STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 12/20/2024

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ATLAS POST ACUTE AT WOODBURY COUNTRY CLUB	467 COOPER STREET WOODBURY, NJ 08096

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F 000	INITIAL COMMENTS A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #'s: NJ00170972, NJ00171675, NJ00173566, NJ00175663, NJ00177015, NJ00178159, NJ00179724, NJ00179726, NJ00180017, and NJ00180066. Survey Census: 90 Sample Size: 28 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. F678IJ Based on interviews, record reviews, and a review of the facility's policy titled "Residents' Rights Regarding Treatment and Advance Directives," it was determined that the facility failed to ensure the physician's orders matched the resident's documented NJ Ex Order 26.4(b)(1), which resulted in NJ Ex Order 26.4(b)(1) being done on a resident (Resident (R) 17) reviewed for NJ Ex Order 26.4(b)(1) out of a total sample of 22 residents. While in the hospital, R17 chose to be a NJ Ex Order 26.4(b)(1)). However, the facility was unable to provide evidence that they implemented their policy for R17 for NJ Ex Order 26.4(b)(1	F 000		

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

Electronically Signed | 01/16/2025

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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NJ Ex Order 26.4(b)(1) upon R17 admission to the facility. On NJ Ex Order 26.4(b)(1), when R17 was NJ Ex Order 26.4(b)(1), the facility performed approximately NJ Ex Order 26.4(b)(1) on the resident before the emergency medical services (EMS) arrived. EMS NJ Ex Order 26.4(b)(1)] R17 when they arrived on site and NJ Ex Order 26.4(b)(1) as they departed the facility for the hospital. R17 NJ Ex Order 26.4(b)(1) leaving the facility.

This failure resulted in an Immediate Jeopardy identified on 12/10/24 and was determined to exist on 02/27/24 at F678: NJ Ex Order 26.4(b)(1) at a Scope and Severity (S/S) of "J." The U.S. FOIA (b) (6) was notified of the Immediate Jeopardy on 12/10/24 at 9:54 PM.

The U.S. FOIA (b) (6) and U.S. FOIA (b) were informed that immediate jeopardy was still present and ongoing at the time of exit from the survey on 12/12/24 at 7:45 PM.

The facility submitted an acceptable removal plan on 12/11/2024. On 12/20/24, the Surveyors conducted a revisit to verify that the Removal Plan was implemented. The facility implemented the Removal Plan. So, the noncompliance remained on 12/20/24 as a level D for "no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy."

F 578K

Based on interviews, record reviews, and a review of the facility's policy, it was determined

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F 000	Continued From page 2 that the facility failed to ensure residents code status was documented in the medical records, the 'NJ Ex Order 26.4(b)(1) reflected the residents NJ Ex Order and the proper documentation was completed so that those NJ Ex Order 26.4(b)(1) were honored in the facility and/or during transport. The facility also failed to follow its policies titled "Residents' Rights Regarding Treatment and Advance Directives" and the "Social Services Director Job Description" for 8 of 28 residents (Resident (R)2, R10, R13, R17, R24, R25, R26, and R28) reviewed for NJ Ex Order 26.4(b)(1). R17 was admitted to the facility from the hospital with documented evidence that he/she had chosen a NJ Ex Order 26.4(b)(1); however, the facility ordered a NJ Ex Order 26.4(b)(1) despite no documented evidence the facility verified with the resident and/or family that R17 wishes were not to NJ Ex Order 26.4(b)(1). On NJ Ex Order 26.4(b)(this failure resulted in NJ Ex Order 26.4(b)(1)) and Emergency Medical Services (EMS) being initiated when the resident became NJ Ex Order 26.4(b)(1) Additionally, R2, who had a NJ Ex Order 26.4(b)(1), was transferred to the hospital via ambulance; however, the facility failed to ensure the proper documentation was completed and provided to the ambulance transport company for the resident's NJ Ex Order 26.4(b)(1) to be honored. This failure resulted in NJ Ex Order 26.4(b)(1) to R2 when the ambulance personnel informed the resident that NJ Ex Orde would be required if he/she became NJ Ex Order 26.4(b)(1) during transport. Also, during R2's readmission to the facility on NJ Ex Order 26.4(b)(, a physician's order was obtained for a NJ Ex Order 26.4(b)(from NJ Ex Order 26.4(b)(until NJ Ex Order 26.4(b)(without verification if R2 had changed his/her NJ Ex Order 26.4(b)(1)	F 000		

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NJ Ex Order 26.4 from NJ Ex Order 26.4(b)(1)

These failures placed R2, R10, R13, R17, R24, R25, R26, R28, and all other residents who were admitted and/or readmitted to the facility in an Immediate Jeopardy (IJ) situation that the likelihood that their NJ Ex Order 26.4(b)(1) would not be honored.

An Immediate Jeopardy was identified on 12/11/24 and was determined to exist on 10/06/24, at §483.10 F578: Request/Refuse/Discontinue; Formulate Advance Directives. The Administrator was notified on 12/11/24 at 7:06 PM of the Immediate Jeopardy.

The facility's U.S. FOIA (b) (6) was informed that the immediate jeopardy was still present and ongoing at the time of exit from the survey on 12/12/24 at 7:45 PM. The IJ ran from 2/27/2024 through 12/12/24 at 4:30 PM, when the facility submitted an acceptable removal plan.

On 12/20/24, the Surveyors conducted a revisit to verify that the Removal Plan was implemented. The facility implemented the Removal Plan. So, the noncompliance remained on 12/20/24 as a level E for "no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy."

The facility implemented the removal plan, which included the following:

The US FOIA (b)(6) educated the US FOIA (b)(6) and the US FOIA (b)(6))on the procedure, ensuring when residents are transferred from the facility to the hospital, the

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F 000	Continued From page 4 ambulance transportation company receives the required documents to honor a resident's end-of-life wishes/cold status. The [redacted] and the [redacted] or [redacted] began re-educating, ensuring when residents are transferred from the facility to the hospital, the ambulance transportation company receives the required documents to honor a resident's end-of-life wishes/cold status. The [redacted] or designee initiates audits of transfers to the hospital to ensure that when residents are transferred from the facility to the hospital, the ambulance transportation company receives the required documents to honor a resident's end-of-life wishes/code status.	F 000		
F 578 SS=K	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		1/21/25

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F 578	Continued From page 5 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00173566 Based on interviews, record reviews, and a review of the facility's policy, it was determined that the facility failed to ensure residents [NJ Ex Order] was documented in the medical records, the '[NJ Ex Order 26.4(b)(1)] ") reflected the residents' end of life wishes and the proper documentation was completed so that those [NJ Ex Order 26.4(b)(1)] were honored in the facility and/or during transport. The facility also failed to follow its policies titled "Residents' Rights Regarding Treatment and Advance Directives" and the "Social Services Director Job Description" for 8 of 28 residents (Resident (R)2, R10, R13, R17, R24, R25, R26,	F 578	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 2 has a [NJ Ex Order 26.4(as of [NJ Ex Order 26.4(b)(. Resident 2 will have a [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] consult for [NJ Ex Order 26.4(b)(1)] support. This was completed on [NJ Ex Order 26.4(b)(. R10- [NJ Ex Order 26.4(b)(1)] was confirmed with Resident, [NJ Ex Order 26.4(was completed. Resident [NJ Ex Order 26.4(b)(1)] in the facility. R13- [NJ Ex Order 26.4(b)(1)] was confirmed with Resident, [NJ Ex Order 26.4(was completed. R17- Resident [NJ Ex Order 26.4(b)(1)] in the facility. R24- [NJ Ex Order 26.4(b)(1)] was confirmed with	

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F 578	Continued From page 6 and R28) reviewed for NJ Ex Order 26.4(b)(1). R17 was admitted to the facility from the hospital with documented evidence that he/she had chosen a NJ Ex Order 26.4(b)(1); however, the facility ordered a NJ Ex Order 26.4(b)(1) despite no documented evidence the facility verified with the resident and/or family that R17 wishes were not to NJ Ex Order 26.4(b)(1). On NJ Ex Order 26.4(b), this failure resulted in NJ Ex Order 26.4(b)(1)) and Emergency Medical Services (EMS) being initiated when the resident became NJ Ex Order 26.4(b)(1) Additionally, R2, who had a NJ Ex Order 26.4(b)(1), was transferred to the hospital via ambulance; however, the facility failed to ensure the proper documentation was completed and provided to the ambulance transport company for the resident's NJ Ex Order 26.4(b)(1) to be honored. This failure resulted in NJ Ex Order 26.4(b)(1) to R2 when the ambulance personnel informed the resident that NJ Ex Order would be required if he/she became NJ Ex Order 26.4(b)(1) during transport. Also, during R2's readmission to the facility on NJ Ex Order 26.4(b)(, a physician's order was obtained for a NJ Ex Order 26.4(b)(from NJ Ex Order 26.4(b)(until NJ Ex Order 26.4(b)(without verification if R2 had changed his/her NJ Ex Order 26.4(b)(1) from NJ Ex Order 26.4(b)(1) These failures placed R2, R10, R13, R17, R24, R25, R26, R28, and all other residents who were admitted and/or readmitted to the facility in an Immediate Jeopardy (IJ) situation that the likelihood that their NJ Ex Order 26.4(b)(1) would not be honored. An Immediate Jeopardy was identified on 12/11/24 and was determined to exist on 10/06/24, at §483.10 F578:	F 578	Responsible Party, NJ Ex Order 26.4(was offered. R25- NJ Ex Order 26.4(b)(1) was confirmed with Responsible Party, NJ Ex Order 26.4(was completed. R26- NJ Ex Order 26.4(b)(1) was confirmed with Responsible Party, NJ Ex Order 26.4(was offered. R28- NJ Ex Order 26.4(b)(1) was confirmed with Resident, NJ Ex Order 26.4(was offered. Resident NJ Ex Order 26.4(b)(1) in the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. No other residents were identified as being affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Regional Director of Clinical Services educated the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) on this procedure: ensuring when residents are transferred from the facility to the hospital, the ambulance transportation company receives the required documents to honor a resident's end of life wishes/code status. This was completed on 12/11/24. After that was completed, The Director of Nursing and Assistant Director of Nursing, or Regional Nurse began re-educating staff: ensuring when residents are transferred from the facility to the hospital, the ambulance transportation company receives the required documents to honor a resident's end of life wishes/code status.	

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F 578	Continued From page 7 Request/Refuse/Discontinue; Formulate [redacted] The [redacted] was notified on 12/11/24 at 7:06 PM of the Immediate Jeopardy. . The IJ ran from 2/27/2024 through 12/12/24 at 4:30 PM, when the facility submitted an acceptable removal plan. On 12/20/24, the Surveyors conducted a revisit to verify that the Removal Plan was implemented. The facility implemented the Removal Plan. So, the noncompliance remained on 12/20/24 as a level E for "no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy." The facility implemented the removal plan, which included the following: The [redacted] educated the [redacted]) and the [redacted])on the procedure, ensuring when residents are transferred from the facility to the hospital, the ambulance transportation company receives the required documents to honor a resident's end-of-life wishes/cold status. The [redacted] and the [redacted] or [redacted] began re-educating, ensuring when residents are transferred from the facility to the hospital, the ambulance transportation company receives the required documents to honor a resident's end-of-life wishes/cold status. The [redacted] or designee initiates audits of transfers to the hospital to ensure that when residents are transferred from the facility to the hospital, the ambulance transportation company receives the	F 578	This began on 12/11/2024. It will continue until all nursing staff have received the in-servicing. Staff will receive the in-servicing prior to working their next scheduled shift. Newly hired staff will receive the in-servicing in orientation when they are hired prior to working on the floor. This procedure will be followed by nursing staff. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Nursing (DON) or designee will initiate audits of transfers to the hospital to ensure when residents are transferred from the facility to the hospital, the ambulance transportation company receives the required documents to honor a resident's end of life wishes/code status. Audits will continue daily for one week, then weekly for three weeks, then monthly for three months. The results will be reviewed in the facility□s Quality Assurance and Performance Improvement (QAPI) meetings.	

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required documents to honor a resident's end-of-life wishes/code status.

Findings include:

1. Review of R17's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR), revealed that R17 was admitted to the facility on [redacted] from the hospital with diagnoses of [redacted], and [redacted].

Review of R17's hospital "History and Physical Report," electronically signed by a provider on [redacted], and uploaded on [redacted] into the "Misc" tab of R17's electronic medical record (EMR), revealed that R17 had a [redacted] of [redacted]

Review of R17's "New Jersey Universal [redacted] Form," dated [redacted] and located in the paper chart, revealed that R17 came from [redacted] to the facility with a [redacted].

Review of R17's "Order Summary Report," located in the "Orders" tab of the EMR, revealed orders dated [redacted] and [redacted] for "[redacted]." The [redacted] signed both orders on [redacted] at 11:56 AM.

Review of an "Admission/Readmission Note," dated [redacted] at 1:23 AM and located in the "Prog Note" tab of the EMR, revealed, "[redacted]." Review of the note showed no documentation that R17 was asked what his/her wishes were regarding [redacted] or to verify a change from a [redacted] to a [redacted]

Review of R17's electronic and hard copy closed

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medical records revealed no documented evidence that the facility spoke with the resident or his/her family to verify his/her NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) after they were admitted to the facility.

Review of a "Progress Note," dated NJ Ex Order 26.4(b)(1) at 8:30 AM, and located in the "Prog Note" tab of R17's EMR, revealed, "At approx [approximately] [7:45 AM] resident was observed NJ Ex Order 26.4(b)(1) to NJ Ex Order 26 and NJ Ex Order 26.4(b)(1). NJ Ex Orde was initiated. NJ Ex Or called. NJ Ex Orde continued. The patient [resident] was transported to [the hospital]."

Review of the facility-provided, 'NJ Ex Order 26.4(b)(1) Documentation," dated NJ Ex Order 26.4(b)(1), revealed NJ Ex Orde was initiated on R17 at 7:45 AM. At 7:53 AM, R17 was NJ Ex Order 26.4(b)(1) EMS arrived at 8:00 AM, took over NJ Exec Orde and NJ Ex Order 26.4(b)(1)] R17 at 8:02 AM.

Review of R17's "Progress Note," dated NJ Ex Order 26.4(b)(1) at 5:02 PM, and located in the "Prog Note" tab of the EMR, documented a follow up call to the hospital revealed R17 NJ Ex Order 26.4(b)(1).

During an interview on 12/09/24 at 3:43 PM, R17's Family Member (FM17) revealed that the resident was NJ Ex Order 26.4 in the hospital and wore a NJ Ex Order 26.4(b)(1) from the hospital during his/her stay at the facility. FM17 stated that if the facility had asked R17 what his/her NJ Ex Order 26.4(b)(1) were, R17 would have been verified and chosen to be NJ Ex Order 26.4.

During an interview on 12/10/24 at 1:38 PM, Licensed Practical Nurse (LPN) 1 stated that the facility received NJ Ex Order 26.4(b)(1) orders from the

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F 578	Continued From page 10	F 578		

provider when a resident was admitted. According to LPN1, the nursing staff verbally spoke to residents about their wishes and relayed them to the provider. Nurses were not allowed to have the resident sign a 'NJ Ex Order 26.4(b)(1) [redacted])." LPN1 stated, "Someone else did that." However, LPN1 was uncertain about who ensured the NJ Ex Order 26.4(forms were signed.

During an interview on 12/10/24 at 2:10 PM, Unit Manager (UM)1 stated the Nurses reviewed the admitting resident's hospital papers to determine what their NJ Ex Order 26.4(b)(1) was in the hospital. UM1 stated that nurses did not ask the residents what their wishes were regarding NJ Ex Order 26.4(b)(1) Instead, they relayed the resident's NJ Ex Order 26.4(b)(1) in the hospital to the physician and obtained the same orders.

During a concurrent interview with the U.S. FOIA (b and U.S. FOIA (b) (6) on NJ Ex Order 26.4(b)(1) at 2:48 PM, they stated the following facility's process: if the hospital records clearly indicate NJ Ex Order or NJ Ex Order 26.4(b)(1), these were the orders the Nurses asked for from the physician when residents were admitted to the facility. On admission or the day after, nursing asked residents if they wanted a consultation with the palliative nurse practitioner to discuss NJ Ex Order [redacted]. When asked what the expectation was regarding the discussion of NJ Ex Order 26.4(b)(1), the U.S. FOIA (b and NJ Ex Order 26.4(b)(1) stated the expectation was that residents were asked what their wishes were regarding NJ Ex Order 26.4(b)(1). It was expected that a nurse practitioner or physician had a conversation with residents regarding NJ Ex Order 26.4(b)(1) and that the nurses followed the physician's orders. If residents did not want a discussion about NJ Ex Order [redacted], then their NJ Ex Order 26.4(b)(1) was whatever the

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doctor confirmed based on hospital records.

In the same interview, the [U.S. FOIA (b)] stated she expected a conversation to be documented in EMR for [NJ Ex Order 26.4(b)(1)] changes. The [NJ Ex Order 26.4(b)(1)] stated if [NJ Ex Order 26.4(b)(1)] changed from the hospital to the facility, she expected documentation of that either in a nurse's assessment, a progress note, or verification with the physician's order. When asked for documentation that R17 had changed [NJ Ex Order 26.4(b)(1)] from [NJ Ex Order] to [NJ Ex Order 26.4(b)(1)], a social service progress note was provided as documentation.

Review of the social service progress note, "Social Services Assessment and Documentation," dated [NJ Ex Order 26.4(b)(1)] revealed no documentation that [NJ Ex Order 26.4(b)(1)] was discussed with R17 or that R17 had changed [NJ Ex Order 26.4(b)(1)] from [NJ Ex Order] to [NJ Ex Order 26.4(b)(1)].

During an interview on 12/10/24 at 8:20 PM, the [U.S. FOIA (b) (6)] stated social services did not ask residents what their wishes for [NJ Ex Order 26.4(b)(1)] were when they were admitted. According to the [U.S. FOIA (b)] within 72 hours of the resident's admission, social services asked residents if they had any [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)] and provided information regarding filling out an [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)] if they wished. If a resident expressed interest in filling out a [NJ Ex Order 26.4(b)] the [U.S. FOIA (b)] assisted but did not otherwise ask residents what their wishes were.

During an interview on 12/10/24 at 6:44 PM, LPN2, the nurse who entered R17's admission orders for a [NJ Ex Order 26.4(b)(1)] into the EMR, stated she was agency staff and worked the night shift.

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LPN2 stated that she had not been trained concerning the facility's NJ Ex Order 26.4(b)(1) policy. LPN2 stated that other nurses instructed her to review the hospital records and request orders from the physician for the NJ Ex Order 26.4(b)(1) the resident had in the hospital. If the records were unclear or did not mention the NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(orders were requested and entered into the EMR. LPN2 stated she was told by other nursing staff that the facility did not want the nurses asking residents for their NJ Ex Order 26.4(b)(1), so she did not ask about their NJ Ex Order 26.4(b)(1).

During an interview on 12/12/24 at 12:26 PM, the U.S. FOIA (b) (6) stated he expected the admitting nurse to attempt to talk to the resident or family about their NJ Ex Order 26.4(b)(1) wishes before calling the provider for orders. If unable to obtain their input, the "Universal Transfer Form" could be used for code status until current wishes were verified. The U.S. FOIA (b) (6) stated there were many opportunities to discuss NJ Ex Order 26.4(b)(1) with the resident by the admitting provider, the palliative nurse practitioner, nursing, or a social worker.

In addition, the U.S. FOIA (b) (6) further stated, "We [the facility] need to make sure we close the loop." The U.S. FOIA (b) (6) further stated he expected NJ Ex Order 26.4(b)(1) to be clarified within 48 to 72 hours after admission to the facility but was uncertain who ensured this was done.

2. Review of R2's undated "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on NJ Ex Order 26.4(b)(and most recently readmitted on NJ Ex Order 26.4(b)(. The undated "Admission Record" also documented under the 'NJ Ex Order 26.4(b)(1)" section, R2 was 'NJ Ex Order 26.4(b)(1)

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NJ Ex Order 26.4(b)(1)]."

A review of R2's untitled hospital record dated NJ Ex Order 26.4(b)(1) and located in the resident's EMR under the "Misc [Miscellaneous]" tab revealed on the second-page order of 'NJ Ex Order 26.4(b)(1)." The order documented," ...I am attending, or I conferred with the attending physician prior to placing this order ...Discussed with Patient ..." The print date of the document was NJ Ex Order 26.4(b)(1) at 4:40 PM.

Review of R2's physician "Order Summary Report (POS)," dated NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) and provided by the facility, revealed an order dated NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1). The order summary report did not have any physician signatures, nor did it have what provider gave the order.

Review of R2's "Admission Agreement," dated NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) after the resident was admitted to the facility), revealed " ... Facility Representative Documentation on NJ Ex Order 26.4(b)(1) : Resident has executed a NJ Ex Order 26.4(b)(1) [marked 'Yes'] ... Resident has executed a Medical Order for NJ Ex Order 26.4(b)(1) [nothing marked] ...Resident has executed a NJ Ex [nothing marked] ..."

Review of R2's nursing "Progress Note," dated NJ Ex Order 26.4(b)(1) and located in the resident's EMR under the "Progress Notes" tab., revealed " ...at 1700 [5:00 PM], patient's son and his/her daughter ...requested that [the] patient [be] transferred out to the hospital. 1810 [6:10 PM] Patient transferred to hospital via stretcher by [name of ambulance transport company] ..."

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Review of R2's "New Jersey Universal Transfer Form," dated [NJ Ex Order 26.4(b)(1)] and provided by the facility, revealed ..NJ Ex Order 26.4(b)(1) [marked], [NJ Ex Or] [marked] ...19. Attached Documents: ..[NJ Ex Order 26.4(b)(1)] [marked] ..." The "New Jersey Universal Transfer Form," dated [NJ Ex Order 26.4(b)(], was completed by Licensed Practical Nurse (LPN) 3. No documents were attached to the facility provided "New Jersey Universal Transfer Form," dated [NJ Ex Order 26.4(b)(].

R2 was readmitted to the facility on [NJ Ex Order 26.4(b)(] and even though the facility was aware the resident was a [NJ Ex Order 2] R2 was ordered NJ Ex Order 26.4(b)(1) until the next day. Review of the "Admission Record" for R2 readmission with a print date of [NJ Ex Order 26.4(b)(], provided by LPN1 and located in the resident's Paper Medical Record adjacent to the 200 nurses' station, revealed that R2 was readmitted to the facility on [NJ Ex Order 26.4(b)(1)] and under the 'NJ Ex Order 26.4(b)(1)" section it was documented '[NJ Ex Order 26.4(b)(1)]."

Review of R2's nursing "Progress Note," dated [NJ Ex Order 26.4(b)(] and located in the resident's EMR under the "Progress Notes" tab, revealed an admission/readmission note of "[R2's Name] arrived at the facility on [NJ Ex Order 26.] [at] 6:15 PM from [NJ] via stretcher ..NJ Ex Order 26.4(b)(1) ..."

Review of R2's "Order Recap Report," revealed an order dated [NJ Ex Order 26.4(b)(] of '[NJ Ex Order 26.4(b)(1)]." The order for the resident to have a [NJ Ex Order 26.4(b)(1)]" status ended on [NJ Ex Order 26.4(b)(] when the order was changed to 'NJ Ex Order 26.4(b)(1) ."

A review of R2's physician's "Progress Note," dated [NJ Ex Order 26.4(b)(] as a late entry and located in the

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resident's EMR under the "Progress Notes" tab, revealed " ...plan of care discussion had with family and patient's NJ Ex Order 26.4(b)(1) was changed to NJ Ex Order 26.4(b)(1) ..."

During an interview on 12/08/24 at 6:13 PM, R2 stated that during the transfer to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1), prior to leaving the facility, the ambulance transport staff informed him/her that the facility could not find the correct paperwork for them to take with them to verify that he/she was NJ Ex Order 26.4(b)(1). The resident stated he/she, and the nurse told the ambulance staff he/she was a NJ Ex Order 26.4(b)(1). The resident stated that he/she had been NJ Ex Order 26.4(b)(1) since admission to the facility. According to the resident, the ambulance staff told him/her that if he/she was to NJ Ex Order 26.4(b)(1) during transfer to the hospital, they would be required to NJ Ex Order 26.4(b)(1). The resident stated this made him/her NJ Ex Order 26.4(b)(1).

During an interview on 12/10/24 at 9:23 AM, LPN3 stated on NJ Ex Order 26.4(b)(1) that he was the nurse who had completed R2's transfer to NJ Ex Order 26.4(b)(1). When asked if there were any concerns with R2's transfer to NJ Ex Order 26.4(b)(1), LPN3 stated he could not locate R2's "NJ Ex Order 26.4(b)(1))" form. LPN3 stated the NJ Ex Order 26.4(b)(1) had R2's NJ Ex Order 26.4(b)(1) on it and was supposed to go with the resident to NJ Ex Order 26.4(b)(1)

LPN3 revealed that because he could not locate R2's NJ Ex Order 26.4(b)(1) the ambulance transport company told him and the resident they would have to make her a "NJ Ex Order 26.4(b)(1)" while being transported. LPN3 also stated he and R2 both verbally told the ambulance personnel that R2 was NJ Ex Order 26.4(b)(1) however, the ambulance personnel stated they

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needed either a copy of the NJ Ex Order 26.4(form or a copy of a signed physician's order for the NJ Ex Order 2 LPN3 further stated he completed the "New Jersey Universal Transfer Form," dated NJ Ex Order 26.4(b)(1) and indicated the resident was NJ Ex Order 26.4 on the form.

In addition, LPN3 stated he sent a copy of R2's "Order Summary Report," which indicated the resident had a physician's order for NJ Ex Order 26.4(b)(1) [redacted]. When asked if R2's "Order Summary Report" had either a physician's signature or a physician's electronic signature on the report, LPN3 stated it did not.

During a record review on 12/10/24 at 2:00 PM, LPN1 reviewed R2's "Paper Medical Record," located adjacent to the nurses' station, and verified the resident's medical record did not contain a signed physician's order for NJ Ex Order 26.4(status or a NJ Ex Order 26.4(form.

During an interview on 12/10/24 at 2:55 PM with the U.S. FOIA (and the U.S. FOIA (b) (6) the U.S. FOIA (stated when a resident was transferred to the hospital from the facility, the facility sends, at a minimum, the resident's order summary report and verbal report of the resident's NJ Ex Order 26.4(b)(1) is given to the ambulance company. The U.S. FOIA (b) (6) stated a NJ Ex Order 26.4(form was not required to be completed; they (the facility) just recommended that it be completed to ensure the residents' wishes are honored. The U.S. FOIA (stated it was her expectation for residents to be offered a NJ Ex Order 26.4(form, and if the resident declined to complete a NJ Ex Order 26.4(form, the declination should be documented in the record.

During a subsequent interview on 12/11/24 at

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11:54 AM, R2 was further asked about his/her transfer to [NJ Ex Order 26.4(b)(1)] on [NJ Ex Order 26.4(b)(1)]. R2 stated when the ambulance staff told him/her since the facility did not have the required document (completed [NJ Ex Order 26.4(b)(1)] or signed physician's order) for his/her [NJ Ex Order 26.4(b)(1)] and if he/she [NJ Ex Order 26.4(b)(1)] on the way to [NJ Ex Order 26.4(b)(1)], they would be required to [NJ Ex Order 26.4(b)(1)], he/she became [NJ Ex Order 26.4(b)(1)] and started [NJ Ex Order 26.4(b)(1)]. R2 stated all he/she could think about was the conversation his/her [NJ Exec Order 26.4b1] had with him/her related to not being [NJ Ex Order 26.4(b)(1)] at his/her age. The resident stated he/she [NJ Ex Order 26.4(b)(1)] when he/she was having this conversation with him/her. R2 stated he/she did not [NJ Ex Order 26.4(b)(1)] and feared that [NJ Ex Order 26.4(b)(1)] on the way to [NJ Ex Order 26.4(b)(1)]. R2 stated even though his/her transfer to [NJ Ex Order 26.4(b)(1)] was not an emergency; the ambulance driver knew he/she was [NJ Ex Order 26.4(b)(1)] and transported him/her with the lights and siren on like it was an emergency to get there quicker. R2 [NJ Ex Order 26.4(b)(1)] while relaying the incident to the surveyor.

During an interview on 12/11/24 at 4:36 PM, when asked if there were documents that were required to be attached to the "New Jersey Universal Transfer Form," the [U.S. FOIA (b)] stated the Medication Administration Record/Treatment Administration Record (MAR/TAR), physician order summary (POS), face sheet, labs, and if the resident had a [NJ Ex Order 26.4(b)(1)]. The continued interview revealed that when the POS (order summary report) was printed out for a transfer, the orders had been approved by the physician, whether verbal or signed. The [U.S. FOIA (b)] verified that the POS did not have a physician's signature/electronic signature (which was required by the EMS to be a valid

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F 578	Continued From page 19 by the ambulance staff during transport. During a record review and interview on 12/10/24 at 2:00 PM, LPN4 verified that R24's medical records did not contain a [NJ Ex Order 26.4(b)(1)] form or a copy of a signed physician's order for [NJ Ex Order 26.4(b)(1)], which EMS required. 6. Review of R25's undated "Admission Record," provided by the facility, revealed the resident was admitted on [NJ Ex Order 26.4(b)(1)] and most recently readmitted on [NJ Ex Order 26.4(b)(1)]. The Admission Record documented the resident's [NJ Ex Order 26.4(b)(1)] as [NJ Ex Order 26.4(b)(1)]. Review of R25's EMR and Paper Medical Record revealed no documented evidence that the resident's record included a [NJ Ex Order 26.4(b)(1)] form or a copy of a signed physician's order for [NJ Ex Order 26.4(b)(1)], which EMS required. 7. Review of R26's undated "Admission Record," provided by the facility revealed the resident was admitted to the facility on [NJ Ex Order 26.4(b)(1)] and documented the resident's [NJ Ex Order 26.4(b)(1)] as [NJ Ex Order 26.4(b)(1)]. Review of R26's EMR and Paper Medical Record revealed no documented evidence the resident's record included a [NJ Ex Order 26.4(b)(1)] form or a copy of a signed physician's order for [NJ Ex Order 26.4(b)(1)], which EMS required. 8. Review of R28's undated "Admission Record," provided by the facility revealed the resident was admitted to the facility on [NJ Ex Order 26.4(b)(1)] and documented the resident's [NJ Ex Order 26.4(b)(1)] as [NJ Ex Order 26.4(b)(1)].	F 578		

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F 578	Continued From page 20 Review of R28's EMR and Paper Medical Record revealed no documented evidence the resident's record included a [NJ Ex Order 26.4(] form or a copy of a signed physician's order for [NJ Ex Order 26.4(b)(1)], which EMS required. During a record review and interview on 12/10/24 at 2:08 PM, Unit Manager (UM) 1 stated a [NJ Ex Order 26.4(] form should be completed and placed in the residents' chart. UM1 verified that R10, R13, R24, R25, R26, and R28's Paper Medical Record and EMR did not include a [NJ Ex Order 26.4(] form or a copy of a signed physician's order for [NJ Ex Order 26.4(b)(1)], which EMS required. Review of the facility's "Social Services Director Job Description, " updated April 2023, revealed, "The Social Services Director will oversee the process of Advance Care Planning for each resident upon admission, and make sure that any Advance Directives are reviewed with the resident/resident representative on a regular basis. The Director will ensure that staff members are made aware of the resident's code status and end-of-life wishes and will assist with informing and educating residents and their representatives about health care options and ramifications." Review of the facility's policy titled, "Residents' Rights Regarding Treatment and Advance Directives," revised 03/05/24 revealed "Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate and advance directive ...Policy Explanation and Compliance Guidelines: ...9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the	F 578		

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ATLAS POST ACUTE AT WOODBURY COUNTRY CLUB	467 COOPER STREET WOODBURY, NJ 08096

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F 578	Continued From page 21 interdisciplinary team and staff responsible for the resident's care ..." A review of the "NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)," form dated August 2019 revealed "DIRECTIONS FOR HEALTHCARE PROFESSIONAL ...POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially when: The person is transferred from one care setting or care level to another ...Any incomplete section of POLST implies full treatment for that section ...Section D. Make a selection for the person's preferences regarding CPR ..." Review of Section D revealed a selection of Attempt CPR or Do not attempt resuscitation/DNAR Allow Natural Death ..." Continued review of the POLST revealed on the front page at the bottom is a signature line for the resident/representative to sign confirming "I have discussed this information with my physician/APN/PA [advanced practice nurse/physician assistant]. The POLST also had a signature line for the physician/APN/PA to sign, making the POLST document an order.	F 578		
F 678 SS=J	NJAC: 8:39-9.6 Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's	F 678		1/21/25

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F 678	Continued From page 22 advance directives. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00173566 Based on interviews, record reviews, and a review of the facility's policy titled "Residents' Rights Regarding Treatment and Advance Directives," it was determined that the facility failed to ensure the physician's orders matched the resident's documented NJ Ex Order 26.4(b)(1), which resulted in NJ Ex Order 26.4(b)(1) being done on a resident (Resident (R) 17) reviewed for NJ Ex Order 26.4(b)(1) out of a total sample of 22 residents. While in the hospital, R17 chose to be NJ Ex Order 26.4(b)(1)). However, the facility was unable to provide evidence that they implemented their policy for R17 for NJ Ex Order 26.4(b)(1) upon R17 admission to the facility. On NJ Ex Order 26.4(b)(1), when R17 was NJ Ex Order 26.4(b)(1), the facility performed approximately NJ Ex Order 26.4(b)(1) on the resident before the emergency medical services (EMS) arrived. EMS NJ Ex Order 26.4(b)(1)] R17 when they arrived on site and NJ Ex Order 26.4(b)(1) as they departed the facility for the hospital. R17 NJ Ex Order 26.4(b)(1) the facility. This failure resulted in an Immediate Jeopardy identified on 12/10/24 and was determined to exist on NJ Ex Order 26.4(b)(at F678: NJ Ex Order 26.4(b)(1)) at a Scope and Severity (S/S) of "J." The U.S. FOIA (b) (6) was notified of the Immediate Jeopardy on 12/10/24 at 9:54 PM. The facility submitted an acceptable removal plan on 12/11/2024. On 12/20/24, the Surveyors	F 678	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 17 NJ Ex Order 26.4(b)(1) in the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All resident's have the potential to be affected. The facility conducted an immediate audit of all resident records as well as speaking to residents and calling families and responsible parties to verify the resident's wishes regarding their NJ Ex Order and if it is accurately reflected in the resident's chart, if they have an NJ Ex Order 26.4(b)(1), and if they have a NJ Ex Order 26.4(b) The interviews were conducted by licensed nurses and registered nurses. Residents who could be interviewed were interviewed to obtain this information. If the resident was not interviewable the resident's responsible party was interviewed. Once then licensed nurse or registered nurse obtained this information, that nurse called the physician to review the information and obtain orders for that NJ Ex Order 26.4(b)(1). If they did not have an NJ Ex Order 26.4(b)(1) or a NJ Ex Order 26.4(b) one was offered. This audit began on 12/10/24 and was completed on 12/11/24. 3. Address what measures will be put	

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F 678	Continued From page 23 conducted a revisit to verify that the Removal Plan was implemented. The facility implemented the Removal Plan. So, the noncompliance remained on 12/20/24 as a level D for "no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy." The facility implemented the removal plan, which included the following: TheUS FOIA (b)(6) educated theUS FOIA (b)(6)) and the US FOIA (b)(6)) on the procedure: ensuring the resident's wishes regarding code status are reflected in the resident's chart, communicating the correct code status to the physician, and interviewing the resident or responsible party regarding completing a POLST form upon admission to the facility. The US FOIA (b) and the US FOIA (b)(6) orUS FOIA (b)(6) began re-educating, all nursing and social services staff on ensuring residents wishes regarding code status are reflected in the resident's chart communicating the correct code status to the physician, and interviewing the resident or responsible party regarding completing a POLST form upon admission to the facility. to the hospital, the ambulance transportation company receives the required documents to honor a resident's end-of-life wishes/cold status. The US FOIA (b) or designee initiates audits of new admission and readmission to ensure the nurse(s) completing the admission have reviewed: residents hospital records are reviewed, if they exist the resident's advanced	F 678	into place or systemic changes made to ensure that the deficient practice will not recur: The Regional Director of Clinical Services educated the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) on this procedure: ensuring the resident's wishes regarding code status are reflected in the resident's chart, communicating the correct code status to the physician, and interviewing the resident or responsible party regarding completing a POLST form upon admission to the facility. After that was completed, The Director of Nursing and Assistant Director of Nursing, or Regional Nurse began re-educating staff: All nursing staff and social services staff will be re-educated on ensuring the resident's wishes regarding code status are reflected in the resident's chart, communicating the correct code status to the physician, and interviewing the resident or responsible party regarding completing a POLST form upon admission to the facility. This began on 12/10/2024. It will continue until all nursing staff have received the in-servicing. Staff will receive the in-servicing prior to working their next scheduled shift. Newly hired staff will receive the in-servicing in orientation when they are hired prior to working on the floor. This procedure will be followed by nursing staff along with the existing Resident Rights Regarding Treatment and Advanced Directives Policy. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting:	

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F 678	Continued From page 24 directives is reviewed, the resident's POLST is reviewed, the resident's Living Will is reviewed, and the wishes regarding code status are reviewed with the resident or responsible party and are reflected accurately in the chart and communicated to the physician and that a POLST was offered if one wasn't already in place. Findings include: Review of R17's hospital "History and Physical Report," electronically signed by a provider on NJ Ex Order 26.4(b)(1), and uploaded on NJ Ex Order 26.4(b)(1) into the "Misc" tab of R17's electronic medical record (EMR), revealed that R17 had a NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1). Review of R17's "New Jersey Universal Transfer Form," from the hospital to the facility dated NJ Ex Order 26.4(b)(1), and located in the resident's paper chart, revealed R17 came from NJ Ex Order 26.4(b)(1) to the facility with a NJ Ex Order 26.4(b)(1). Review of R17's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR), revealed R17 was admitted to the facility on NJ Ex Order 26.4(b)(1) from the hospital with diagnoses of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). Review of an "Admission/Readmission Note," dated NJ Ex Order 26.4(b)(1) at 1:23 AM, and located in the "Prog Note" tab of the EMR, revealed, "NJ Ex Order 26.4(b)(1)." Further review of the note revealed no documentation that R17 was asked what his/her wishes were regarding NJ Ex Order 26.4(b)(1) or to verify whether R17 had changed his/her NJ Ex Order 26.4(b)(1) to a NJ Ex Order 26.4(b)(1).	F 678	The Director of Nursing (DON) or designee will initiate audits of new admissions and readmissions to ensure the nurse(s) completing the admission have reviewed: resident's hospital records are reviewed, if they exist—the resident's advanced directives is reviewed, the resident's POLST is reviewed, the resident's Living will is reviewed, and the wishes regarding code status are reviewed with the resident or responsible party and are reflected accurately in the chart and communicated to the physician and that a POLST was offered if one wasn't already in place. Audits will continue daily for one week, then weekly for three weeks, then monthly for three months. The results will be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings.	

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Review of R17's "Order Summary Report," located in the "Orders" tab of the EMR, revealed orders dated [redacted] and [redacted] for "[redacted]." The U.S. FOIA (b) (6) signed both orders on [redacted] at 11:56 AM.

Review of the R17's electronic and hard copy closed medical records revealed no documented evidence that the resident or his/her family changed R17's [redacted] from [redacted] to [redacted] after he/she was admitted to the facility.

Review of a "Progress Note," dated [redacted] at 8:30 AM, and located in the "Prog Note" tab of R17's EMR, revealed, "At approx [approximately] [7:45 AM] resident was observed [redacted] to [redacted] and [redacted]. [redacted] was initiated. [redacted] called. [redacted] continued. Patient was transported to [hospital]."

Review of the facility-provided, "[redacted] Documentation," dated [redacted] revealed [redacted] was initiated on R17 at 7:45 AM. At 7:53 AM, R17 was [redacted]). EMS arrived at 8:00 AM, took over [redacted] and [redacted] R17 at 8:02 AM.

Review of R17's "Progress Note," dated [redacted] at 5:02 PM, and located in the "Prog Note" tab of the EMR, documented a follow up call to the hospital revealed R17 had [redacted]

During an interview on 12/09/24 at 3:43 PM, Family Member (FM)17 revealed that R17 was [redacted] in the hospital and wore [redacted] wristband from the hospital during his/her stay at the facility. FM17 stated if the facility had asked R17 what

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his/her NJ Ex Order 26.4(b)(1) were, R17 he/she would have chosen to continue to be NJ Ex Order 26.4(

During an interview on 12/10/24 at 1:22 PM, the U.S. FOIA (b) (6)) stated that when a resident was admitted to the facility, the admitting nurse relayed the NJ Ex Order 26.4(b)(1) the resident had at the hospital to the Doctor to obtain an order. If there was a discrepancy in the hospital records, the Doctor was likely to order NJ Ex Order 26.4(b)(1).

During a concurrent interview with the U.S. FOIA (b and U.S. FOIA (b) (6) on 12/20/24 at 2:48 PM, they stated if the hospital records clearly indicated NJ Ex Order or NJ Ex Order 26.4(b)(, these were the orders the nurses asked for from the physician when residents were admitted to the facility.

During an interview on 12/10/24 at 6:44 PM, LPN2, the nurse who entered R17's admission orders of a NJ Ex Order 26.4(b)(1) into the EMR, stated she was agency staff and worked the night shift. LPN2 stated she was not provided with the facility's NJ Ex Order 26.4(b)(1) policy. She further stated that other nurses she had worked with instructed her to review the hospital records and request orders from the physician for the NJ Ex Order 26.4(b)(1) of the resident in the hospital. LPN2 no longer worked at the facility and could not remember why she entered NJ Ex Order 26.4(b)(1) as R17's NJ Ex Order 26.4(b)(1).

During an interview on 12/12/24 at 12:26 PM, the U.S. FOIA (b) (6) stated he expected the admitting nurse to attempt to talk to the resident or family about their wishes regarding NJ Ex Order 26.4(b)(1) prior to calling the provider for orders. If unable to obtain their input, the "Universal Transfer Form" could be used for NJ Ex Order 26.4(b)(1) until current wishes were verified within 48 to 72 hours after admission to

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F 678	Continued From page 27 the facility. When asked if he verified what NJ Ex Order R17 wanted before signing the orders, the U.S. FOIA (b) (6) stated he could not remember R17 but that physicians and Nurse Practitioners had an area in the progress notes to document any discussions with the resident or family about NJ Ex Order 26.4(b)(1). Review of the facility's policy titled, "Residents' Rights Regarding Treatment and Advance Directives" reviewed/revised 02/23/23, included the following: Under "Policy:" revealed "It is the policy of the facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive." Under "Definitions:" showed "Advance directive" is a a written instruction, such as a living will or a durable power of attorney for health care ..." Under: "Policy Explanation and Compliance Guidelines:" included "1. On, admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, ..." 9. "Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care." NJAC: 8:39-4.1(a)2 NJAC: 8;39-9.6 (b)	F 678		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		1/21/25

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F 755	Continued From page 28 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: C#'s: NJ00177015 and NJ00180017. Based on interviews, record review, and review of the facility's policy, the facility failed to ensure documentation of NJ Ex Order 26.4(b)(1)	F 755	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 4 was NJ Ex Order 26.4(b)(1) Resident	

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F 755	Continued From page 29 medications accurately reflected disposition and administration times in 3 of 28 residents (Resident (R)4, R23, and R24). The facility's failure placed residents who were ordered and administered NJ Ex Order 26.4(b)(1) at risk of their NJ Ex Order 26.4(b)(1) being misappropriated/diverted. This provided inaccurate documented evidence during the investigation of misappropriation/diversion events and/or allegations. Findings include: 1. Review of R4's undated "Admission Record," located in the resident's EMR under the "Profile" tab, revealed the resident was admitted to the facility on [redacted]. Review of R4's physician "Orders," located in the resident's EMR under the "Orders" tab revealed the resident was ordered [redacted] twice a day. Review of R4's untitled and undated document provided by the facility revealed R4 was administered NJ Ex Order 26.4(b)(1) on [redacted] at 12:53 PM. The medication was scheduled to be administered at 12:00 PM. Review of R4's "Individual Patient [redacted] Administration Record-30 dose," for [redacted] with a received date of [redacted] revealed it was documented on [redacted] under the "Time" column, that the [redacted] was removed from the [redacted] lock box at "1200" (53 minutes before the medication was administered to the resident).	F 755	was interviewed and resident stated they received their medications accordingly. Resident 23 was [redacted]. Resident was NJ Exec Order 26.4b1. Resident [redacted] in the facility. Resident 24 was [redacted]. Resident was NJ Exec Order 26.4b1. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who receive controlled medications have the potential to be affected. No other residents were identified as being affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director or Nursing or Assistant Director of Nursing initiated in-servicing on this procedure: ensuring documentation of controlled substance medications accurately reflects disposition and administration times. It will continue until all nursing staff have received the in-servicing. Staff will receive the in-servicing prior to working their next scheduled shift. Newly hired staff will receive the in-servicing in orientation when they are hired prior to working on the floor. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Nursing (DON) or designee will initiate audits on five	

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F 755	Continued From page 30 2. Review of R23's undated "Admission Record," provided by the facility, revealed the resident was admitted on [redacted]. Review of R23's physician "Order Summary Report," provided by the facility revealed the resident was ordered NJ Ex Order 26.4(b)(1) for [redacted] on [redacted]. Review of R23's untitled and undated document provided by the facility revealed that R23 was administered [redacted] capsule on [redacted] at 8:04 AM. The medication was scheduled to be administered at 9:00 AM. Review of R23's "Individual Patient [redacted] Administration Record-30 dose," for [redacted] with a received date of [redacted] revealed it was documented on [redacted] under the "Time" column, that the [redacted] was removed from the [redacted] lock box at "0900 [9:00 AM] (56 minutes after the medication was administered to the resident). 3. Review of R24's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on [redacted]. Review of R24's physician "Orders," located in the resident's electronic medical record (EMR) under the "Orders" tab, revealed the resident was ordered [redacted] (NJ Ex Order 26.4(b)(1) [redacted] on [redacted]. Review of R24's untitled and undated document provided by the facility revealed R24 was administered a NJ Ex Order 26.4(b)(1)) capsule on [redacted] at 8:31 AM. The medication was	F 755	residents who received controlled medications to ensure documentation accurately reflects disposition and medication administration times. Audits will continue daily for one week, then weekly for three weeks, then monthly for three months. The results will be reviewed in the facility□s Quality Assurance and Performance Improvement (QAPI) meetings.	

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F 755	Continued From page 31 scheduled to be administered at 9:00 AM. Review of R24's "Individual Patient Controlled Substance Administration Record-30 dose," for [redacted] with a received date of [redacted] revealed on [redacted] under the "Time" column, that the [redacted] was removed from the NJ Ex Order 26.4(b)(1) at "0900 [9:00 AM] (31 minutes after the medication had been administered to the resident). During record reviews and interview on 12/12/24 at 9:28 AM, the U.S. FOIA (b) (6)) reviewed the Individual Patient [redacted] Administration Records (controlled drug records) and medication administration records (MAR) for R4, R23, and R24. The [redacted] stated the nurses were documenting the scheduled administration time for the controlled medications because they (nurses) knew it would be time-stamped on the MAR when the medication was administered. When asked about the Individual Patient NJ Ex Order 26.4(b)(1) Administration Records for the residents having documentation of the scheduled administration times for the [redacted] medications and not reflecting the time the nurse retrieved the [redacted] medication from the [redacted] lock box, the [redacted] stated it was her expectation the nurse would document the scheduled medication administration time on the residents' Individual Patient NJ Ex Order 26.4(b)(1) Administration Record. The [redacted] stated the facility's current practice of completing the Individual Patient NJ Ex Order 26.4(b)(1) Administration Records was acceptable since the MAR documents the actual time of administration.	F 755		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTRY CLUB	467 COOPER STREET WOODBURY, NJ 08096

(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 755	Continued From page 32 During an interview on 12/12/24 at 11:13 AM, when asked about how residents' Individual Patient NJ Ex Order 26.4(b)(1) Administration Records should be completed, the U.S. FOIA (b) (6) [redacted] stated as a nurse, she would document the Individual Patient NJ Ex Order 26.4(b)(1) [redacted] Administration Record the times she pulled the NJ Ex Order 26.4(b)(1) medication from the NJ Ex Order 26.4(b)(1) medication lock box. During an interview on 12/12/24 at 4:45 PM, Licensed Practical Nurse (LPN) 6 stated when she administered a NJ Ex Order 26.4(b)(1) medication to a resident, she recorded the time she administered the medication on the Individual Patient NJ Ex Order 26.4(b)(1) Administration Record. During an interview on 12/12/24 at 4:48 PM, Registered Nurse (RN)2 stated he documented the time the controlled medication was scheduled to be administered to the resident and not the time he punched the NJ Ex Order 26.4(b)(1) medication out. During an interview on 12/12/24 at 5:54 PM, when asked what the expected procedure was for signing out controlled medications, the facility's U.S. FOIA (b) (6) [redacted] stated the facility used declining inventory sheets (Individual Patient NJ Ex Order 26.4(b)(1) Administration Record). The U.S. FC [redacted] also stated as soon as the nurse pops the medication out from the mediation card, they sign the declining inventory sheet. The U.S. FC [redacted] further stated that if the NJ Ex Order 26.4(b)(1) medication was routinely scheduled, the nurses were to document the medication administration time. When asked, was she indicating the declining inventory sheet was not a reflection of when the scheduled NJ Ex Order 26.4(b)(1) [redacted] medications were punched (removed from the lockbox/medication card) but	F 755		

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F 755	Continued From page 33 a reflection of when the [NJ Ex Order 26.4(b)(1)] medications were scheduled, the [U.S. FC] stated, "Yes, that's correct." Review of the facility's policy titled "Controlled Substances," revised November 2022, revealed "The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Scheduled II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) ...4 ...an individual resident controlled substance record is made for each resident who will be receiving a controlled substance ...This record contains: ...a. name of resident; b. name and strength of the medication; c. quantity received; d. number on hand; e. name of the prescriber ...h. date and time received; i. time of administration ...Storing Controlled Substances. 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing, and disposition of controlled substances includes the following: a. records of personnel access and usage; b. Medication administration records ..." NJAC: 8:39-29.3 NJAC: 8:39-29.4	F 755		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		1/21/25

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F 880	Continued From page 34	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§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;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 35 circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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: C#'s: NJ00177015 and NJ00180017. Based on observations, interviews, and record review, it was determined that the facility failed to utilize the proper personal protective equipment (PPE) for residents on NJ Ex Order 26.4(b)(1) precautions for 4 of 22 residents (Residents (R) 10, R11, R12, and R13) reviewed for NJ Ex Order 26.4(b)(1) out of a sample of 22 residents. The facility also failed to follow its "COVID-19 Prevention, Response, and Reporting" policy. This created the potential for the transmission of infection to staff and other residents. Findings include:	F 880	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 10 was NJ Ex Order 26.4(b)(1). Resident 11 was NJ Ex Order 26.4(b)(1). Resident 12 was NJ Ex Order 26.4(b)(1). Resident 13 was NJ Ex Order 26.4(b)(1). 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected.	

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F 880	Continued From page 36 1. Review of R10's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed she was admitted to the facility on [redacted] with a diagnosis of [redacted] On [redacted], [redacted] was added as a diagnosis. Review of R10's "Prog Note" tab revealed a "Skilled Note," dated [redacted] at 10:34 PM, "During the first shift, resident [redacted] for [redacted] All NJ Exec Order 26.4b1 put in place..." A review of R10's "Care Plan," located in the "Care Plan" tab of the EMR, revealed a focus area, "I am [redacted] and exhibiting [redacted] consistent with [redacted]," initiated [redacted] Interventions included "NJ Ex Order 26.4(b)(1) precautions" and "instruct staff to wear PPE when entering the room." In addition, the "Care Plan" revealed a focus area, "I require [redacted] precautions R/T [related to] [redacted]," initiated [redacted]. Under: Interventions included "Place protective equipment [redacted] station at the entrance of the room." During an observation on 12/08/24 at 6:21 PM, Certified Nurse Aide (CNA) 1 walked into R10's room wearing a surgical mask over an [redacted] mask, gown, and gloves. No [redacted] protection was worn. The "NJ Ex Order 26.4(b)(1) Precautions" sign on R10's door staged to wear gloves, gown, a mask, fit tested [redacted] if doing aerosolizing procedures, and eye protection. A three-drawer cart with PPE was in the hall outside the room. During an interview on 12/08/24 at 6:23 PM, when CNA1 exited R10's room and was asked about wearing [redacted] protection, she opened the PPE cart, pointed to a face shield, and asked if it	F 880	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 12/8/24, the Director or Nursing or Assistant Director of Nursing initiated in-servicing on this procedure: The COVID-19 Prevention, Response, and Reporting" policy as it relates to proper personal protective equipment (PPE) for residents with Covid 19 infection. It will continue until all nursing staff have received the in-servicing. Staff will receive the in-servicing prior to working their next scheduled shift. Newly hired staff will receive the in-servicing in orientation when they are hired prior to working on the floor. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Nursing (DON) or designee will initiate complete PPE donning and doffing competencies on three random staff members to ensure the task is completed appropriately. The audits will continue daily for one week, then weekly for three weeks, then monthly for three months. The results will be reviewed in the facility□s Quality Assurance and Performance Improvement (QAPI) meetings.	

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F 880	Continued From page 37	F 880		

was the [redacted] protection being referred to. CNA1 then walked down the hall to speak to another staff member.

2. Review of R11's "Admission Record" located in the "Profile" tab of the EMR revealed she was admitted to the facility on [redacted] with a diagnosis of NJ Ex Order 26.4(b)(1) [redacted].

Review of R11's "Prog Note" tab revealed a "Nurses Note," dated [redacted] at 4:02 PM, "Rapid [redacted] test completed on a patient [resident] with [redacted] results. [Provider] made aware and notified. Patient NJ Ex Order 26.4(b)(1) [redacted].."

Review of R11's "Care Plan," located in the "Care Plan" tab of the EMR, revealed a focus area, "I am [redacted] and exhibiting symptoms consistent with [redacted] initiated [redacted]. Under: Interventions included "[redacted] precautions" and "instruct staff to wear PPE when entering the room." In addition, the "Care Plan" revealed a focus area, "I require NJ Ex Order 26.4(b)(1) precautions R/T [related to] [redacted]," initiated [redacted]. Interventions included "Place protective equipment [redacted] station at the entrance of the room."

During an observation on 12/08/24 at 6:18 PM, the Licensed Practical Nurse (LPN)5 was observed in F11's room with the door open. LPN5 wore a gown, [redacted] mask, and gloves but had no [redacted] protection other than her glasses. The "NJ Ex Order 26.4(b)(1) Precautions" sign on R11's door staged to wear gloves, gown, a mask, fit tested [redacted] if doing aerosolizing procedures,

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F 880	Continued From page 38	F 880		

and [redacted] protection. A three-drawer cart with PPE was in the hall outside the room.

During an interview on 12/08/24 at 6:24 PM, LPN5 stated the facility had face shields, but she did not wear them unless the resident was having symptoms such as [redacted] or [redacted] She stated that R11 had [redacted]. LPN5 reported nurses and CNAs care for both [redacted] and [redacted] residents in the hall during their shifts.

3. Review of R12's "Admission Record" located in the "Profile" tab of the EMR revealed she was admitted to the facility on [redacted] with a diagnosis of [redacted] On [redacted], [redacted] was added as a diagnosis.

Review of R12's "Prog Note" tab revealed a "Nurses Note," dated [redacted] at 4:21 PM, "Rapid [redacted] test completed on patient with [redacted] results. [Practitioner] made aware and notified. Patient [redacted] stated [redacted] and [redacted] at this time ..."

Review of R12's "Care Plan," located in the "Care Plan" tab of the EMR, revealed a focus area, "I am [redacted] and [redacted] consistent with [redacted]," initiated [redacted]. Under: Interventions included "[redacted] precautions" and "instruct staff to wear PPE when entering the room." In addition, the "Care Plan" revealed a focus area, "I require [redacted] precautions R/T [related to] [redacted]," initiated [redacted]. Interventions included "Place protective equipment [redacted] station at the entrance of the room."

During an observation on 12/08/24 at 6:15 PM,

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F 880	Continued From page 39	F 880		

CNA2 entered R12's room after donning a gown, gloves, and a surgical mask over the surgical mask already worn. She wore glasses but no additional [redacted] protection. The "[redacted] Precautions" sign on R12's door staged to wear gloves, gown, a mask, fit tested [redacted] if doing aerosolizing procedures, and [redacted] protection. A three-drawer cart with PPE was in the hall outside the room.

During an interview on 12/08/24 at 7:15 PM, CNA2 stated the caddy did not have an [redacted] mask, so she put on two surgical masks. It also had no [redacted] protection, so she used her glasses.

4. Review of R13's "Admission Record" in the "Profile" tab of the EMR revealed she was re-admitted to the facility on [redacted] with a diagnosis of NJ Ex Order 26.4(b)(1). On [redacted] was added as a diagnosis.

Review of R13's "Prog Note" tab revealed a "Skilled Note," dated [redacted] at 2:20 PM, "Earlier during this shift, resident was seen [redacted] in bed c/o [complaining of] [redacted] ... Resident tested [redacted] for [redacted] and was immediately put on NJ Exec Order 26.4b1 ..."

Review of R13's "Care Plan," located in the "Care Plan" tab of the EMR, revealed a focus area, "I am [redacted]," initiated [redacted]. Under: Interventions included NJ Ex Order 26.4(b)(1) precautions" and "instruct staff to wear PPE when entering the room." In addition, the "Care Plan" revealed a focus area, "I require NJ Ex Order 26.4(b)(1) precautions R/T [related to] [redacted] initiated [redacted]. Interventions included "Place protective equipment [redacted] station at the entrance of the room."

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F 880	Continued From page 40 During an observation on 12/08/24 at 6:45 PM, Registered Nurse (RN) 1 went into R13's room after donning a gown, gloves, and [redacted] mask but no [redacted] protection. The "Special [redacted] Precautions" sign on R13's door staged to wear gloves, gown, a mask, fit tested [redacted] if doing aerosolizing procedures, and [redacted] protection. A three-drawer cart with PPE was in the hall outside the room. During an interview on 12/08/24 at 7:15 PM, RN1 verified he had not worn [redacted] protection. RN1 stated the expectation was to wear [redacted] protection, but R13 did not have the correct PPE set up. During an interview on 12/09/24 at 4:22 PM, the [redacted]) stated she expected staff to wear a gown, goggles or face shield, gloves, and an [redacted] mask when entering a room of a resident who has [redacted]. Failure to wear the correct PPE could spread [redacted] to the staff or others in the facility. During an interview on 12/09/24 at 4:25 PM, the [redacted]) stated she expected staff to wear a gown, goggles or face shield, gloves, and an [redacted] mask when entering a room of a resident who has [redacted]. Review of the facility's "COVID-19 Prevention, Response, and Reporting" policy, dated 05/29/24, revealed, "HCP [health care personnel] who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye	F 880		

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F 880	Continued From page 41 protection." NJAC: 8:39-19.4(a)	F 880		

New Jersey Department of Health

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	08008	A. BUILDING: _____ B. WING _____	C 12/20/2024

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S 000	Initial Comments Complaint #: NJ00170972, NJ00171675, NJ00173566, NJ00175663, NJ00177015, NJ00178159, NJ00179724, NJ00179726, NJ00180017, and NJ00180066. Survey Census: 90 Sample Size: 22 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 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #'s: NJ00170972, NJ00171675, NJ00173566, NJ00175663, NJ00177015, NJ00178159, NJ00179724, NJ00179726, NJ00180017, and NJ00180066. Based on review of pertinent facility	S 560	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified nor immediately affected by the failure to	1/21/25

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

Electronically Signed | 01/16/25

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S 560	Continued From page 1 documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 13 of 21- day shifts. The deficient practice was evidenced by the following: 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 as 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 (CNA) 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 of all staff members shall be CNAs and each direct staff member shall be signed into 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 CNA and perform CNA duties. 1. For the 3 weeks of Complaint staffing from 01/14/2024 to 02/03/2024, the facility was deficient in CNA staffing for residents on 13 of 21 day shifts as follows: -01/14/24 had 7 CNAs for 116 residents on the day shift, required at least 14 CNAs. -01/15/24 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -01/16/24 had 9 CNAs for 115 residents on the	S 560	provide minimum staffing levels as mandated by the State of New Jersey. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Recruitment efforts continue to include: wage analysis and adjustments, vacant shift bonuses, online job listings, ongoing onsite job fairs, on-demand orientation classes, daily interviews to walk-ins, shift differentials and referral bonuses. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Administrator or designee will review staffing schedules weekly to ensure adequate staffing for all shifts. Any findings will be followed up and documented on and then reported during the quarterly QAPI meetings for one years□ time, or until staffing levels are no longer an issue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTR	467 COOPER STREET WOODBURY, NJ 08096

(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) COMPLETE DATE
S 560	Continued From page 2 day shift, required at least 14 CNAs. -01/19/24 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -01/21/24 had 9 CNAs for 121 residents on the day shift, required at least 15 CNAs. -01/22/24 had 12 CNAs for 120 residents on the day shift, required at least 15 CNAs. -01/24/24 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. -01/26/24 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -01/27/24 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs. -01/28/24 had 9 CNAs for 121 residents on the day shift, required at least 15 CNAs. -01/29/24 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. 01/30/24 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. 02/01/2024 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. 2. For the week of Complaint staffing from 02/25/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -02/25/24 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -02/26/24 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -02/27/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -03/01/24 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -03/02/24 had 7 CNAs for 100 residents on the day shift, required at least 12 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 12/20/2024

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ATLAS POST ACUTE AT WOODBURY COUNTR	467 COOPER STREET WOODBURY, NJ 08096

(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) COMPLETE DATE
S 560	Continued From page 3 3. For the 2 weeks of Complaint staffing from 07/14/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: - 07/14/24 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/15/24 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs. -07/16/24 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs. -07/19/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/21/24 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/24/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -07/26/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -07/27/24 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. 4. For the 3 weeks of Complaint staffing from 08/18/2024 to 09/07/2024, the facility was deficient in CNA staffing for residents on 8 of 21 day shifts as follows: -08/25/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/26/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/30/24 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. -08/31/24 had 9 CNAs for 116 residents on the day shift, required at least 14 CNAs. -09/01/24 had 9 CNAs for 116 residents on the day shift, required at least 14 CNAs. -09/02/24 had 11 CNAs for 112 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTR	467 COOPER STREET WOODBURY, NJ 08096

(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) COMPLETE DATE
S 560	Continued From page 4 day shift, required at least 14 CNAs. -09/06/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -09/07/24 had 10 CNAs for 103 residents on the day shift, required at least13 CNAs. 5. For the week of Complaint staffing from 10/27/2024 to 11/02/2024, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -10/27/24 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -10/28/24 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -10/31/24 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/01/24 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. 6. For the 3 weeks of staffing prior to survey from 11/17/2024 to 12/07/2024, the facility was deficient in CNA staffing for residents on 12 of 21 day shifts as follows: -11/18/24 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/19/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/21/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/23/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/24/24 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/26/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -11/27/24 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08008	A. BUILDING: _____ B. WING _____	C 12/20/2024

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S 560	Continued From page 5 -11/29/24 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -11/30/24 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/02/24 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs. -12/05/24 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. -12/07/24 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs.	S 560		

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	1/22/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTRY CLUB	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 F0578	Correction	ID Prefix F0678	Correction	ID Prefix F0755	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.24(a)(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	01/21/2025	LSC	01/21/2025	LSC	01/21/2025
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/21/2025	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	

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?
12/20/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
08008 Y1	A. Building B. Wing Y2	1/22/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTRY CLUB	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	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/21/2025	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO