31/2025	ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 03/31/2025	ID Prefix F0688 Reg. # 483.25(c)(1)-(3) LSC	Correction Completed 03/31/2025
ID Prefix F0836 Reg. # 483.70(a)-(c) LSC	Correction Completed 03/12/2025	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/31/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/25/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061601	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 4/15/2025	Y3
NAME OF FACILITY ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	03/12/2025	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/25/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061601	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/15/2025
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NAME OF FACILITY ATRIUM POST ACUTE CARE OF WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/12/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/25/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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

PRINTED: 07/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 02/25/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000			
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 02/25/25 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K 000			
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324		3/12/25	

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

TITLE

(X6) DATE

Electronically Signed

03/12/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 324	<p>Continued From page 1</p> <p>toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2</p> <p>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Kitchen's Automatic Extinguishing System was tested every six months in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 edition) 11.2.1. This deficient practice had the potential to affect all 144 residents and was evidenced by the following:</p> <p>A document review on 02/25/25 from 9:00 AM to 11:30 AM of the untitled safety binder revealed the Automatic Extinguishing System was tested in April 2024 and in December 2024. The system should have been tested in October 2024.</p> <p>During an interview at 11:40 AM, the <u>U.S. FOIA (b) (6)</u> verified the Automatic Extinguishing</p>	K 324	<p>K324- Cooking Facilities</p> <p>1. The following corrective actions have been accomplished for the identified deficiency: - The Automatic Extinguishing System was tested on December 20 2024</p> <p>2. All residents have the potential to be affected by the deficient practice of a delay in the testing of the Automatic Extinguishing System</p> <p>3. The following measures have been put into place to prevent the deficient practice from recurring: - The <u>U.S. FOIA (b) (6)</u> was re-educated on NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations for scheduled testing of Cooking Facilities</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 324	Continued From page 2 System was not inspected every six months. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K 324	- The Maintenance Director confirmed the system was tested in December 2024 and the facility is currently in compliance 4. The Maintenance Director or Designee will audit the Automatic Extinguishing System monthly x 6 months and the facility yearly inspections calendar monthly x 6 months to ensure testing is scheduled and completed as per NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. The findings will be reported to the quarterly QAPI committee.		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure fire extinguishers were serviced every six years or hydrostatic tested every 12 years in accordance with NFPA 10, Standard for Portable Fire Extinguishers (2010 Edition) 7.3.1.2.1 and 7.4.5.2. This deficient practice had the potential to affect all 144 residents and was evidenced by the following: An observation on 02/25/25 at 11:39 AM of a 10 lbs. ABC fire extinguisher at the main entrance revealed the extinguisher had a manufacturer's date of 2006. The fire extinguisher was not hydrostatic tested in 2018 but, did have a six-year	K 355	K355 <input type="checkbox"/> Portable Fire Extinguishers 1. The following corrective actions have been accomplished for the identified deficiency: - The identified ABC extinguisher at the main entrance is scheduled to be replaced 3/14/25 by facility vendor - The identified ABC extinguisher outside the laundry area is scheduled to be serviced or replaced 3/14/25 by facility vendor - The identified ABC extinguisher in the kitchen is scheduled to be replaced or have the gauge assembly 3/14/25 by	3/17/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 355	<p>Continued From page 3 service collar in 2021.</p> <p>An observation on 02/25/25 at 12:15 PM of a 10 lbs. ABC fire extinguisher outside the laundry revealed the extinguisher was on the discharge side and should have been removed and serviced.</p> <p>An observation on 02/25/25 at 12:17 PM of a 10 lbs. ABC fire extinguisher in kitchen had a bent gauge assembly. The fire extinguisher should have been removed from service and the gauge assembly replaced.</p> <p>An observation on 02/25/25 at 12:18 PM of a K-Guard fire extinguisher in the kitchen revealed it was manufactured in 2011 and was not serviced in 2016.</p> <p>During an interview at the time of each observation, the <u>U.S. FOIA (b) (6)</u> confirmed the fire extinguishers were not serviced and the gauge assembly was bent.</p> <p>NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 96</p>	K 355	<p>facility vendor</p> <ul style="list-style-type: none"> - The identified K-Guard fire extinguisher in the kitchen is scheduled to be replaced 3/14/25 by facility vendor 2. All residents have the potential to be affected by the deficient practice of fire extinguishers not being serviced timely or having a bent gauge. 3. The following measures have been put into place to prevent the deficient practice from recurring: <ul style="list-style-type: none"> - The <u>U.S. FOIA (b) (6)</u> was re-educated on NFPA 10, Standard for Portable Fire Extinguishers. - The outside vendor for the fire extinguishers was contacted and will replace the identified fire extinguishers on 3/12/25 - All Fire Extinguishers in the facility were inspected with no further findings 4. The Maintenance Director or Designee will inspect the fire extinguishers monthly x 6 months to ensure there are no bent gauges and that all fire extinguishers have been serviced or hydrostatic tested in accordance with NFPA 10 . The findings will be reported to the quarterly QAPI committee. 		
K 918 SS=F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this</p>	K 918		3/12/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 918	<p>Continued From page 4</p> <p>capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure a load bank test was completed on the diesel-powered emergency generator once every 36 months in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.4.9. and 5.6.5.6. This deficient practice had the potential to affect all 144 residents and was evidenced by the following:</p>	K 918	<p>K918 Electrical Systems <input type="checkbox"/> Essential Electric System</p> <p>1. The following corrective actions have been accomplished for the identified deficiency: - The Generator 3 Year Load Bank Test was completed by the generator company vendor on 3/10/25 2. All residents have the potential to be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER ATRIUM POST ACUTE CARE OF WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 918	<p>Continued From page 5</p> <p>A review of the facility's untitled generator reports dated for the years 2023 and 2024, provided by the facility, revealed a three-year load bank test had not been completed for the diesel-powered emergency generator.</p> <p>During an interview on 02/25/25 at 12:45 PM, the U.S. FOIA (b) (6) confirmed the three-year load bank test had not been completed on the diesel-powered emergency generator.</p> <p>NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110</p>	K 918	<p>affected by the deficient practice of a delay in the 36 month testing of the Generator</p> <p>3. The following measures have been put into place to prevent the deficient practice from recurring:</p> <ul style="list-style-type: none"> - The U.S. FOIA (b) (6) was re-educated on NFPA 110 for testing of electrical systems. - The Generator 4 Hour Load Bank Test was completed by the generator company vendor on 3/10/25 - The Maintenance Director added the 3 Year generator Load Bank Test to his Yearly inspections calendar 4. The Maintenance Director or Designee will audit the generator reports monthly x 6 months and the facility yearly inspections calendar monthly x 6 months to ensure all Generator inspections are scheduled and completed timely. The findings will be reported to the quarterly QAPI committee. 		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315335	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 4/15/2025	Y3
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NAME OF FACILITY ATRIUM POST ACUTE CARE OF WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	03/12/2025	LSC K0355	03/17/2025	LSC K0918	03/12/2025
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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FOLLOWUP TO SURVEY COMPLETED ON 2/25/2025	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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