STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT#: NJ157969, NJ160570 CENSUS: 113 SAMPLE SIZE: 6 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 COMPLAINT VISIT.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint#: NJ157969, NJ160570 Based on interviews, medical records review, and review of other pertinent facility documentation on 12/21/2022, 12/22/2022, 1/8/2023 & 1/10/2023, it was determined that the facility failed to follow standards of clinical practice and document medications and treatments as ordered by the Physician for 2 of 6 residents (Resident #1 and #2) reviewed for documentation. The facility also failed to follow its policy titled "Charting and Documentation." This deficient practice was evidenced by the following: 1. According to the "Admission Record (AR),"	F 658	Spring Hills Post-Acute Care Woodbury Plan of Corrections January 10th Complaint Survey F658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) 483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality Complaint #NJ157969, NJ160570 I. During the complaint survey it was	2/20/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/20/2023

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

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F 658	Continued From page 1 Resident #1 was admitted to the facility on EX. Order 26.(4) B1 with diagnoses which included but were not limited to EX. Order 26.(4) B1 and EX. Order 26.(4) B1 According to the Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4) B1, Resident #1 had a Brief Interview of Mental Status (BIMS) score of EX. Order 26., indicating the Resident was EX. Order 26.(4) B1. The MDS also showed the Resident needed complete assistance with Activities of Daily Living (ADLs). A review of the "Order Summary report (OSR)" for Resident #1 dated EX. O. Order 26.(4) B1 included the following Physician's Orders (POs): EX. Order 26.(4) B1 to EX. Order 26.(4) B1 on at 6:00 a.m. and off at 6:00 p.m. for EX. Order 26.(4) B1 dated EX. Order Order 26.(4) B1. Apply EX. Order 26.(4) B1 q (every) shift (day, evening, and night shift) for EX. Order 26.(4) B1 dated EX. Order 26.(4) B1 A review of the Treatment Administration Record (TAR) dated EX. Order 26.(4) B for Resident # 1 revealed the above POs were not administered because there was no documented evidence that the staff gave the treatment to the Resident, as evidenced by the following: EX. Order 26.(4) B1 to EX. Order 26.(4) B1 on at 6:00 a.m. and off at 6:00 p.m. for EX. Order 26.(4 on EX. Order 26.(4) B1 EX. Order 26.(4) B1 at 6:00 a.m., was blank. Apply EX. Order 26.(4) B1 to EX. Order 26.(4) B q (every) shift (day,	F 658	noted that the facility was not in compliance, based on interviews, medical records review, and review of other pertinent facility documentation on 12/21/2022, 12/22/2022, 1/8/2023 & 1/10/2023, it was determined that the facility failed to follow standards of clinical practice and document medications and treatments as ordered by the Physician for 2 of 6 residents (Resident #1 and #2) reviewed for documentation. The facility also failed to follow its policy titled "Charting and Documentation." A. Residents #1 and #2 are no longer in the facility as both were discharged. B. All licensed nursing staff was educated/in-serviced on the importance of completing documentation and signing out physician orders in the MAR/TARs. II. All residents have the potential to be affected by this deficient practice. A random chart audit of 12 charts for MAR/TAR documentation was conducted with no new findings. III. All licensed nursing staff was educated on facility policy on charting and documentation. DON or designee will review MAR/TAR documentation in morning clinical meeting to ensure that documentation is completed. IV. DON, ADON or designee will audit MAR/TAR documentation weekly for (4) four weeks, then monthly for (3) three months to ensure compliance. Results will be forwarded to the QA committee monthly for (4) four months for tracking,	

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	315521	A. BUILDING _____ B. WING _____	C 01/10/2023

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ATRIUM POST ACUTE CARE OF WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

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F 658	Continued From page 2 evening, and night shift) for EX. Order 26.(4) B1 on EX. Order 26.(4) B1 and EX. Order 26.(4) B1 on the night shift (11:00 p.m. to 7:00 a.m. shift) was blank. 2. According to the AR, Resident #2 was admitted to the facility on EX. Order 26.(4) B1 with diagnoses which included but were not limited to EX. Order 26.(4) B1, and EX. Order 26.(4) B1 on the EX.EX. O and EX. Order 26.(4) B1. According to the MDS, an assessment tool dated EX. Order 26.(4) B1, Resident # 2 had a BIMS score of EX. Order 26, which indicated the Resident was EX. Order 26.(4) B1. The MDS also showed Resident #2 needed limited assistance with one-person physical assistance with most ADLs. A review of Resident #2's OSR, Active Orders as of EX. Order 26.(4) B1, revealed the following POs: EX. Order 26.(4) B1 Tablet EX. Orde MG (milligram). Give 1 tablet by mouth every 12 hours for EX. Order 26.(4) B1 EX. Order 26.(4), order date EX. Order 26.(4) B1. Cleanse EX. Order 26.(4) B1 with EX. Order 26.(4) B1, pack EX. Order 26.(4) with EX. Order gauze soaked with EX. Order 26.(4) B1, then cover with EX. Orde EX. Order 26.(4) B1 dressing and secure with paper tape daily and prn (as needed) everyday shift for EX. Order 26.(4 care, order date EX. Order 26.(4) B1. Cleanse EX. Order 26.(4) B1 with EX. Order 26, pack EX. Order 26.(4) with EX. Order gauze soaked with EX. Order 26.(4) B1, then cover with EX. Order 26.(4) B and secure with paper tape daily and prn every shift for EX. Order 26.(4) Healing, order date EX. Order 26.(4) B1.	F 658	trending and implementation of an action plan as necessary.	

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F 658		F 658		

Continued From page 3

EX. Order 26 (4) B1 every shift, order date EX. Order 26.(4) B1.

EX. Order 26.(4) B1 every shift, order date EX. Order 26.(4) B1.

Half side rails to serve as an enabler and to promote independence every shift, order date EX. Order 26.(4) B1.

EX. Order 26.(4) B1 Tablet EX. Ord MG Give 1 tablet by mouth every 8 hours for EX. Order 26.(4) B1, order date EX. Order 26.(4) B1.

EX. Orde Assessment every shift (EX. Order 26.(4) B1) every shift, order date EX. Order 26.(4) B1

EX. Order 26.(4) B1) EX. Order 26.(4) B EX. Ord MG Give 2 capsules by mouth at bedtime for EX. Order 26.(4) B1, order date EX. Order 26.(4) B1.

A review of Resident #2's Medication Administration Record (MAR) and the TAR dated EX. Order 26.(4) B1 revealed the aforementioned POs were not administered because there was no documented evidence that the staff gave the medications and treatments to the Resident, as evidenced by the following:

EX. Order 26.(4) B1 MG (milligram) Give 1 tablet by mouth every 12 hours for EX. Order 26.(4) B1 on the evening shift on EX. Order 26.(4) B1 was blank.

EX. Order 26.(4) B1 Tablet EX. Ord MG Give 1 tablet by mouth every 8 hours for EX. Order 26.(4) B1 on the evening shift on EX. Order 26.(4) B1, and the day shift on EX. Order 26.(4) B1 was blank.

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ATRIUM POST ACUTE CARE OF WOODBURY	**467 COOPER STREET WOODBURY, NJ 08096**

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F 658	Continued From page 4 EX. Order Assessment every shift EX. Order 26.(4) B1 on EX. Order 26.(4) B1 on the night shift was blank. EX. Order 26.(4) B1) Capsule EX. Ord MG Give 2 capsules by mouth at bedtime for EX. Order 26.(4) B1 on the evening shift on EX. Order 26.(4) B1 was blank. Cleanse EX. Order 26.(4) B1, pack EX. Order 26.(4) with EX. Order gauze soaked with EX. Order 26.(4) B1, then cover with EX. Order 26.(4) B and secure with paper tape daily and prn everyday shift for EX. Order 26.(4) care on EX. Order 26.(4) B1 was blank. Cleanse EX. Order 26.(4) B1 with EX. Order 26 pack EX. Order 26.(4) with EX. Order 26 gauze soaked with EX. Order 26.(4) B1, then cover with EX. Order 26.(4) B and secure with paper tape daily and prn every shift for EX. Order 26.(4) B Healing on the night shift on EX. Order 26.(4) B1 was blank. EX. Order 26 (4) B1 every shift on the day shift on EX. Order 26.(4) B1, EX. Order 26.(4) B1, and the night shift on EX. Order 26.(4) B1 was blank. EX. Order 26.(4) B1 every shift on the day shift on EX. Order 26.(4) B1, and EX. Order 26.(4) B1 on the evening shift on EX. Order 26.(4) B1, and on the night shift on EX. Order 26.(4) B1 and EX. Order 26.(4) B1 was blank. Half side rails to serve as an enabler and to promote independence every shift on the day shift on EX. Order 26.(4) B1 and EX. Order 26.(4) B1, and the night shift on EX. Order 26.(4) B1 was blank. During an interview on 12/21/2022 at 3:55 p.m., when the Surveyor showed the Licensed Practice Nurse (LPN) the blank spaces on the TAR, she stated, "It [blank spaces] may mean it (treatment) was not done, I'm not sure."	F 658		

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F 658	Continued From page 5	F 658		

During an interview on 12/22/2022 at 11:46 a.m., when the Surveyor showed the blank spaces on the MAR and TAR, the Director of Nursing (DON) stated, "it means it [medication/treatment] was not done. The DON continued to say, "To me, I see a blank; the [medication] treatment wasn't done, (and) nurses could have forgotten to sign." The DON also stated, " the expectation is that they, the nurses, sign it [the MAR/TAR]."

The nurses who cared for Resident #2 were unavailable for interviews at the time of the survey.

A review of the facility policy titled "Charting and Documentation" with a revised date of July 2022, revealed the following: Under "Policy Statement,": "All services provided to the Resident, progress toward the care plan goals, or any changes in the Resident's medical, physical, functional or psychosocial condition, shall be documented in the Resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the Resident's condition and response to care." Under "Policy Interpretation and Implementation": "1. Documentation in the medical record may be electronic, manual or combination. 2. The following information is to be documented in the resident medical record: ...b. Medications administered; c. Treatments or services performed; ...3. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate... 7. Documentation of procedures and treatments will include care-specific details, including a. The date and time of the procedure/treatment was provided; b. The name and title of the

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 6 individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the Resident tolerated the procedure/treatment; e. Whether the Resident refused the procedure/treatment; f. Notification of family, Physician or other staff, if indicated; and g. The signature and title of the individual documenting." N.J.A.C.: 8.39-27.1(a) N.J.A.C.: 8.39-29.2 (d)	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint#: NJ157969, NJ160570 Based on interviews, medical records review, and review of other pertinent facility documentation on 12/21/2022, 12/22/2022, 1/8/2023 & 1/10/2023, it was determined that the facility failed to consistently complete the Resident's "Documentation Survey Report v2" for 1 of 6 residents (Resident #4) reviewed for Activities of Daily Living. The facility also failed to follow its policy titled "Charting and Documentation." This deficient practice was evidenced by the following: Review of the Electronic Medical Record was as follows:	F 677	Spring Hills Post-Acute Care Woodbury Plan of Corrections January 10th Complaint Survey F677 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) 483.21(b)(3) Comprehensive Care Plans A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Complaint #NJ157969, NJ160570 I. During the complaint survey it was	2/20/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 7 According to the "Admission Record (AR)," Resident #4 was admitted to the facility on EX. Order 26.(4) B1 with diagnoses which included but were not limited to EX. Order 26.(4) B1, and EX. Order 26.(4) B1. According to the MDS, an assessment tool dated EX. Order 26.(4) B1, Resident #4 had a (BIMS) score of EX. Order, indicating the Resident had EX. Order 26.(4) B1 EX. Order 26.(4) B1 The MDS also showed the Resident needed complete assistance with Activities of Daily Living (ADLs). A review of Resident #4's undated Care Plan indicated ADLs Self-Care Performance Deficit. The Surveyor reviewed Resident #4's Documentation Survey Report v2 (DSR), an ADL care task provided to the Resident and documented by the Certified Nursing Assistants (CNA) during their assigned shift. The DSR from December 1st, 2022, through December 30th, 2022, revealed the following: The DSR forms had assigned ADL care tasks which included but were not limited to Bathing, Bed Mobility, Bed Mobility (3/2) Extensive Assist, Behavior Symptoms, Bladder Continence, Bowel Management, Dressing Extensive Assist, Locomotion off Unit, Locomotion on Unit, Mouth Care, Personal Hygiene, Skin Observation, Toilet Use Extensive Assist, Transferring Extensive Assist, Turning and Repositioning, Walk in Corridor, Walk in Room, Amount Eaten, Eating Setup only. Further review of Resident #4's Progress Notes and the aforementioned ADL care tasks on the DSR form revealed that the tasks from December	F 677	noted that the facility was not in compliance, based on interviews, medical records review, and review of other pertinent facility documentation on 12/21/2022, 12/22/2022, 1/8/2023 & 1/10/2023, it was determined that the facility failed to consistently complete the Resident's "Documentation Survey Report v2" for 1 of 6 residents (Resident #4) reviewed for Activities of Daily Living. The facility also failed to follow its policy titled "Charting and Documentation." A. Resident #4 is no longer in the facility as they were discharged. B. All nursing assistants were educated/in-serviced on the importance of completing ADL documentation. II. All residents have the potential to be affected by this deficient practice. A random audit of 12 patient□s POC documentation was conducted. Staff educated/in-serviced with any unsigned or blanks found. III. All nursing assistants were educated on facility policy on charting and documentation and the importance of completing their documentation. DON or designee will review POC documentation in morning clinical meeting to ensure that documentation is completed. IV. DON, ADON or designee will audit POC documentation compliance weekly for (4) four weeks, then monthly for (3) three months to ensure compliance. Results will be forwarded to the QA	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 01/10/2023

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ATRIUM POST ACUTE CARE OF WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

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F 677	Continued From page 8 1st, 2022, through December 30th, 2022, were left blank or unsigned on the following days and shifts. NJ Exec. Order 26:4 every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, was blank. NJ Exec. Order 26 4.b.1 every shift, during the 7:00 a.m. to the 3:00 p.m. shift on 12/8/2022 and the 11:00 p.m. to 7:00 a.m. shift on the 12/2/2022, 12/10/2022, 12/16/2022, 12/18/2022 through 12/22/2022, 12/24/2022, 12/26/2022, 12/27/2022, 12/29/2022 through 12/31/2022, was blank. NJ Exec. Order 26:4.b.1 every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022 and during the 11:00 p.m. to 7:00 a.m. shift on 12/10/2022, 12/16/2022, 12/18/2022 through 12/22/2022, 12/24/2022, 12/26/2022, 12/27/2022 and 12/29/2022 through 12/31/2022, was blank. NJ Exec. Order 26:4.b.1 every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, during the 11:00 p.m. to 7:00 a.m. shift on 12/2/2022, 12/10/2022, 12/16/2022, 12/18/2022 through 12/22/2022, 12/24/2022, 12/26/2022, 12/27/2022, 12/29/2022 through 12/31/2022, was blank. NJ Exec. Order 26:4.b.1 every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, during the 11:00 p.m. to 7:00 a.m. shift on 12/2/2022, 12/10/2022, 12/16/2022, 12/18/2022 through 12/22/2022, 12/24/2022, 12/26/2022, 12/27/2022, 12/29/2022 through 12/31/2022, was blank. NJ Exec. Order 26:4.b every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, was blank. NJ Exec. Order 26:4.b.1 Unit every shift, during the 7:00	F 677	committee monthly for (4) four months for tracking, trending and implementation of an action plan as necessary.	

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a.m. to 3:00 p.m. shift on 12/8/2022, was blank.

NJ Exec. Order 26:4.b.1 Unit every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, was blank.

NJ Exec. Order 26 4.b.1 every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, was blank.

NJ Exec. Order 26:4.b.1 every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, was blank.

NJ Exec. Order 26:4.b.1 every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, during the 11:00 p.m. to 7:00 a.m. shift on 12/2/2022, 12/10/2022, 12/16/2022, 12/18/2022 through 12/22/2022, 12/24/2022, 12/26/2022, 12/27/2022, 12/29/2022 through 12/31/2022 was blank.

NJ Exec. Order 26:4.b.1 every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, during the 11:00 p.m. to 7:00 a.m. shift on 12/2/2022, 12/10/2022, 12/16/2022, 12/18/2022 through 12/22/2022, 12/24/2022, 12/26/2022, 12/27/2022, 12/29/2022 through 12/31/2022, was blank.

NJ Exec. Order 26:4.b.1 every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, was blank.

NJ Exec. Order 26:4.b.1 n every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, during the 11:00 p.m. to 7:00 a.m. shift on 12/2/2022, 12/10/2022, 12/16/2022, 12/18/2022 through 12/22/2022, 12/24/2022, 12/26/2022, 12/27/2022, 12/29/2022 through 12/31/2022, was blank.

NJ Exec. Order 26:4.b.1 for every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, was blank.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 10	F 677		

NJ Exec. Order 26:4.b.1 every shift, during the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, was blank.

NJ Exec. Order 26:4.b.1 every shift, on the 7:00 a.m. to 3:00 p.m. shift on 12/8/2022, was blank.

NJ Exec. Order 26:4.b.1 help only every shift at 8:00 a.m. and 12:00 p.m. on 12/8/2022, and 12:00 p.m. on 12/11/2022 and 12/28/2022 was blank.

Resident #4 had no ill effects from the aforementioned task not being completed or left blank.

During an interview on 1/10/2023 at 12:11 p.m., the Certified Nurses Assistant (CNA) assigned to Resident #4 stated, "I won't say the task was not completed; I would say we [CNA] could not get to the kiosk to document." The CNA further stated it is expected that the CNA completes the DSR at the end of each shift.

During an interview on 1/10/2023 at 1:13 p.m., when the Surveyor showed the blank spaces on the DSR, the Director of Nursing (DON) stated," the blank spaces could mean one or two things." "The CNA was busy and forgot to sign it [ADL] off." The DON further stated, "If it [task] is not documented, it does not mean it [task] wasn't done." "The task was completed, and the CNAs could have gotten busy and forgot to sign it [ADL] off." The DON also stated, "the expectation is that the DSR is completed at the end of every shift."

A review of the facility policy titled "Charting and Documentation" with a revised date of July 2022, revealed the following: Under "Policy Statement,":

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

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F 677	Continued From page 11 "All services provided to the Resident, progress toward the care plan goals, or any changes in the Resident's medical, physical, functional or psychosocial condition, shall be documented in the Resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the Resident's condition and response to care." Under "Policy Interpretation and Implementation": "1. Documentation in the medical record may be electronic, manual or combination. 2. The following information is to be documented in the resident medical record: ...b. Medications administered; c. Treatments or services performed; ...3. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. 4 ....Certified Nursing Assistants may only make entries in the Resident's medical chart as permitted by facility policy ..." N.J.A.C.: 8.39-27.1(a)	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: COMPLAINT#: NJ157969 Based on facility document review on 12/21/2022, 12/22/2022, 1/8/2023, and 1/10/2023, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 24 of 28-day shifts and 1 of 28 evening shifts. Reference: New Jersey Department of Health (N.J.D.O.H.) 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	S 560	Spring Hills Post-Acute Care Woodbury Plan of Corrections January 10th Complaint Survey S560 8:39-5.19(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. COMPLAINT#: NJ157969 I. During the complaint survey on 12/21/22, 12/22/22, 1/8/23 and 1/10/23 it was determined that the facility failed to ensure that staffing ratios were met on 24 of the 28 shifts that were reviewed, for day shift, and 1 of the 28 shifts, for night shift,	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
ATRIUM POST ACUTE CARE OF WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

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S 560	Continued From page 1 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 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (C.N.A.) to every eight residents for the day shift. 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 C.N.A.s, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and 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 C.N.A. and perform C.N.A. duties. The facility was deficient in C.N.A. staffing for 24 of 28-day shifts and for 1 of 28 evening shifts that required 1/2 CNAs as follows: 06/12/2022 C.N.A. Staff was 11 for 108 residents. Staffing should have been 13. 06/13/2022 C.N.A. Staff was 10 for 103 residents. Staffing should have been 13. 06/14/2022 C.N.A. Staff was 11 for 103 residents. Staffing should have been 13. 06/15/2022 C.N.A. Staff was 11 for 103 residents. Staffing should have been 13. 06/16/2022 C.N.A. Staff was 10 for 103 residents. Staffing should have been 13. 06/172022 C.N.A. Staff was 11 for 103 residents. Staffing should have been 13. 06/18/2022 C.N.A. Staff was 11 for 104 residents. Staffing should have been 13. 06/21/2022 C.N.A. Staff was 12 for 103 residents. Staffing should have been 13. 06/22/2022 C.N.A. Staff was 11 for 103 residents.	S 560	that were reviewed from dates in June, July and December of 2022. No residents were identified nor immediately affected by the failure to provide minimum staffing levels. II. All residents have the potential to be affected by this deficient practice. III. The facility has made over 40 CNA hires between June 2022 and January 2023 in an attempt to bolster staffing ratios. In addition, contracts with 3 different agencies have been signed, so that the facility may supplement with agency staff when needed. Staffing coordinator will inform DON or designee of any call out(s) that result in insufficient staffing levels. This will be reported as soon as possible. Any staffing deficiencies will be filled prior to the start of the shift with other associates or agency as needed. IV. The DON or designee will report any staffing issues daily to the administrator or designee. Any findings will be followed up and documented on and then reported during the quarterly QAPI meetings for one year□s time, or until staffing levels are no longer an issue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
ATRIUM POST ACUTE CARE OF WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 Staffing should have been 13. 06/23/2022 C.N.A. Staff was 10 for 103 residents. Staffing should have been 13. 06/24/2022 C.N.A. Staff was 10 for 103 residents. Staffing should have been 13. 06/25/2022 C.N.A. Staff was 11 for 106 residents. Staffing should have been 13. 06/26/2022 C.N.A. Staff was 10 for 106 residents. Staffing should have been 13. 06/27/2022 C.N.A. Staff was 9 for 107 residents. Staffing should have been 13. 06/28/2022 C.N.A. Staff was 10 for 104 residents. Staffing should have been 13. 06/29/2022 C.N.A. Staff was 11 for 104 residents. Staffing should have been 13. 06/30/2022 C.N.A. Staff was 8 for 104 residents. Staffing should have been 13. 07/01/2022 C.N.A. Staff was 10 for 105 residents. Staffing should have been 13. 07/02/2022 C.N.A. Staff was 10 for 104 residents. Staffing should have been 13. 12/11/2022 C.N.A. Staff was 10 for 95 residents. Staffing should have been 12. 12/16/2022 C.N.A. Staff was 11 for 97 residents. Staffing should have been 12. 12/17/2022 C.N.A. Staff was 11 for 98 residents. Staffing should have been 12. 1/2 06/14/2022 C.N.A. Staff was 6 for 103 residents. 1/2 CNA should have been 8.	S 560		
S2420	8:39-31.8(b) Mandatory Physical Environment (b) All exit doors to the facility shall be kept externally locked from 8:00 P.M. until 6:30 A.M.	S2420		2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S2420	Continued From page 3 This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ157969, NJ160570 Based on observation, interviews, and review of other pertinent facility documentation on 12/21/2022, 12/22/2022, 1/8/2023, and 1/10/2023, it was determined that the facility failed to lock and to secure the facility front doors at night and follow its policy titled "Visitation." This deficient practice was evident by the following: On 1/8/2023 at 10:07 p.m., the Surveyor entered the facility through the unlocked front double doors into the lobby. The double doors automatically opened when the Surveyor approached the doors to enter the facility. The Surveyor observed a doorbell panel on the left side of the wall between the two double doors with a sign above it to "CALL FOR ASSISTANCE." Upon entry, there was no receptionist at the front desk. During an interview on 1/8/2023 at 10:14 p.m., the Licensed Practical Nurse (LPN) stated the doors are usually locked at 8:00 p.m., and a receptionist usually locks the door, and she is there [until] 12:00 a.m. During an interview on 1/8/2023 at 10:15 p.m., the Certified Nursing Assistant (CNA #1) stated that sometimes they [the doors] are locked and sometimes they are unlocked because of the night shift, but she could not provide specific dates when the doors were left unlocked. At the time of the survey, the facility had no residents at risk for elopements.	S2420	Spring Hills Post-Acute Care Woodbury Plan of Corrections January 10th Complaint Survey S2420 8:39-31.8(b) Mandatory Physical Environment (b) All exit doors to the facility shall be kept externally locked from 8:00pm until 6:30am I. During the complaint survey it was noted that the facility was not in compliance, as when the surveyor visited on 1/8/23 at 10:07pm, the front doors opened automatically as she approached. The night receptionist did not follow the correct process to make sure the door was locked and set on the correct setting so that the doors on the outside do not open after hours. No residents were found to be affected by this deficient practice. II. All residents have the potential to be affected by this deficient practice. III. All front desk personnel were in-serviced on correct process for locking doors at night, with return demonstration. When doors are properly locked, the doors will allow guests to leave from inside, while also maintaining the outside doors locked. Front door lock is marked with a black line, with the correct area to turn the key to, when locking the doors at night.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
ATRIUM POST ACUTE CARE OF WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

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S2420	Continued From page 4 Record review of the elopement assessements done on the sampled residents revealed no resdient with exit seeking behaviors. During an interview on 1/8/2023 at 10:57 p.m., the Regional Nurse stated after our front desk [staff] leaves, the doors get locked. When the Surveyor asked her if the front doors should be locked, she replied, "yes, when you came in the front doors, [they] should have been locked if no one [was] at the front desk." The Regional Nurse continued, "the front desk [staff] locks the front door; the door only opens leaving the facility but should be locked when coming into the facility." In the same interview, when the Surveyor asked her if she knew the procedure to lock the door, the Regional Nurse stated, "there's a switch like a light switch to open and close the door, controls the [door] mechanism." When the Surveyor asked her if families are allowed to visit after hours, she stated family [families] can leave the facility, but they need to make arrangements with the Nurse to return. Upon return, the family would ring the doorbell located between the double doors for re-entry into the facility. The bell rings at the Nurse's station after hours. " During an interview on 1/8/2023 at 11:30 p.m., the Director of Nursing (DON) stated the doors should be locked at 8:00 p.m. by the Receptionist. "I don't know why it was unlocked. You have to call [doorbell], and it rings at Nurse's station; someone has to let you in." During an interview on 1/9/2023 at 12:00 a.m., CNA #2 stated when there is not a receptionist at the front desk, the [front] doors are locked, and when there is a receptionist, the doors are	S2420	IV. The front door will now be monitored during nightly building rounds conducted by the 3-11 and 11-7 Supervisors to ensure the safety of our residents, visitors and staff. Both supervisors have access to the keys that can lock the front door to the correct setting, as required. Results will be reported to DON or designee, who will report to Administrator or designee. Results will be reviewed in QAPI meetings on a monthly basis. QAPI committee will determine the need for additional audits based on the findings presented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 01/10/2023

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ATRIUM POST ACUTE CARE OF WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

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S2420	Continued From page 5	S2420		

unlocked. Tonight, I came in at 10:30 p.m., and the doors were unlocked. He continued to say, "we [staff] come in the front door, if [the doors are] locked, press button [doorbell] and rings at the nurse's station to get into [the] facility."

During an interview on 1/9/2023 at 12:25 a.m., the Administrator stated the door[s] should be locked when the Receptionist leaves. She uses a key. He continued to say the Receptionist worked until 8:00 p.m.

During an interview on 1/9/2023 at 12:36 a.m., when the Surveyor asked about the protocol to lock the doors, the Maintenance Assistant (MA) stated there's a setting on the door to lock the inner [double] doors, on the inside double door, on the top right side, there's a keyhole with labeled black markings [lines] on it. The process is to turn the key [downward] to the "night mode (NM)" line to lock the door for one-way [access}, and to unlock the door is to turn the key [upward] to the line noted as "automatic" for access both ways. There are labeled black markings [lines] on the door; only these two settings are used.

On 1/9/2023 at 12:46 a.m., the Surveyor observed the process of locking and unlocking the door with the MA.

During an interview on 1/10/2023 at 9:42 a.m., the Maintenance Director (MD) stated the front desk keeps the door key on a lanyard with all the keys, and the doors are locked at 8:00 p.m. til [until] 8:00 a.m. by whoever is the last Receptionist for the night.

During an interview on 1/10/2023 at 2:33 p.m., the Administrator stated the facility does not have any wanderers, we [facility] try not to take [admit]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 01/10/2023

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S2420	Continued From page 6 any wanderers here, not that type of facility. He continued to say "the elopement assessment is part of the admission assessment." A review of a facility policy titled "Visitation," with a revised date of August 2022, revealed the following: Under "Policy Statement,": "Our facility permitted residents to receive visitors subject to the resident's wishes and the protection of the rights of other residents in the facility." Under "Policy Interpretation and Implementation": "1. Residents are permitted to have visitors of their choosing at the time of their choosing." Under "Reasonable Clinical and Safety Restrictions": "1. Some visitation may be subject to reasonable clinical and safety restrictions that protect the health, safety, security and/or right of the facility's residents such as: a. keeping the facility locked or secured at night with a system in place for allowing visitors approved by the resident; ..."	S2420		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315521 Y1	A. Building B. Wing Y2	2/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

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 F0658	Correction	ID Prefix F0677	Correction	ID Prefix	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. #	Completed
LSC	02/21/2023	LSC	02/21/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/10/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
08008 Y1	A. Building B. Wing Y2	2/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE WOODBURY	467 COOPER STREET WOODBURY, NJ 08096

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S2420	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-31.8(b)	Completed	Reg. #	Completed
LSC	02/21/2023	LSC	02/21/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/10/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO