STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER: ATRIUM AT NAVESINK HARBOR, THE		STREET ADDRESS, CITY, STATE, ZIP CODE: 40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Survey Date: 2/25/26 Census: 32 Sample: 12 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		04/08/2026
F0802 SS = F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined the the facility failed to ensure that the Dietary staff had the appropriate skill sets and competencies to ensure a) staff maintained a sanitary dietary environment, b) a process was in place to ensure recipes were followed to ensure	F0802	1. All residents are potentially at risk. Immediate corrective actions included: removal of all expired, unlabeled, and improperly stored food items from the refrigerator and dry storage; removal of all worn cutting boards; deep cleaning of the walk-in refrigerator, oven, steam table, dry storage room, and all food contact surfaces; and replacement of rusted food storage racks. 2. All residents were potentially at risk for foodborne illness or inadequate nutritional intake as a result of this deficient practice. A 100% audit of the kitchen environment and dietary staff practices will be completed by the Director of Dining Services (DDS) and Licensed Nursing Home Administrator. All food items were inspected, mislabeled or expired products were discarded, and all food contact surfaces were cleaned and sanitized. All dietary staff, including contracted personnel, were in-serviced by the Director of Operations, or designee, on kitchen sanitation, recipe compliance of fortified foods and provision of diets as ordered by physician, the proper process for taking food temperatures with proper recording of food temperatures and cleaning of thermometers, handwashing and glove use compliance and a review of labeling, dating and discard policy.	04/08/2026

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

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F0802 SS = F	Continued from page 1 nutrition adequacy of fortified foods, and appropriate physician ordered diets were provided to residents, c) cooking temperatures were consistently monitored, d) staff were competent in utilizing food temperature measuring devices, e) infection control practices were consistently implemented with glove use and hand hygiene, and f) foods were appropriately labeled, dated and discarded by use by dates. The deficient practice places all resident at risk for potential food borne illness, affected all residents who resided at the facility and was evidenced by the following: Refer to F812, F804, and F805 On 02/18/26 at 8:24 AM, the surveyor toured the kitchen with the [redacted] and the [redacted]) observed that refrigerated and potentially hazardous foods were not consistently labeled with a use by date, and foods were also observed in use and had expired Discard Dates. Observations included, but were not limited to the following: -The [redacted] exited the refrigerated walk- in box and did not have all his [redacted] covered. -The [redacted] was also observed cooking food and he did not have all of his [redacted], and when asked if it should be covered, he confirmed that the [redacted] should be covered. -The walls, ceilings and floor throughout the walk-in box had visible debris, including splatter type debris, and crumb type debris was observed under the food racks, debris was also embedded on the green racks which also appeared rusted in several areas. When the surveyor showed the [redacted] the observations and asked the [redacted] if it looked clean, he confirmed it did not, and he stated it should be cleaned daily. - A jar of strawberry topping, was labeled “Opened, 2/13/26 and Discard 2/16/26.” - A container of sauerkraut was opened, splatter observed on outside of the container and it was not labeled with a “use by date”, the vender sticker was dated 1/2/26 and the [redacted] confirmed there was no “use by date.” - Corned Beef was wrapped in plastic and was on the shelf, with a label affixed, “Opened 2/14/26- Discard- 2/14/27”. The [redacted] stated the sticker was placed on by the staff and it was the wrong information on the label because the staff “had a	F0802	Continued from page 1 3. The following systemic changes were implemented: Competencies on all areas of deficiency were completed on 3/26/26 with all dining staff with renewal of competencies to be completed annually by the System Registered Dietitian. A weekly audit of all fortified food recipe compliance was initiated on 3/23/26 A weekly tray accuracy audit of 10 mechanically altered trays will be conducted to ensure compliance with the diet order from the kitchen to point of service for three months. All audits will be reviewed weekly with the System Registered Dietitian (SRD) with updates to Plan of Correction (POC) as needed. Quarterly review of handwashing and glove use will be initiated for all healthcare dining staff for the next year and then completed annually by the Infection Preventionist (IP). Weekly kitchen safety and sanitation audits will be completed by either the Regional Director of Operations, and/or designee. 4. All audits will be reviewed weekly by the Food Service Director/Registered Dietitian for identification of areas of noncompliance All audits will be reviewed monthly with the System Registered Dietitian for identification of compliance All audits will be provided to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) committee for review monthly	04/08/2026

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F0802 SS = F	Continued from page 2 hard time understanding." -A container of fresh peeled shallots, was labeled with a sticker "Opened 2/11/26 and Discard 2/14/26", the [redacted] again acknowledged the item was past the expiration date and stated the item was incorrectly dated. -A jar of capers had a label, "Opened 2/15/26 and Discard 2/15/27" -A white container of opened kalamata olives pitted, with splatter on the exterior, did not have a "use by date". -A partially opened container of soft [redacted] cheese was visibly soiled around the rim of the container and was labeled as "Opened 2/8/26 and Discard 2/14/26." -A bag of sundried tomatoes, was labeled "Opened 2/14/26 and Discard 2/17/26." -A metal pan was located on top of the meat area in the refrigerator, when asked what the item was, the [redacted] proceeded to remove what was identified as defrosting fish, which was loosely wrapped. When the item was pulled off of the top shelf, a fluid spilled onto the floor. -A raw pork loin was wrapped in plastic wrap and placed directly on top of a shelf, over a box with a blue bag that had raw chicken inside. -A cardboard box contained a blue bag of raw chicken, and was located next to a plastic container with a lid, and another cardboard box. All three containers contained raw chicken. When asked about any dates that were affixed to the items, and when they were pulled from the freezer, or what the use by date was, or any dates at all. The [redacted] stated, "obviously" they were not dated. -Four white bins were stored underneath a stainless-steel shelf opposite the walk-in refrigerator, and contained flour, breadcrumbs stored inside the bags, and thickener. The bins were visibly soiled on the lids with debris on the outside of the bins. -The stainless-steel table contained 4 loaves of French style bread that were stored on top of a plastic lid for a bin. Three of the loaves were completely uncovered and stored adjacent to non-stick canned spray. The [redacted] stated the loaves were defrosting.	F0802		04/08/2026

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F0802 SS = F	Continued from page 3 - The plastic wrap container was also visibly soiled with grease type stains. -The can opener that was affixed to the same stainless-steel table had visible metal shavings around the blade and when asked when the blade was last changed, the [redacted] stated that the whole opener would be thrown out and the blade would not get changed. -Clean knives were also stored underneath a visibly soiled blackened sink pipe, in an open container by the hand washing sink. -The dry storage room contained a dented can on the rack and the bottles of gravy making product had visible dark colored debris on the outside. -The green food storage racks in the dry storage room were visibly rusted through and were missing a finish in several areas, had embedded food type debris on the racks, and the floor in the dry storage room was visibly soiled. -The juice dispenser was visibly soiled by the three nozzles and there was visible spatter on the exterior of the machine. -The gasket for the healthcare refrigeration reach in refrigerator was soiled. -A multi-tiered gray cart was also observed by the reach in refrigeration unit and was visibly soiled with various colored debris throughout the cart. -Eight cutting boards that were white, green and red were visibly stained, soiled and appeared to have deep grooves. The [redacted] stated they were all worn and removed the cutting boards. -The pass though stainless-steel shelf underside, between the steam table and where the meals were plated and passed through was heavily soiled with debris. -The plate dolly was stored by the entrance to the kitchen and the plates were stored upright and not uncovered. -The oven was heavily soiled with caked on dark grease like debris inside the interior and by the oven door. -There were two snack carts by the entrance to the kitchen and the staff stated they were from the	F0802		04/08/2026

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F0802 SS = F	Continued from page 4 previous and had debris on them. -When asked the [redacted] for the cleaning schedules for the kitchen, he stated the kitchen "should look better" and then showed the surveyor an Equipment Cleaning Log for the Week of 2/18/26 which was incomplete and did not include all the above areas. On 02/18/26 at 12:14 PM, the surveyor began an observation of the meal service in the 3rd floor food service pantry and the following observations included, but were not limited to the following: -A person was observed in the pantry with their hair not fully covered and one side was hanging outside of the hair net. They identified themself as the [redacted], [redacted]) for the management company. When brought to their attention, they restrained all their hair and confirmed it should all be covered. The [redacted] then proceeded to wash her hands in the sink, used a paper towel to dry her hands, then used the same paper towel to wipe the water off the area surrounding the sink. When the surveyor asked her what role was regarding the meal, she stated "QA" (quality assurance) and exited the pantry. At that time the surveyor observed another staff member, who identified herself as the [redacted]) and was at the steam table in the pantry. When asked about the mealtime, as residents were seated in the dining room, she stated that the crab cakes and the rice did not come up from the kitchen at the appropriate temperatures and were sent back down to be reheated. - The surveyor then observed the storage refrigerator in the pantry. The lower freezer drawer was observed with two plates of taco salad, one plate was identified as a mechanical soft salad which contained ground beef, beans, cheese, tomato, over lettuce, a scoop of sour cream, and was wrapped in plastic wrap and on top of ice cream containers. A second salad was a regular consistency taco salad that also contained ground beef, sour cream, beans, and was wrapped in plastic and stored directly on top of the ice cream containers in the freezer. The surveyor asked the [redacted] if the beef was supposed to be hot and was that the normal process to store a salad in the freezer? The [redacted] stated that the [redacted] thought that the salads would not hold temperature and instructed the [redacted] to place the salads in the freezer. The [redacted] stated that was not how the salads should	F0802		04/08/2026

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F0802 SS = F	Continued from page 5 have been stored as the beef would normally be served hot. -The [redacted] did not perform hand hygiene (HH) and used her bare hands and removed the containers of reheated rice, crab cake, lima beans, puree beans, puree crab cake in the steam table and then observed the that the [redacted] failed to perform HH prior to glove use, used here bare hands to take food temperatures and reused an alcohol wipe that was left on top of a worn cutting board to wipe a thermometer probe. At one point the [redacted] placed gloves on her hands without washing her hands first and proceeded to use the same alcohol wipe that was sitting on the cutting board and inserted the probe into additional food items. After taking the temperatures, she washed hands with less than 20 seconds of friction and then rinsed and placed gloves on her hands to serve the food. The [redacted] removed gloves, exited the pantry and placed a meal plate in front of a resident. The [redacted] then returned to the pantry and washed hands for 6 seconds of friction after soap applied and rinsed in water. On 02/18/26 at 12:35 PM, the surveyor observed the [redacted]) plate puree meals that were served to residents. The plates had three food items on each plate, all touching one another. One food item was peach colored; one food item was white, and the other food item was light green in color. All the items appeared loose and did not hold shape on the plate when they were plated up by the [redacted] and served to the residents in the dining room. The [redacted] stated the puree consisted of puree salmon, rice and lima beans. At 12:42 PM, the [redacted] began setting up meal trays for room service and the surveyor observed that the [redacted] uses a slotted spoon (not a portion spoon) to scoop the puree salmon out of a metal container, and the puree item also appeared runny and did not hold shape. The surveyor asked about the portion size of the puree salmon and the spoon that was used. The [redacted] stated, that she would usually “used a portion black handled scoop”, but because the food was not hot enough and had to be sent back to the kitchen, the slotted spoon was left in the metal pan when the food was sent back up, and that was what she used. The [redacted] removed the mechanical soft salad from the freezer and the surveyor asked her what the	F0802		04/08/2026

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

FORM APPROVED
OMB NO. 0938-0391

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	315515	A. BUILDING B. WING	02/25/2026

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F0802 SS = F	Continued from page 6 temperature was prior to serving the resident and the [redacted] used the thermometer to check the temperature and informed the surveyor that the temperature of the beef was 57 degrees Farenheight. On 02/18/26 at 12:50 PM, the surveyor interviewed the [redacted]), in main kitchen regarding if recipes were used for the puree items. The [redacted] looked through a recipe book located in the kitchen and was unable to locate recipes for the puree items and exited the kitchen. The surveyor then interviewed the [redacted] who prepared the lunch meal and asked him if he had used any recipes for any of the puree items that were observed during the lunch meal. The cook stated, "no", he did not use recipes. When asked how he knew how to prepare the puree items, and how would he know how much thickener to use for the puree items, he stated, "I usually just eyeball" and stated he was culinary trained. Another person interjected and stated he was the [redacted] for the food service management company and stated, "we have recipes." At that time the [redacted] returned with other books and was attempting to locate recipes for the puree food items. On 02/18/26 at 1:01 PM, the surveyor interviewed the [redacted] again regarding using recipes and asked if recipes should be utilized for the puree items. The [redacted] stated "yes, it was important to use recipes for consistency and portion sizes. When asked was it also important for nutritional adequacy he stated, "yes, and to make sure it was prepared correctly." At that time the [redacted] was unable to locate any recipes for the puree items. When asked if puree items should be liquid- like and run together on the plate, the [redacted] stated, "no, and then confirmed that he did not have a recipe for the puree salmon, puree crab cake, puree rice or puree lima beans. On 02/18/26 at 1:13 PM, the surveyor interviewed the [redacted] who prepared the lunch meal that the surveyor observed on the third floor. The [redacted] confirmed that he prepared the lunch meal and the surveyor requested to see the food temperature log for the meal. The [redacted] showed the surveyor a clipboard with a blank log listing all of the items that were prepared and were observed served for the Wednesday lunch, The [redacted] stated, "no temps (temperatures) were written down for lunch" and in the presence of the surveyor, started to fill in the log and stated, "I'm doing now." When asked where the	F0802		04/08/2026

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F0802 SS = F	Continued from page 7 temperature documentation was located, he stated it was "all in his head." When asked whether it was important to record food temperatures at the same time the food was prepared, he stated, "yes, to make sure the food was safe." The surveyor then asked the [redacted] about the food temperatures for hot food at the point of service. The [redacted] stated at the point of service the hot food should be over 150 degrees Farenheight (F) and stated there should be no hot foods served between 40 to 140 degrees F. The [redacted] was made aware of the surveyor concerns regarding the ground beef on top of the taco salad in the freezer and stated that the taco salad beef was a hot item and will provide a copy of the recipe. On 02/18/26 at 1:22 PM, the [redacted] confirmed that the taco salad was a hot salad (Beef) and provided a recipe. When asked why the salad was stored in the freezer, he stated he had been there for only three weeks and he didn't know why as it did not match the taco salad recipe. A review of the Taco Beef Corn Tortilla recipe that was provided by the [redacted] did not match the item observed by the surveyor, and revealed the taco beef filling should be held at 140 degrees F. The recipe did not identify the salad, cheese, sour cream or beans that were observed and held in the freezer. On 02/18/26 at 2:07 PM, the surveyor interviewed the [redacted]) for the Food Management Company who stated the expiration dates should follow the policy. On 02/20/26 at 8:43 AM, the surveyor continued the observation and then asked the resident if the surveyor could look at the meal ticket and the resident handed the ticket to the surveyor. The meal ticket had [redacted]" and "[redacted]" listed. On 2/20/26 at 8:44 AM, a [redacted] entered the room, and began cutting up the meal, which was sausage, and cut the sausage into circles, and put the spoon in the resident's hand. Surveyor then interviewed the [redacted] about the meal ticket and asked what does "[redacted]" mean and the [redacted] stated she was "not sure" but the resident had "sausage not [redacted]	F0802		04/08/2026

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F0802 SS = F	Continued from page 8 On 2/20/26 at 9:33 AM, the surveyor interviewed the [redacted] and [redacted] regarding a recipe for the super cereal that the surveyor observed a loose in appearance, milky like super cereal in a bowl. The [redacted] was present also, and when asked what recipe they used for the super cereal, he stated he did not use a recipe, while the kitchen the [redacted] looked through a book for the recipe and then confirmed he did not use a recipe and the [redacted] could not locate a recipe for the super cereal. The [redacted] confirmed the purpose of using the super cereal was "for someone who needs to gain weight." On 2/20/26 at 9:35 AM, the surveyor interviewed the [redacted] while in the main kitchen, regarding the process to check the temperatures of the food. The [redacted] stated that an alcohol swab was used to wipe the probe, then place the thermometer in the thickest part of the food, then the process would be repeated. When asked if the alcohol swab was reused, he stated "no". When asked if HH would be performed, he stated, "of course, before any task and glove use." The [redacted] then stated that hands were always washed prior to placing gloves on hands and then the task would be completed." The surveyor asked if temperatures could be taken without wearing gloves, and could the alcohol wipe be reused? The [redacted] stated, "bare hands could not be used, and if the thermometer was not clean the food could become contaminated." The [redacted] stated that a single alcohol wipe had to be used for each temperature taken and could not reuse the wipe. When asked if after hands were washed it was okay to wipe the sink with the same paper towel, the [redacted] stated "no." The surveyor then reviewed above observations with the [redacted] When asked if the Dietary staff were trained. The [redacted] stated staff were trained. When asked if competencies were assessed, he stated there no competencies assessed and he had been there for three months. The [redacted] stated, for training they gave out printed material and it would be reviewed. On 02/20/26 at 5:30 PM, the surveyor reviewed the Facility Assessment (FA) provided on 2/18/26 revealed "Consider" competencies and there were no competencies or integration related to the contracted food service department. On 02/25/26 at 8:41 AM, during an interview with the [redacted] she confirmed there was no training/competencies identified for the Dietary staff included in the FA.	F0802		04/08/2026

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F0802 SS = F	Continued from page 9 A review of the Assistance with Meal Service Policy Revised 1/15/26 revealed: 4. For all residents, hot foods shall be held at a temperature of 135 degrees or above until served. Cold foods shall be held at 41 degrees or below until served … 6. All employees who provide residents assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. A review of the Sanitation and Infection Prevention Policy, Issued 5/1995 revealed: In the Food & Nutrition Services Department: All associates associated with the handling of food shall wash hands with soap and water at the following times... Before handling food or clean utensils/ dishes/ equipment; Before putting on gloves, After removing gloves, After any other activity that may contaminate the hands. Hands must be washed with soap and water when plating food on patient/resident units. Alcohol-based hand sanitizer is only used to decontaminate hands when delivering trays and there is no visible soiling of the hands (food or other materials). When hands are visibly soiled with food or other materials, hands are washed with soap and water. Procedures: All food handlers: Use only sinks designated for hand washing...All hand wash sinks should be easily accessible with nothing blocking their access in food production, food service and dishwashing areas. Hand washing sinks ...should be clean and stocked with soap, paper towels, a covered waste receptacle, and a Hand Wash sign..., Wet hands with warm water and apply a disinfectant soap, lathering up to mid arm. Work later into hands for 20 seconds, including areas under fingernails, between fingers, on the inside and outside of hands. Keep hands away from sides of sink. Rinse thoroughly under warm running water, allowing the water to flow from the arms, down top the fingertips. Use a paper towel to turn off the faucet to avoid contact with faucet germs. Dry hands with a single use, disposable towel. Do not use common towels for drying or wiping hands. The Uniform Dress Code Policy, issued 5/1995 revealed: Associates working with food: Wear the	F0802		04/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER: **ATRIUM AT NAVESINK HARBOR, THE**		STREET ADDRESS, CITY, STATE, ZIP CODE: **40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701**	

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F0802 SS = F	Continued from page 10 approved hair restraint when on duty regardless of length or presence of hair. Restrain all facial hair with a beard net/restraint. The Food Contact Surfaces Policy Issued 5/1995 revealed: Food Contact Surfaces: Food contact surfaces are in good condition, made of non-toxic material and are easily cleanable... The food contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. Discard any food contact surfaces with chips, nicks or broken pieces ...which cannot be cleaned properly. Nonfood Contact Surfaces: Food carts are sanitized after each meal. Nonfood contact surfaces of equipment, such as handles on reach in units, sides of sinks, gaskets on cooler and freezer doors ...shall be cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris. The Food and Supply Policy, Issues 5/1995 revealed: All food, non-food items and supplies used in food preparations shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Procedures: ...Date and rotate items: first in, first out. Discard food past the sue by date or expiration date. Cover, label and date, any unused portions of open packages ...Products are good through the close of business on the date noted on the label. Dry Storage: Store foods in their original packages. Foods that must be opened must be stored in NSF (National Sanitation Foundation certified food safe) approved containers that have tight-fitting lids. Label both the bin and the lid. On 02/24/26 at 2:54 PM, the survey team met with the [redacted]), [redacted], and [redacted]) to discuss the above concerns. NJAC 8:36-17.1(a)	F0802		04/08/2026
F0804 SS = F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F0804	1. The Director Dining Services (DDS) removed the improperly stored taco salad from service. The Cook was immediately counseled by the Regional Director of Operations on the requirement to use recipes, monitor and document food temperatures, and maintain hot food at ≥135°F until served.	04/08/2026

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F0804 SS = F	Continued from page 11 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to ensure a process was in place to ensure a) modified texture foods were prepared utilizing standardized recipes to ensure adequate nutritional content and appropriate modified food texture, b) appropriate portions were provided for all texture modified foods and c) ensure all foods were served at appropriate temperatures. The deficient practice was observed during a meal observation and affected 6 of 6 residents who received puree diets and 4 of 4 residents who received mechanical soft diets, and was evidenced by the following: On 02/18/26 at 12:14 PM, the surveyor observed the meal service in the 3rd floor food service pantry and observed the following: A person was observed in the pantry with their hair not fully covered and one side was hanging outside of the hair net. They identified themself as the [redacted], [redacted] ([redacted]) for the management company. When the surveyor asked her what role was regarding the meal, she stated "QA" (quality assurance) and exited the pantry. At that time the surveyor observed another staff member, who identified herself as the [redacted]) and was at the steam table in the pantry. When asked about the mealtime, as residents were seated in the dining room, she stated that the crab cakes and the rice did not come up from the kitchen at the appropriate temperatures and were sent back down to be reheated. The surveyor then observed the storage refrigerator in the pantry. The lower freezer drawer was observed with two plates of taco salad, one plate was identified as a mechanical soft salad which contained beef, beans, cheese, tomato, over lettuce, a scoop of sour cream, and was wrapped in plastic wrap and on top of ice cream containers. A second salad was a regular consistency taco salad that also contained ground beef, sour cream, beans, and was wrapped in plastic and stored directly on top of the ice cream containers in the freezer. The surveyor asked the [redacted] if the beef was supposed to be hot	F0804	Continued from page 11 2. On 2/19/26 all cooks and [redacted] were provided with in servicing by the Regional Director of Operations and/ or designee on proper production of puree and mechanical soft consistency in compliance with standardized recipes and policy #C208/#C224 On 3/27/26 all dining staff were in serviced by the Regional Director of Operations and/ or designee and deemed competent to utilize food thermometers appropriately, identify food temperatures out of compliance and management of any temperature out of compliance per policy #E006 On 3/27/26 all staff were in serviced by the Regional Director of Operations and/ or designee and deemed competent to understand proper portioning of food to meet nutritional requirements of residents and in compliance with that which is documented on resident tray tickets through the use of proper portioning utensils 3. Puree and modified diet recipe files were reviewed with the Executive Chef and Community cooking staff on 3/27/26. Education was provided by the Regional Director of Operations and/ or designee to all production staff on how puree food should be provided to residents and how food should be presented to residents on a mechanical soft diet. Recipe books will be found in the cook's area on the worktable open at the day/meal of service Weekly audit of all puree and mechanical soft diet food recipe compliance will be conducted by the Food Service Director of designee A weekly tray accuracy audit of 10 mechanically altered (puree/mechanical soft) trays will be conducted to ensure compliance with the diet order from the kitchen to point of service for three months. Tray accuracy audits will review consistency appropriateness/temperature of food and portion of all foods presented.	04/08/2026

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F0804 SS = F	Continued from page 12 and was that the normal process to store a salad in the freezer? The [redacted] stated that the [redacted] thought that the salads would not hold temperature and instructed the [redacted] to put the salads in the freezer. The [redacted] stated that was not how the salads should have been stored as the beef would be hot. On 02/18/26 at 12:35 PM, the surveyor observed the [redacted]) plate puree meals that were served to residents. The plates had three food items on each plate. One food item was peach colored; one food item was white, and the other food item was light green in color. All the items appeared loose and did not hold shape on the plate when they were plated up by the [redacted] and served to the residents in the dining room. The [redacted] stated the puree consisted of puree salmon, rice and lima beans. At 12:42 PM, the [redacted] began setting up meal trays for room service and the surveyor observed that the [redacted] uses a slotted spoon (not a portion spoon) to scoop the puree salmon out of a metal container, and the puree item also appeared runny and did not hold shape. The surveyor asked about the portion size of the puree salmon and the spoon that was used. The [redacted] stated, that she would usually "used a portion black handled scoop", but because the food was not hot enough and had to be sent back to the kitchen, the slotted spoon was left in the metal pan when the food was sent back up, and that was what she used. The [redacted] removed the mechanical soft salad from the freezer and the surveyor asked her what the temperature was prior to serving the resident and the [redacted] used the thermometer to check the temperature and informed the surveyor that the temperature of the beef was 57 degrees Farenheight. On 02/18/26 at 12:50 PM, the surveyor interviewed the [redacted]), in main kitchen regarding if recipes were used for the puree items. The [redacted] looked through a recipe book located in the kitchen and was unable to locate recipes for the puree items and exited the kitchen. The surveyor then interviewed the [redacted] who prepared the lunch meal and asked him if he had used any recipes for any of the puree items that were observed during the lunch meal. The [redacted] stated, "no", he did not use recipes. When asked how he knew how to prepare the puree items, and how would he know how much thickener to use for the puree items, he stated, "I usually just eyeball" and stated he was culinary trained. Another person interjected and stated he was the [redacted]	F0804	Continued from page 12 Education for all staff by the Regional Director of Operations and/ or designee on utilization of proper portioning of foods based on spreadsheets All audits will be reviewed weekly with the Director of Dietary Services (DDS) with updates to Plan of Correction (POC) as needed. All audits will be compiled weekly and reviewed by the System Registered Dietitian 4. All audits will be reviewed weekly by the Food Service Director/Registered Dietitian for identification of areas of noncompliance All audits will be reviewed monthly with the System Registered Dietitian for identification of compliance All audits will be presented to QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) monthly for review	04/08/2026

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F0804 SS = F	Continued from page 13 [redacted]) for the food service management company and stated, “we have recipes.” At that time the [redacted] returned with other books and was attempting to locate recipes for the puree food items. On 02/18/26 at 1:01 PM, the surveyor interviewed the [redacted] again regarding using recipes and asked if recipes should be utilized for the puree items. The [redacted] stated “yes, it was important to use recipes for consistency and portion sizes. When asked was it also important for nutritional adequacy he stated, “yes, and to make sure it was prepared correctly.” At that time the [redacted] was unable to locate any recipes for the puree items. When asked if puree items should be liquid like and run together on the plate, the [redacted] stated, “no, and then confirmed that he did not have a recipe for the puree salmon, puree crab cake, puree rice or puree lima beans. On 02/18/26 at 1:13 PM, the surveyor interviewed the [redacted] who prepared the lunch meal that the surveyor observed on the third floor. The [redacted] confirmed that he prepared the lunch meal and the surveyor requested to see the food temperature log for the meal. The [redacted] showed the surveyor a clipboard with a blank log listing all of the items that were prepared and were observed served for the Wednesday lunch, The [redacted] stated, "no temps (temperatures) were written down for lunch" and in the presence of the surveyor, started to fill in the log and stated, "I'm doing now." When asked where the temperature documentation was located, he stated it was "all in his head." When asked whether it was important to record food temperatures at the same time the food was prepared, he stated, "yes, to make sure the food was safe." The surveyor then asked the [redacted] about the food temperatures for hot food at the point of service. The [redacted] tated at the point of service the hot food should be over 150 degrees Farenheight (F) and stated there should be no hot foods served between 40 to 140 degrees F. The [redacted] was made aware of the surveyor concerns regarding the ground beef on top of the taco salad in the freezer and stated that the taco salad beef was a hot item and will provide a copy of the recipe. On 02/18/26 at 1:22 PM, the [redacted] confirmed that the taco salad was a hot salad (Beef) and provided a recipe. When asked why the salad was stored in the	F0804		04/08/2026

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F0804 SS = F	Continued from page 14 freezer, he stated he had been there for only three weeks and he didn't know why as it did not match the taco salad recipe. A review of the Taco Beef Corn Tortilla recipe that was provided by the [redacted], did not match the item observed by the surveyor, and revealed the taco beef filling should be held at 140 degrees F. The recipe did not identify the salad, cheese, sour cream or beans that were observed and held in the freezer. The surveyor reviewed the menus and portion sizes provided to the survey team on 2/18/26 at 11:35 AM which revealed the portion size of the puree shellfish was 4 ounces, the puree salmon was not listed. On 02/24/26 at 2:54 PM, the survey team met with the [redacted]), [redacted] [redacted] [redacted] [redacted] [redacted]), and [redacted]) to discuss the above concerns. On 02/25/26 at 2:31 PM, the survey team met with [redacted], [redacted] and [redacted] and the facility had no additional information to provide. NJAC 8:39-17.4(a)2	F0804		04/08/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from	F0812	1. All residents were potentially affected by the deficient practice. On 3/27/26, all dining staff were provided with inservicing by the Regional Director of Operations of Morrison and/or designee regarding (a)cleanliness of the main and satellite kitchen per policy #B003 (b)labeling, dating and discarding of food per policy #B007, (c)in serviced and deemed competent on handwashing, glove use and hair/beard coverage compliance (d)proper use of thermometer, the proper method for taking and recording food temperatures in both the main kitchen and the kitchenettes 2.	04/08/2026

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. BUILDING B. WING	02/25/2026

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F0812 SS = F	Continued from page 15 consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure a) all food was appropriately stored and food temperatures were monitored in a manner to prevent foodborne illness, b) all kitchen equipment and the environment in the main kitchen and remote service kitchen was maintained in a clean and sanitary manner, c) staff practiced hand hygiene and restrained their hair appropriately. This deficient practice affected all residents and increased the potential for the development of food borne illness, the potential from contamination from foreign substances and was evidenced by the following: On 02/18/26 at 8:24 AM, the surveyor toured the kitchen with the [redacted] the [redacted]) and observed the following: -The [redacted] exited the refrigerated walk- in box and did not have all his [redacted]. -The [redacted] was cooking and he did not have all of his [redacted]. When asked if it should be covered, he confirmed that the [redacted] should be covered. Inside the refrigerated walk-in box: -Two stacks of fresh food items were in boxes, including produce, and were stored directly on the floor. -Walls, ceilings and floor throughout had visible debris, including splatter type debris, and crumb type debris was observed under the food racks, and also embedded on the green racks which appeared rusted in several areas. When the surveyor showed the [redacted] the observations and asked the [redacted] if it looked clean? The [redacted] confirmed it did not appear clean, and he stated it should be cleaned daily. - A jar of strawberry topping, was labeled "Opened, 2/13/26 and Discard 2/16/26". - A container of sauerkraut was opened, splatter	F0812	Continued from page 15 All residents are identified as at risk of deficient practice. On 3/18/26 a full safety and sanitation walkthrough of the main kitchen and satellite kitchens was performed by the Food Service Director/Executive Chef and Regional Director of Operations and no further areas of deficient practice were noted. 3. Competencies on all areas of deficient practice were completed on 3/27/26 for all healthcare dining staff by the Regional Director of Operations and/or designee . Weekly safety and sanitation audits of the main kitchen and kitchenette will be conducted by the Food Service Director or designee to ensure compliance with all areas of deficiency including labeling/dating/discarding of outdated food/ hair/beard restraint and visual review of handwashing and glove wearing techniques. A daily line up will be held to ensure all dining staff have proper hair restraint in the kitchen and during point of service. This daily line up will be conducted by the Food Service Director or designee. All audits will be reviewed weekly with the System Registered Dietitian with updates to Plan of Correction (POC). All weekly audits will be provided to the Quality Assurance Performance Improvement (QAPI) committee monthly. 4. All audits will be reviewed weekly by the Food Service Director/System Registered Dietitian or designee for identification of areas of noncompliance All audits will be reviewed monthly with the System Registered Dietitian for identification of compliance	04/08/2026

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F0812 SS = F	Continued from page 16 was observed on the outside of the container and the container was not labeled with a “use by date”, the vender sticker was dated 1/2/26 and the [redacted] confirmed there was no “use by date.” - Corned Beef was wrapped in plastic and was directly on the shelf, with a label affixed, “Opened 2/14/26- Discard- 2/14/27”. The [redacted] stated the sticker was placed on by the staff and it was the wrong information on the label because the staff “had a hard time understanding.” -A container of fresh peeled shallots, was labeled with a sticker “Opened 2/11/26 and Discard 2/14/26”, the [redacted] again, acknowledged the item was past the expiration date and stated the item was incorrectly dated. -A jar of capers had a label affixed, “Opened 2/15/26 and Discard 2/15/27” -A package of unopened cheddar cheese was in the corner on the floor in the walk in refrigerator. When asked about the package, the [redacted] stated it fell off the shelf. -A bag of liquid eggs was stored directly on top of shelled eggs which were inside of a box on a shelf. -A white container of opened pitted kalamata olives, had splatter on the exterior and did not contain a “use by date”. -A partially opened container (lid ajar) of soft Boursin cheese was visibly soiled around the rim of the container. The container was labeled as “Opened 2/8/26 and Discard 2/14/26.” -A bag of sundried tomatoes was labeled “Opened 2/14/26 and and Discard 2/17/26.” -A metal pan was located on a top shelf of the meat area. When asked what the item was, the [redacted] proceeded to remove, what was identified as defrosting fish which was loosely wrapped with plastic. When the item was pulled off of the top shelf the fluid spilled onto the floor and onto the [redacted]. -A raw pork loin was wrapped in plastic wrap and located directly on top of a shelf, over a box with a blue bag that contained raw chicken inside. -A cardboard box contained a blue bag of raw chicken, which was located next to a plastic container with a lid, and another cardboard box. All three containers contained raw chicken. When asked	F0812	Continued from page 16 All audits will be presented to QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) monthly for review.	04/08/2026

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F0812 SS = F	Continued from page 17 about any dates that the items were pulled from the freezer, or what the "use by date" was, or any dates that were located on the items. The [redacted] stated, “obviously” not dated. -Four white bins were stored underneath a stainless-steel shelf opposite the walk-in refrigerator, and contained flour, breadcrumbs in the bags, and thickener. The bins were visibly soiled on the lids with debris on the outside of the bins. -The stainless- steel table contained 4 loaves of French style bread that were stored on top of a plastic lid for a bin. Three of the loaves were completely uncovered and stored adjacent to non-stick spray. The [redacted] said the loaves were defrosting. -A visibly soiled, with grease type stains, plastic wrap container was located on the same table. -The can opener that was affixed to the same stainless-steel table had visible metal shavings around the blade. When asked when the blade was last changed, the [redacted] stated that the whole opener would be thrown out and the blade would not get changed. -Two knife storage racks were affixed to the wall over the stainless-steel table and had visible crumb type debris inside the plastic type covering to the racks where the knives were stored. One of the racks was dripping liquid as if the knives were placed in the racks wet. -Clean knives were also stored underneath a visibly soiled with black debris sink pipe (white pipe), in an open container under he hand washing sink. -The garbage can for the hand washing sink by the walk-in refrigerator, was not located next to the sink, and it was visibly soiled on the exterior. -The dry storage room contained a dented can on the rack, and the bottles of gravy making product had visible dark colored debris on the outside of the bottle. -The green food storage racks in the dry storage room were visibly rusted through, and were missing a finish in several areas. There was embedded food type debris affixed to the the racks. -The floor in the dry storage room was visibly soiled with debris under the racks.	F0812		04/08/2026

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

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F0812 SS = F	Continued from page 18 -The juice dispenser was visibly soiled by the three nozzles, and there was visible spatter on the exterior of the machine. -The 4-ounce insulated cups were stored in an open bin on a lower shelf by the juice machine, there were visible crumbs, and debris including an artificial sugar packet in the bin. Mugs were also stored in a bin in the same area, next to the cup bin, and were stored on top of another. -The handwashing sink by the healthcare preparation side had food debris inside the sink, and the garbage can did not have a liner inside. There was visible debris on the floor by the garbage can. -The gasket for the healthcare refrigeration reach -in refrigerator was soiled. -A multi-tiered gray cart was also observed by the reach- in refrigeration unit and was visibly soiled with various colored debris throughout the cart. -Eight cutting boards that were white, green and red were visibly stained, soiled and appeared to have deep grooves. The [redacted] stated they were all worn and removed the cutting boards. -There was an empty red sanitizer bucket by the cutting boards on a shelf with debris affixed to it, and the window ledge in the area appeared soiled with dust like debris. -The pass though stainless-steel shelf underside, between the steam table and where the meals were plated and passed through was heavily soiled with debris. -The plate dolly was stored by the entrance to the kitchen and the plates were stored upright and uncovered. -The oven was soiled with heavily caked on dark grease like debris inside the interior and by the oven door. -There were two snack carts by the entrance to the kitchen and the staff stated they were from the previous night, and had debris on them and food items. -When asked the [redacted] for the cleaning schedules for the kitchen, he stated the kitchen "should look better". The [redacted] then showed the surveyor an Equipment Cleaning Log for the Week of 2/18/26	F0812		04/08/2026

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

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F0812 SS = F	Continued from page 19 which was incomplete and did not identify all areas observed by the surveyor. - The ice cream utensil was sitting in running water next to the ice cream freezer. There were flies affixed to the white microwave in that area. On 02/18/26 at 12:14 PM, the surveyor observed the meal service in the 3rd floor food service pantry and observed the following: -A person was observed in the pantry with their hair not fully covered and one side was hanging outside of the hair net. They identified themself as the [redacted], [redacted]) for the management company. When brought to their attention, they restrained all their hair and confirmed it should all be covered. The [redacted] then proceeded to wash her hands in the sink, used a paper towel to dry her hands, then used the same paper towel to wipe the water off the area surrounding the sink. When the surveyor asked her what role was regarding the meal, she stated "QA" (quality assurance) and exited the pantry. At that time the surveyor observed another staff member, who identified herself as the [redacted]) and was at the steam table in the pantry. When asked about the mealtime, as residents were seated in the dining room, she stated that the crab cakes and the rice did not come up from the kitchen at the appropriate temperatures and were sent back down to be reheated. On 2/18/26 at 12:27 PM, the food cart arrived at the pantry and the surveyor observed the [redacted] did not perform hand hygiene (HH) and used her bare hands and removed the containers of rice, crab cake, lima beans, puree beans, puree crab cake in the steam table and observed the following: - The [redacted], without performing HH, proceeded to wipe the thermometer probe with an alcohol wipe, and left the wipe on the visibly worn, stained cutting board affixed to the steam table, and the temperature of the lima beans. -The [redacted] then, without using HH, picked up the same wipe that was on the cutting board with her bare hands used, without first performing HH and wiped the thermometer probe, and then tested the temperature of the rice.	F0812		04/08/2026

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F0812 SS = F	Continued from page 20 -The [redacted], then after the rice, placed gloves on her hands without first washing her hands and proceeded to use the same wipe that was left on the cutting board to test the temperature of the crab cake, puree crab cake and puree lima beans. -The [redacted] then after taking the temperatures, she washed hands with hands for less than 20 seconds of friction and then rinsed and placed gloves on her hands to serve the food. On 02/18/26 at 12:35 PM, the surveyor observed the [redacted] remove gloves, exit the pantry and place a meal plate in front of a resident. The [redacted] then returned to the pantry and washed hands for 6 seconds of friction after soap applied and rinsed in water. On 02/18/26 at 12:42 PM, the [redacted] began setting up meal trays for room service, removed both gloves and placed a new pair of gloves on her hands without first performing HH. On 02/18/26 at 12:46 PM, the surveyor exited the pantry and observed a pile of insulated mugs and bowls stacked up on top of one another on a tray next to lemonade type drink. The bowls were observed with crumb like debris in two of the bowls. The surveyor asked the [redacted] if the bowls were clean and [redacted] stated the bowls were clean. On 02/18/26 at 1:13 PM, the surveyor interviewed the Cook who prepared the lunch meal that the surveyor observed on the third floor. The [redacted] confirmed that he prepared the lunch meal and the surveyor requested to see the food temperature log for the meal. The [redacted] showed the surveyor a clipboard with a blank log listing all of he items that were prepared and were observed served for the Wednesday lunch,. The [redacted] stated, "no temps (temperatures) were written down for lunch" and in the presence of the surveyor, started to fill in the log and stated, "I'm doing now." When asked where was the temperature documentation located, he stated it is "all in his head." When asked was it important to record food temperatures at the same time the food was prepared, he stated, "yes, to make sure the food was safe." On 02/18/26 at 2:07 PM, the surveyor interviewed the [redacted]) for the Food	F0812		04/08/2026

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F0812 SS = F	Continued from page 21 Management Company who stated the expiration dates should follow the policy. On 2/20/26 at 9:35 AM, the surveyor interviewed the [redacted], while in the main kitchen, regarding the process to check the temperatures of the food. The [redacted] stated that an alcohol swab was used to wipe the probe, then place the thermometer in the thickest part of the food, then the process would be repeated. When asked if the alcohol swab was reused, he stated "no". When asked if HH would be performed, he stated, "of course, before any task and glove use." The [redacted] stated that hands are always washed prior to placing gloves on hands and then the task would be completed." The surveyor asked if temperatures could be taken without wearing gloves, and could the alcohol wipe be reused? The [redacted] stated, "bare hands could not be used, and if the thermometer was not clean the food could become contaminated." The [redacted] stated that a single alcohol wipe had to be used for each temperature taken and could not reuse the wipe. When asked if after hands were washed it was okay to wipe the sink with the same paper towel, the [redacted] stated "no." The surveyor then reviewed above observations with the [redacted] On 2/20/26 at 9:35 AM, the surveyor observed that the clean plates were still stored in the entry way of the kitchen, and remained uncovered. A review of the Assistance with Meal Service Policy Revised 1/15/26 revealed: 4. For all residents, hot foods shall be held at a temperature of 135 degrees or above until served. Cold foods shall be held at 41 degrees or below until served ... 6. All employees who provide residents assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. A review of the Sanitation and Infection Prevention Policy, Issued 5/1995 revealed: In the Food & Nutrition Services Department: All associates associated with the handling of food shall wash hands with soap and water at the following times... Before handling food or clean utensils/ dishes/ equipment; Before putting on gloves, After removing	F0812		04/08/2026

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F0812 SS = F	Continued from page 22 gloves, After any other activity that may contaminate the hands. Hands must be washed with soap and water when plating food on patient/resident units. Alcohol-based hand sanitizer is only used to decontaminate hands when delivering trays and there is no visible soiling of the hands (food or other materials). When hands are visibly soiled with food or other materials, hands are washed with soap and water. Procedures: All food handlers: Use only sinks designated for hand washing...All hand wash sinks should be easily accessible with nothing blocking their access in food production, food service and dishwashing areas. Hand washing sinks ...should be clean and stocked with soap, paper towels, a covered waste receptacle, and a Hand Wash sign..., Wet hands with warm water and apply a disinfectant soap, lathering up to mid arm. Work later into hands for 20 seconds, including areas under fingernails, between fingers, on the inside and outside of hands. Keep hands away from sides of sink. Rinse thoroughly under warm running water, allowing the water to flow from the arms, down top the fingertips. Use a paper towel to turn off the faucet to avoid contact with faucet germs. Dry hands with a single use, disposable towel. Do not use common towels for drying or wiping hands. The Uniform Dress Code Policy, Issued 5/1995 revealed: Associates working with food: Wear the approved hair restraint when on duty regardless of length or presence of hair. Restrain all facial hair with a beard net/restraint. The Food Contact Surfaces Policy Issued 5/1995 revealed: Food Contact Surfaces: Food contact surfaces are in good condition, made of non-toxic material and are easily cleanable... The food contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. Discard any food contact surfaces with chips, nicks or broken pieces ...which cannot be cleaned properly. Nonfood Contact Surfaces: Food carts are sanitized after each meal. Nonfood contact surfaces of equipment, such as handles on reach in units, sides of sinks, gaskets on cooler and freezer doors ...shall be cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris. The Food and Supply Policy, Issues 5/1995 revealed: All food, non-food items and supplies used in food preparations shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human	F0812		04/08/2026

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F0812 SS = F	Continued from page 23 consumption. Procedures: ...Date and rotate items: first in, first out. Discard food past the sue by date or expiration date. Cover, label and date, any unused portions of open packages ...Products are good through the close of business on the date noted on the label. Dry Storage: Store foods in their original packages. Foods that must be opened must be stored in NSF (National Sanitation Foundation certified food safe) approved containers that have tight-fitting lids. Label both the bin and the lid. On 02/24/26 at 2:54 PM, the survey team met with the [redacted]), [redacted], [redacted], and [redacted]) to discuss the above concerns. On 02/25/26 at 2:31 PM, the survey team met with the [redacted], [redacted] and [redacted] and the facility had no additional information to provide. NJAC 8:39- 17.(1);2(a)	F0812		04/08/2026
F0814 SS = F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that garbage was properly contained in dumpsters and ensure cardboard was properly disposed of and the garbage area was maintained in a clean and sanitary manner to prevent the harborage and feeding of pests. The deficient practice affected all residents who resided at the facility and was evidenced by the following: On 2/18/26 at 8:54 AM, during the initial tour of the kitchen with the [redacted] the surveyor observed an alcove area prior to the exit from the kitchen toward the dumpster area. The area had cardboard boxes strewn about and were piled up on the floor, and were against the walls. The cardboard boxes were also covering a black bin that appeared to have broken down cardboard boxes inside. Immediately outside the exit door revealed that multiple large garbage bags were piled up in a garbage can, the blue dumpster was overflowing	F0814	1. Immediate actions included clearing all cardboard from the interior alcove, breaking down and recycling cardboard appropriately, and contacting the garbage contractor to arrange an additional pickup on 2/19/26. 2. All residents are potentially affected by improper refuse disposal due to the risk of pest harborage and fire. A review of the communication process between the kitchen contractor and the Director of Facilities Management (DFM) was completed to establish a clear escalation pathway when garbage accumulation occurs or scheduled pickups are missed. 3. The following systemic changes were implemented: - The kitchen contractor was instructed in writing that all garbage concerns, including missed pickups, overflow, and cardboard accumulation, must be reported to the DFM immediately.	04/08/2026

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F0814 SS = F	Continued from page 24 with what appeared to be cardboard boxes, in clear bags which were lifting up the lid the the dumpster, the adjacent dumpsters were also overflowing with black garbage bags that were not exposed. The [redacted] stated there was no garbage pick up on Monday due to a holiday (2 days prior). On 02/19/26 at 9:53 AM, the surveyor interviewed the [redacted] who was responsible for maintenance, housekeeping and security. The surveyor asked when was the garbage and recycling pick up scheduled. He stated that garbage was picked up throughout the building three times per day and it would be brought out and it would be in the receptacles that were kept in the garage which would include garbage and recycling from the health care unit also. When asked about the garbage accumulated in the kitchen, he stated, "The kitchen is separate from us." When asked about concerns related to any recently missed garbage pick- ups, he stated that there were a couple of pick-ups missed due to trucks blocking the ability for the garbage trucks to access the dumpsters. The [redacted] stated that the garbage was picked up three days per week and two days per week for recycling and included Monday, Wednesday and Friday. When asked about the garbage that was observed piled up outside the building, the dumpsters that were overflowing with garbage and the boxes that were piled up inside of the building, the [redacted] stated the facility has the ability to call for additional garbage pick up it that was needed and the kitchen staff should have informed the [redacted] if there had been a concern. When asked if there were any garbage pick-ups missed due to the holiday, the [redacted] stated, "there were no pick ups missed, they (garbage truck) was supposed to come on Tuesday and there was a delivery truck blocking access and the garbage truck left." When asked what should have happened, the [redacted] stated the garbage truck could have been called to come back to the facility. On 02/19/26 at 10:06 AM, the surveyor showed the [redacted] the pictures of the garbage outside and boxes piled up inside and asked if that was okay? The [redacted] stated, "it is not okay" they were a separate company (kitchen contractor) and the boxes should be tied and put in bundles and then put in the recycling bin, "you could get mice, and there is a fire risk." The [redacted] stated there was another area in the garbage that could have been utilized if he had been made aware. The [redacted] stated he was not responsible for the kitchen since it was run by a contractor and he does not go into to the kitchen, but they could report concerns to him.	F0814	Continued from page 24 - The DFM established a protocol for requesting an emergency garbage pickup when scheduled collections are missed. - Cardboard boxes must be broken down and placed in the recycling dumpster same-day; no cardboard storage is permitted inside the building. - A weekly walk-through of the garbage and refuse area by the DFM was added to the environmental rounding schedule. 4. The DFM will inspect the garbage and refuse area and the kitchen alcove daily for two weeks and weekly for four weeks to confirm proper disposal. Any cardboard accumulation or dumpster overflow will be addressed within 24 hours. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly for three months.	04/08/2026

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F0814 SS = F	Continued from page 25 NJAC 8:39- 19.3(a)	F0814		04/08/2026
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following:	F0838	1. The Licensed Nursing Home Administrator (LNHA) and other department heads reviewed the Facility Assessment (FA) and initiated competencies for the contracted dietary staff. In addition, the competencies for all nursing staff were reviewed and competencies were initiated. 2. All residents are potentially affected by an incomplete FA that does not reflect required competencies for all staff providing care. A review of the FA was initiated. by the LNHA, Director Of Nursing (DON), and department heads to identify all gaps in the competency and training sections, including those for the contracted dietary service. 3. The Licensed Nursing Home Administrator convened a multidisciplinary team including nursing, dietary, and other relevant departments to revise the Facility Assessment. The revised FA will include: - Specific staff competencies and skill sets required for each department, including the contracted dietary service, consistent with the resident population's care needs. - Required training topics and competency validation methods for nursing, dietary, and ancillary staff. - Integration of the contracted food service department as a required component of the FA under the resources section (contracted services). The FA will be reviewed and updated at least annually or whenever there is a significant change in the resident population, staffing, or contracted services. 4. The Licensed Nursing Home Administrator will review the completed and revised FA with department heads monthly and confirm all sections are facility-specific and include required competencies. Compliance will be reported to the Quality Assurance Performance Improvement (QAPI)	04/08/2026

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F0838 SS = F	Continued from page 26 (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the	F0838	Continued from page 26 committee monthly for three months. A 100% review of the FA will be conducted at six months and at the annual review.	04/08/2026

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F0838 SS = F	Continued from page 27 appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interview and document review it was determined that the facility failed identify and include the staff competencies and skill sets that were necessary to provide the level and types of care needed for the resident population which included the contracted food service department. The deficient practice affected all residents who resided at the facility and was identified by the following: On 2/18/26, the facility provided the survey team with a copy of the Facility Assessment (FA). A review of the document revealed the following: Staff training/education and competencies: Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education, training competency instruction and testing policies. “The [facility name] utilizes [name of computer	F0838		04/08/2026

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F0838 SS = F	Continued from page 28 training" as well as live training, conduct competencies and review policies and procedures. See competency binder." There were no specific competencies listed and "Consider the following training topics (this is not an inclusive list): The FA appeared to be a template that was not specific to the facility. On 2/20/26 at 12:55 PM, the surveyor interviewed the [redacted]) regarding staff education. The [redacted] stated that she was overall responsible for staff education and stated "we do all of our education on [computer education program name]. On 2/20/26 at 1:07 PM, the [redacted] provided the education book utilized by the [redacted]. The surveyor asked if the Dietary department was included in any training, or competencies and she stated they were not. When asked to list all the competencies completed for the staff, the [redacted] stated, Wound Competencies were completed by a [redacted] and had respiratory training competencies, and no other competencies were completed by the facility. On 2/25/26 at 8:41 AM, the surveyor interviewed the [redacted]) about what the purpose of the FA was. The [redacted] stated to make sure resources were available to take care of residents. The surveyor asked the [redacted] if the FA included any competencies or education required by the contracted Dietary Department and she stated, "no" the Dietary Department was not included in the FA. NJAC 8:39-33.4	F0838		04/08/2026
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program	F0865	1. Immediate corrective action included adding each identified deficiency from this survey as an active Quality Assurance Performance Improvement (QAPI) performance improvement activity regarding multiple systemic deficiencies during the survey—including kitchen sanitation, pest management, garbage disposal, modified-texture food preparation, meal service practices, wound care order clarification, and staff education. 2. A comprehensive review of the current Quarter Quality Assurance Performance Improvement (QAPI)	04/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER: **ATRIUM AT NAVESINK HARBOR, THE**		STREET ADDRESS, CITY, STATE, ZIP CODE: **40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701**	

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F0865 SS = F	Continued from page 29 that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership.	F0865	Continued from page 29 meeting minutes and active Quality Assurance Performance Improvement (QAPI) plans will be completed by the Licensed Nursing Home Administrator to identify any additional care or service areas that should be incorporated into the Quality Assurance Performance Improvement (QAPI) program. 3. The Licensed Nursing Home Administrator revised the Quality Assurance Performance Improvement (QAPI) process to require: - Quarterly Quality Assurance Performance Improvement (QAPI) committee meetings with attendance from all department heads. - All departments to submit data-driven Quality Assurance Performance Improvement (QAPI) reports at each meeting based on audit findings, incident trends, complaint patterns, and survey results. - The dietary department to submit monthly sanitation audit results and quarterly food service quality data to the Quality Assurance Performance Improvement (QAPI) committee. - Any survey findings to be immediately added to the Quality Assurance Performance Improvement (QAPI) action plan for tracking and follow-up. 4. The Licensed Nursing Home Administrator will chair monthly Quality Assurance Performance Improvement (QAPI) committee meetings that include representation from all departments. Quality Assurance Performance Improvement (QAPI) meeting minutes will document: identified concerns, root cause analysis, corrective actions, responsible parties, compliance thresholds, and target completion dates. The adequacy of Quality Assurance Performance Improvement (QAPI) self-identification will be evaluated at each quarterly meeting. Compliance with the Quality Assurance Performance Improvement (QAPI) program requirements will be reported to the governing body as required.	04/08/2026

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F0865 SS = F	Continued from page 30 The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review it was determined that the facility failed to self-identify areas of concerns and develop	F0865		04/08/2026

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F0865 SS = F	Continued from page 31 comprehensive data driven Quality Assurance Performance Improvement plans to address sanitation, pest management, garbage disposal, appropriate meal preparation and meal service, and also failed to self-identify concerns related to timely implementation of wound care recommendations and clarification of wound care orders. The deficient practice affected all residents who resided in the facility and was evidenced by the following: Refer to : F550, F686, F802, F804, F805, F812, F925 On 02/25/26 at 8:48 AM, the surveyor interviewed the [redacted] about the Quality Assurance Performance Improvement (QAPI) process and what the current active QAPI plans included. The [redacted] stated the most recent QAPI was the 4th Quarter QAPI meeting that was held on 1/15/26. The [redacted] stated that if the QAPI team thought a process had improved, that it would not be included. The [redacted] stated the current QAPIs included the following: Pharmacy report; Nursing online education completion and nursing competencies were not reviewed or identified as a concern by the QAPI team. The [redacted] stated pressure ulcer averages. When asked if there was anything related to the ensuring wound recommendations were clarified, she stated that there were no QAPIs related to wound recommendations or wound orders. The [redacted] stated accidents and incidents were reviewed, and infection prevention related to enhanced barrier precautions, vaccines and antibiotic stewardship. The [redacted] stated social services had a QAPI related to reporting. The [redacted] stated the maintenance department reviewed responses to work orders as their QAPI. The surveyor asked the [redacted] if the concerns regarding the kitchen sanitation, the failure of the kitchen to use recipes for modified foods, the lack of hand hygiene during meals, the overflowing garbage or flies that were also observed in the kitchen have been brought to QAPI? The surveyor also asked there was anything related to staff education for the Dietary staff identified by the QAPI team. The [redacted] stated there was "nothing" related to QAPIs from the Dietary Department other than the Registered Dietitian's review of weight changes. The [redacted] confirmed that there were QAPI plans related to garbage disposal concerns or pest concerns identified during the survey. The Facility QAPI Plan 2025 revealed the facility	F0865		04/08/2026

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F0865 SS = F	Continued from page 32 delivered care across the continuum, impacting both clinical outcomes and quality of life for all residents. All departments and services will participate in Quality Assessment and Assurance (QAA) activities to promote ongoing performance improvement. A review of the Assistance with Meals Policy, last reviewed 1/15/26 revealed Procedure: ... 6. All employees who provide residents assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. NJAC 8:39-33.1	F0865		04/08/2026
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility provided documentation, it was determined that the facility failed to ensure that the [redacted] had completed specialized training in infection prevention and control per Centers for Medicare & Medicaid Services (CMS) guidance for one (1) of one (1) employee reviewed for [redacted] Refer to: F882: An IP must have obtained	F0882	1. The Infection Preventionist completed the specialized IP training that covers the topics specified by CMS guidance, including infection surveillance, outbreak management, standard and transmission-based precautions, antibiotic stewardship, and quality assurance. The Infection Preventionist was notified that the final modules of mandatory training needed to be completed before returning to work. 2. All residents are potentially affected by an IP who has not completed the required specialized training. The required IP training was completed on 2/28/26. 3. The Licensed Nursing Home Administrator and Director Of Nursing (DON) identified a qualified IP training program that meets the CMS-specified topic requirements for specialized infection prevention and control training. The IP completed the required training on 2/28/26. The IP job description was reviewed and updated to align with the current CMS requirements effective 8/8/24, removing the prior exception allowing five years of experience as a substitute for specialized training. 4. The Licensed Nursing Home Administrator will maintain a record of the IP's training completion certificate and verify that it meets all CMS-required topic areas. The IP's training status will be reviewed	04/08/2026

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F0882 SS = F	Continued from page 33 specialized IPC training beyond initial professional training or education prior to assuming the role. Training can occur through more than one course, but the IP must provide evidence of training through a certificate(s) of completion or equivalent documentation. CMS recommends specialized training include the following topics: • Infection prevention and control program overview, • The infection preventionist’s role, • Infection surveillance, • Outbreaks, • Principles of standard precautions (e.g., content on hand hygiene, personal protective equipment, injection safety, respiratory hygiene and cough etiquette, environmental cleaning and disinfection, and reprocessing reusable resident care equipment), • Principles of transmission-based precautions, • Resident care activities (e.g., use and care of indwelling urinary and central venous catheters, wound management, and point-of-care blood testing), • Water management, • Linen management, • Preventing respiratory infections (e.g., influenza, pneumonia), • Tuberculosis prevention, • Occupational health considerations (e.g., employee vaccinations, exposure control plan, and work exclusions), • Quality assurance and performance improvement, • Antibiotic stewardship, and • Care transitions. This deficient practice was evidenced by the following: On 2/24/26 at 9:14 AM, upon entrance the facility,	F0882	Continued from page 33 at the annual IP role review and at any time the IP role changes. The updated job description will be implemented for all future hires or role assignments. Completion will be reported to the Quality Assurance Performance Improvement (QAPI) at March 2026 meeting. Infection preventionist credentials will be reviewed yearly at Quarter 1 Quality Assurance Performance Improvement meeting, and upon any new hire.	04/08/2026

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F0882 SS = F	Continued from page 34 the surveyor was provided with a “Certificate of Attendance” for a “Basic Course” for Infection Prevention and Control. The course was not designed to meet federal, state, and specialized industry requirements for infection preventionists. On 2/24/26 at 10:27 AM, the surveyor interviewed the [redacted]) and the [redacted]). The [redacted] stated that he was covering for the [redacted] who was out on [redacted] The surveyor requested to review the [redacted] specialized training in infection prevention and control per CMS. The [redacted] stated she would obtain a copy of the training certificate and provide it to the surveyor. On 2/25/26 at 12:25 PM, [redacted] provided the surveyor with the same document that was provided during the entrance conference, as referenced above. The [redacted] confirmed and stated, “that was all they had.” On 2/25/26 at 2:31 PM, during the exit conference held with the [redacted]), [redacted] and [redacted] The [redacted] stated that Certificate of Attendance that was previously provided for the [redacted] was acceptable specialized training because the [redacted] had [redacted] of infection control experience and that was the information that was included in the [redacted] job description. No further information was provided. A review of the [redacted] job description provided, dated 11/30/2023, included the following, and was not reflective of the current regulation (Implemented by CMS on 08-08-24) Qualifications: has primary professional training in medicine, nursing, medical technology, microbiology, epidemiology, or a related field; is qualified by education, training, and at least (5) years of infection control experience or by certification in infection control by the Certification Board of Infection Control and Epidemiology; is employed by the facility consistent with the requirements… has completed specialized training in infection prevention and control.	F0882		04/08/2026

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

FORM APPROVED
OMB NO. 0938-0391

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F0882 SS = F	Continued from page 35 N.J.A.C. 8:39-19.1(b)	F0882		04/08/2026
F0925 SS = F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and review of pertinent documents it was determined that the facility failed to ensure an effective pest management program was in effect to control flies in the kitchen. The deficient practice affected all residents who resided in the facility and was evidenced by the following: On 2/18/26 during a kitchen tour conducted by the surveyor that began on 8:24 AM, with the [redacted] and the [redacted]), the surveyor observed small black flies sporadically in the kitchen, and observed black flies were on the front and side of the white microware oven in the area where the ice cream freezer was located. The [redacted] stated the flies were due to a leak in a pipe that had a crack. On 02/19/26 at 9:53 AM, the surveyor interviewed the [redacted]) who was responsible for maintenance, housekeeping and security. The surveyor inquired if there was a pest log for the kitchen and if there were any concerns reported regarding an issue with a leak due to a cracked pipe. The [redacted] stated there was no pest log and he had not been made aware of a cracked pipe. When asked about the flies that were observed in the kitchen and the relationship with a cracked pipe, he stated they were aware that there were flies in the kitchen and the kitchen was supposed to flush the drains for the flies when the kitchen was cleaned. The [redacted] stated the used environmentally safe fly traps in the kitchen and the kitchen was supposed to notify him if the flies were still present. The [redacted] confirmed he was not notified of the continued presence of the flies. The surveyor requested any policies or information related to the flies. On 2/19/25 at 10:25 AM, the [redacted] provided the surveyor with the Pest Service Record for the facility from 1/12/24 through 2/11/26 which revealed: an	F0925	1 Flies were observed in the kitchen during the 2/18/26 tour, including flies affixed to the white microwave near the ice cream freezer. The Director of Facilities Management (DFM) confirmed awareness of flies in the kitchen and that the pest control service had made prior recommendations to flush the drains. However, no follow-up to confirm resolution had been documented, and the DFM had not been informed of the continued presence of the flies. Immediate corrective action included: a visit by the pest control contractor on 3/16/26 flushing and cleaning all kitchen drains; deep cleaning was done at the area where the ice cream freezer is located; pipes were inspected and no cracks were noted. 2. All residents are potentially affected by an ineffective pest management program. A review of all pest control service records was completed to confirm previous recommendations have been acted upon. 3. The following systemic changes were implemented: - A pest control communication log was established requiring the kitchen contractor to notify the DFM of any new pest activity or pest control recommendations within 24 hours of identification. - The DFM will review pest control service records monthly to confirm all prior recommendations have been acted upon. - A Pest Activity Log was implemented in the kitchen, requiring the Director of Dining Services (DDS) or Executive Chef to document any observed pest activity and report it to the DFM on the same business day. - The pest control contractor was directed to inspect and treat the kitchen drains at each scheduled visit and to provide written recommendations to both the kitchen contractor and the DFM.	04/08/2026

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F0925 SS = F	Continued from page 36 entry on 6/13/25 "inspected and treated for flies in kitchen"; an entry dated 12/12/25 "flies in kitchen area" Recommend all pails to be washed out with bleach and drain traps to be degreased/cleaned to Head Chef; an entry 2/11/26 fly vinegar traps replaced in soda fountain area inspected treated food preparation area kitchen for flies ... to the [redacted] to have drains checked for break with camera ... On 02/24/26 at 2:54 PM, the survey team met with the [redacted]), and [redacted]) to discuss the above concerns. On 02/25/26 at 2:31 PM, the survey team met with the [redacted], [redacted] and [redacted] and the facility had no additional information to provide. NJAC 8:39-31.5(a)	F0925	Continued from page 36 4. The DFM will inspect the kitchen and refuse areas weekly for evidence of pest activity for four weeks, then monthly for three months. The DFM will review pest control service reports within five business days of each visit to confirm all recommendations have been addressed. The DDS will complete a daily pest activity check as part of the kitchen opening procedure. Any pest sighting will be reported to the DFM within 24 hours. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly.	04/08/2026
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F0550	1. Residents #5, #18, #22, and #24 were identified as affected by this deficient practice. Immediately upon identification, each resident's care plan was reviewed to confirm [redacted] requirements, appropriate [redacted], and dignity-related interventions. Resident #24's [redacted] was corrected to ensure [redacted] are [redacted] and [redacted] is provided at [redacted] consistent with the care plan. Nursing Staff assigned to Resident #24 were instructed that [redacted] or [redacted] must be provided in accordance with the Minimum Data Set coding. Resident #22's [redacted] will no longer be placed in front of the resident unless nursing staff are present to [redacted]. If a staff member cannot be immediately available, the [redacted] will remain in the unit [redacted] or [redacted] until [redacted] is [redacted] Staff instructed to bring resident into dining room when available to [redacted] resident. Resident #18 was observed receiving meal [redacted] with gloves present. Staff involved were immediately counseled that glove use during dining assistance in the dayroom is a dignity violation. The [redacted] was re-educated on the appropriate use of personal protective equipment. The [redacted]. [redacted] effective immediately	04/08/2026

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F0550 SS = E	Continued from page 37	F0550	Continued from page 37	04/08/2026

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

This REQUIREMENT is NOT MET as evidenced by:

Based on observation, interview, and record review, it was determined that the facility failed to consistently treat residents in a dignified manner. This deficient practice was identified during the meal observation for three 4 of eight 8 residents (Resident #5, Resident #18, Resident #22, Resident #24) observed during breakfast and lunch on 2 of 2 resident units and was evidenced by the following.

1. On 02/18/26 at 8:30 AM, the surveyor toured the [redacted] Unit and observed the meal delivery system. Some residents were observed eating in their rooms while other residents were at the nursing station waiting for assistance with the breakfast meal.

The surveyor observed Resident #24 in bed with the [redacted] on the bedside table. The surveyor observed that Resident #24 was [redacted] with their [redacted]. The surveyor observed that Resident #24 had [redacted] or [redacted] and had [redacted] the [redacted] and bringing the [redacted] to their [redacted] at the same time.

On 02/20/26 at 8:40AM, the surveyor observed the residents eating breakfast in the dayroom, there was no staff in attendance. The surveyor observed the [redacted]) in the hallway and inquired who was responsible for monitoring the residents during meals. The [redacted] stated that residents should be monitored while eating in the dining room. While interviewing the [redacted] in the hallway, a resident started [redacted] and the [redacted] exited the interview and went to the dining room to assist the resident.

On 02/20/26 the surveyor reviewed Resident #24's

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from the position, and no further action is required.

Resident #5's [redacted]. were counseled on the use of respectful, person-centered language and instructed that the term [redacted]" is a dignity violation.

2.

All residents have the potential to be affected by this practice. A facility-wide review of meal assistance practices was completed by the Director of Nursing (DIRECTOR OF NURSING (DON)) to identify any additional residents who may not be receiving dignity-centered meal assistance in accordance with their care plans.

All direct care staff will receive in-service education on: (1) dignified meal assistance practices including proper setup, supervision, and language; (2) the facility Dignity policy and Assistance with Meals policy; and (3) prohibition on the use of degrading labels such as "feeder." (4) Staff educated not to bring residents into dining room until staff is present to provide residents with assistance who require it. Education will be completed by the DIRECTOR OF NURSING (DON) or designee. Any additional concerns identified during the audit will be immediately corrected.

3.

The Assistance with Meals and the Dignity policy were reviewed with all direct care staff and nursing supervisors. Both policies were reinforced to include:

- Staff will not bring residents into the dining room who are dependent for assistance with meals until staff is present to provide assistance.

- Staff are prohibited from wearing gloves in the dining room unless medically indicated and documented.

- Respectful, person-centered language is required at all times; degrading labels are prohibited.

- Residents requiring meal assistance are identified on the Certified Nursing Assistant (CNA) assignment sheet, and staff are accountable to that assignment.

Director Of Nursing (DON) or designee will complete in-service training with all direct care staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **315515**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/25/2026**
NAME OF PROVIDER OR SUPPLIER **ATRIUM AT NAVESINK HARBOR, THE**		STREET ADDRESS, CITY, STATE, ZIP CODE **40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0550 SS = E	Continued from page 38 medical record. A review of the resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted], [redacted] and [redacted]. A review of the Physician Order Sheet reflected an order dated [redacted] for a [redacted] and [redacted]. The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate management of care, reflected that Resident #24 had [redacted]. Resident #24 scored [redacted] out of 15 on the Brief Interview for Mental Status (BIMS). Section [redacted] of the MDS which addressed [redacted]" Resident #24 was coded as [redacted] reflected that Resident #24 [redacted] or [redacted]. [redacted] only prior to or following the activity. A review of Resident #24's Comprehensive Care Plan revealed a problem for [redacted] related to history of [redacted], [redacted], and [redacted]t. The goals were for staff to anticipate the residents' needs. Interventions included: Assist me with [redacted] and [redacted] of [redacted] and [redacted] Please [redacted] to go back to dining room if I leave before [redacted] was completed. On 02/19/26 at 12:35 PM, the surveyor interviewed the [redacted] regarding the above observation on 02/18/2026 during breakfast. The [redacted] stated the Resident #24 [redacted] with [redacted], and the [redacted] should have been [redacted]. The [redacted] added if the kitchen failed to [redacted] the [redacted], the staff who delivered the meal should have [redacted] the [redacted] and [redacted] Resident #24. 2. On 02/18/2026 at 12:21 PM, the surveyor went to the dayroom to observe the lunch meal on the 3rd floor. The surveyor observed 8 residents in the dayroom. Some residents were being assisted while others were being cued to eat their meals. The surveyor observed Resident #22 seated in a [redacted] chair in the dayroom. Their lunch tray was placed uncovered on the bedside table next to the resident. The resident was looking at other residents eating their meals while waiting to be [redacted] Most of the residents had completed their meals, Resident # 22 was still waiting. At 12:56 PM, the surveyor observed a [redacted]	F0550	Continued from page 38 4. The Unit Manager or designee will conduct meal observation audits during breakfast and lunch daily for two weeks, then weekly for four weeks, and monthly thereafter for three months or until substantial compliance is achieved. Audits will assess: meal setup, presence of staff during meals, appropriateness of language, and glove use practices. Compliance threshold is set at 90%. Findings below threshold will trigger immediate corrective action. Audit results will be reported at monthly Quality Assurance Performance Improvement (QAPI) meetings.	04/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER: **ATRIUM AT NAVESINK HARBOR, THE**		STREET ADDRESS, CITY, STATE, ZIP CODE: **40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701**	

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F0550 SS = E	Continued from page 39 entered the dayroom, proceeded to wash her hands, then sat next to Resident #22 to [redacted] with the [redacted] that had been sitting uncovered on the table for more than 30 minutes. The surveyor then inquired about how long the meal had been sitting on the table. The [redacted] stated that she was busy in the room providing care as all residents had to be out of bed by 12:00 PM, and she was not aware that the lunch tray had been sitting on the table. The [redacted]) who was in the dayroom and assisted also with the meal delivery, prompted the [redacted] to [redacted] the [redacted] at that time. The [redacted] took the tray in the kitchen and [redacted] the [redacted] at 1:06 PM. On 02/18/26 at 1:30 PM, the surveyor interviewed the [redacted] who was also in the dayroom regarding the meal delivery and the above observation. The [redacted] stated that the lunch tray should not have been placed on the table in front of the resident if there was no staff available to assist with the meal. The tray should have been left in the kitchen. On 02/18/26 at 1:40 PM, the surveyor interviewed the nurse who was present in the dining room and observed Resident # 22 [redacted] with the [redacted]. The nurse stated that the resident should have been removed from the dayroom, and the [redacted] should have been left in the kitchen until the resident could be [redacted] On 02/20/26 the surveyor reviewed the medical record for Resident # 22. A review of the resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, [redacted], [redacted]). The quarterly Minimum Data Set (MDS), an assessment tool used by the facility to prioritize care dated [redacted], reflected that Resident #22 had a BIMS Score o[redacted] out of 15, indicative of [redacted]. Resident #18 was [redacted]t on staff for all activities of daily living. Section GG of the MDS which addressed Activities of daily living (ADLs) reflected that the resident was [redacted]" for [redacted] indicating that the [redacted] was [redacted] due to medical condition or safety concerns.	F0550		04/08/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
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F0550 SS = E	Continued from page 40 The resident was assessed as being [redacted] on staff for all activities of daily living including being [redacted] with [redacted]. The surveyor attempted to interview the resident but the resident [redacted] with the interview. 3. On 12/19/26 at 12:15 PM, the surveyor entered the dayroom to observe lunch. The surveyor observed a [redacted] seated in the back of the room who [redacted] Resident #18 with the [redacted] and proceeded to also converse with another [redacted] while [redacted] Resident #18. The surveyor also observed 7 other residents in the room. The surveyor exited the dayroom to inquire regarding if the [redacted] could wear gloves on while [redacted] the resident and then interviewed the [redacted] who was in the hallway. The surveyor escorted the [redacted] to the dayroom, and we both observed the [redacted] with her gloves on while [redacted] the resident with the [redacted]. The [redacted] went to the back of the room and informed the [redacted] that she could not have gloves on in the dayroom while [redacted] with [redacted] On 02/19/26 at 12:30 PM, the surveyor returned to the room and observed the same [redacted], again [redacted] the resident using her gloved hands. The [redacted] also continued to have a conversation with the other [redacted] while [redacted] Resident #18. The [redacted] then during the observation, removed one of the gloves off of her hand while in the presence of the surveyor. On 02/19/26 at 12:40 PM, the surveyor interviewed the [redacted] regarding having gloves on while [redacted] the resident in the dining room. When inquired regarding the rationale for having gloves on while in the dining room, the [redacted] stated, “I was told that Resident #18 [redacted] and [redacted] during [redacted], I put the gloves on to [redacted] myself”. The [redacted] showed to the surveyor her [redacted] with a [redacted]. The surveyor then asked the [redacted] what should have been done if she had a [redacted]. The [redacted] replied, “I should [redacted] with a [redacted].” When inquired if it was the facility policy to use gloves while assisting residents in the dining room, she stated, “No”. When asked for the rationale, she stated, “it is a dignity issue.” The surveyor then reviewed the medical record for Resident #18 which revealed, the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted], [redacted] and [redacted] The Quarterly Minimum Data Set (MDS) an	F0550		04/08/2026

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F0550 SS = E	Continued from page 41 assessment tool dated [redacted] reflected that Resident #18 scored [redacted] out of 15 on the Brief Interview for Mental Status (BIMS) indicative of [redacted] Section GG of the MDS, which addressed Activities of Daily Living reflected that Resident #18 was [redacted] for all activities of daily living. A review of the Comprehensive Care Plan (undated) provided by the facility identified a problem of [redacted] related to [redacted] and [redacted] The goals were for [redacted] will [redacted] my [redacted] throughout the next review. The interventions were to [redacted] with [redacted]. 4. On 02/20/26 at 8:29 AM, the surveyor observed Resident #5's breakfast meal in their room, and a [redacted] entered Resident #5's room, put the [redacted] in front of the resident, did not open the [redacted] and did not finish setting up the resident's [redacted] at that time. The surveyor asked the [redacted] about the resident and the [redacted] stated that she was assigned to the roommate who was the only [redacted]" that she had, but that the resident was [redacted] and she was not assigned to Resident #5 but knew they [redacted]. When asked the [redacted] about what a [redacted]" was and should that be used to describe the residents? The [redacted] asked the surveyor "what should I use?" and stated she was not told to use any term besides [redacted]" On 2/24/26 at 2:54 PM, during a meeting with the survey team, the above concerns were discussed with the [redacted], [redacted], [redacted], the [redacted] and the [redacted]). The [redacted] informed the surveyor that the [redacted] reported the concerns to the administrative staff. No additional information was provided during the exit conference held on 2/25/26. A review of the facility's policy titled, " Dignity" dated and last revised 1/8/26… reflected the following: Residents shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Procedure. 2. Treated with dignity means the resident will be assisted in maintaining, and enhancing his or her self-esteem and self worth. 3. Residents shall be groomed as they with to be groomed (hair styles, nails, facial hair, etc.), 7 Staff shall always speak respectfully to residents, including addressing the resident by his or her name of choice, and not "labeling" or	F0550		04/08/2026

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F0550 SS = E	Continued from page 42 referring to the resident by his or her room number, diagnosis, or care needs. A review of the Assistance with Meals Policy, last reviewed 1/15/26 revealed Procedure: B. Nursing staff will perform hand hygiene before serving residents. D. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, by nursing staff: for example: a. Not standing over residents while assisting them with meals, , b. Keeping interactions with other staff to a minimum while assisting residents with meals, c. avoiding the use of labels when referring to residents (e.g., "feeders"), a. Nursing staff will feed those residents needing full assistance within 15 minutes of the delivery of food trays. 4. For all resident, hot foods shall be held at a temperature of 135 degrees or above until served. Cold foods shall be held at 41 degrees or below until served. Nursing and Dietary Services will establish procedures such that delivery of food to serving areas accommodate this requirement. 6. All employees who provide residents assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. ...	F0550		04/08/2026
F0607 SS = E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not	F0607	1. No residents were harmed as a result of this deficient practice. Employees #8, #22, and #56 were identified as having no criminal background report in their files. Employee #44 had a background check that was completed 264 days after the hire date. Immediate actions included placing each affected employee on administrative review status pending completion and verification of background checks. The Human Resources Director (HRD) expedited all outstanding background checks. 2. All residents had the potential to be harmed with failure to conduct criminal background checks.. A 100% audit of all employee files for staff hired since the last recertification survey was completed by Human Resources to identify any additional employees with missing or late background checks. All contracted dietary employees were also reviewed per the Dining Service Agreement. Any employee found to have an incomplete file was flagged and the appropriate background check process was initiated.	04/08/2026

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F0607 SS = E	Continued from page 43 limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, it was determined that the facility failed to have a system in place to ensure a) prior to hire, all employees were pre-screened to ensure that they had not been found guilty in a court of law of abuse, neglect, or misappropriation, or had findings entered into the state nurse aide registry or against a professional license, and b) a process was in place to maintain documentation to confirm an appropriate pre-screening had occurred for all contracted facility employees which included dietary. The deficient practice was identified for 3 of 56 employee files reviewed that were provided by the facility. The evidence was as follows: A review of facility policy "Hiring Policy: Employment Application & Pre-Employment Checks", revised April 2025 included: Policy: [Facility Name], Inc. (SSL) is an equal opportunity employer and believes in the fair treatment of all applicants… It is SSL's policy to hire only those individuals who successfully complete the pre-employment assessment criteria, mandatory drug screen, fitness for duty exam, criminal background check, satisfactory references, and regulatory health testing when applicable. On 2/18/2026 at 9:40 AM, the surveyor requested a list of all employees, including contracted employees, that had been hired since 9/19/24 (last recertification survey date) and included employee name, date of hire, title, and date of separation (if applicable) from the [redacted] A review of employee files revealed the following: Employee # 8 was hired on [redacted], and there was no criminal background report in the file.	F0607	Continued from page 43 3. The Human Resources Director (HDR) reviewed the Hiring Policy to include: - A mandatory pre-employment background check verification step that must be completed and documented before any employee begins work. - The contract for the dietary management company was reviewed to confirm the contractor's responsibility to ensure pre-employment background screening for all contractor personnel in collaboration with the Human Resources Director at The Atrium at Navesink Harbor. -The Atrium at Navesink Harbor will keep a copy of the pre-employment background screening for all contracted dietary employees. - HRD staff were in-serviced on the revised process, documentation requirements, and the contractual obligations of the dietary management company. 4. The HRD will audit 100% of new hire employee files within 72 hours of hire to confirm background checks are completed prior to start date. Audits will continue weekly for four weeks and monthly for three months. Compliance threshold is 100%. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly.	04/08/2026

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F0607 SS = E	Continued from page 44 **Employee # 22 was hired on [redacted] and there was no criminal background report in the file.** Employee # 44 was hired on [redacted], and a criminal background search was completed and dated [redacted] (264 days after employee #44 began working). **Employee # 56 was hired on [redacted], and there was no criminal background report in the file.** On 2/20/26 at 2:00 PM, the [redacted] provided a copy of the Dining Service Agreement (Contractor) effective on 6/01/22, which revealed: the Contractor would provide the services identified on 1.3 Purchasing. (a) Employee pre-employment background screening for {name redacted} personnel. On 2/25/26 at 2:31 PM, during an exit conference held with the [redacted]), [redacted] ([redacted]) and [redacted]), no further information was provided. NJAC 8:39-9.3(b)	F0607		04/08/2026
F0677 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: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure dependent residents were provided with routine and appropriate [redacted] care in a timely manner. This deficient practice was identified for 1 of 2 resident reviewed for Activities of Daily Living Care (Residents #18) and was evidenced by the following: On 02/18/2026 at 8:25 AM, the surveyor observed Resident #18, seated in a [redacted] chair adjacent to the nursing, their breakfast tray was on the bedside table. The surveyor observed the resident's [redacted] The resident was [redacted] the surveyor's inquiries when asked if they would like their [redacted] to be [redacted] and [redacted]	F0677	1. Resident #18 was identified as having [redacted] with a [redacted] under the [redacted] on multiple survey observations over six days. The resident was [redacted] for all ADLs. Immediate corrective action included [redacted] being performed for Resident #18 on [redacted]. The resident's care plan was reviewed and updated to reflect [redacted] care responsibilities. 2. A facility-wide audit of all residents who are dependent on staff for ADLs was completed to assess the status of nail care and personal hygiene. Any resident identified with unmet nail care needs received care immediately. The ADL policy was reviewed with all nursing staff, clarifying that Certified Nursing Assistant (CNA) are responsible for routine nail care during care and nurses are responsible for more complex nail care needs. 3. The Director Of Nursing (DON) re-educated all nursing staff and [redacted]	04/08/2026

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F0677 SS = E	Continued from page 45 On 02/19/2026 at 12:50 AM, the surveyor observed Resident #18 being [redacted] with the [redacted] by a [redacted]), the resident's [redacted] On 02/20/2026 the surveyor reviewed Resident #18's electronic medical record (EMR). The admission face sheet (an admission summary) reflected that Resident #18 had diagnoses which included but were not limited to: [redacted] and [redacted]. The Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that Resident #18 scored [redacted] out of 15 on the Brief Interview for Mental Status (BIMS) indicative of [redacted]. Section GG of the MDS, which addressed Activities of Daily Living reflected that Resident #18 was [redacted] staff for all activities of daily living (ADLs). A review of the Comprehensive Care Plan (undated) provided by the facility identified a problem of [redacted] related to [redacted] and [redacted]. The goals were for staff will [redacted] my [redacted] throughout the next review. The interventions were to [redacted]. The surveyor reviewed the Treatment Administration Record (TAR) and noted that Resident #18 was [redacted] to have their [redacted] on [redacted] and [redacted] during the 3:00 PM-11:00 PM shift. A review of the TAR failed to indicate that Resident #18 [redacted] a [redacted] on [redacted] during the 3:00 PM-11:00 PM shift. The TAR was left blank. On 02/24/2026 at 10:30 AM (6 days after the initial observation), the surveyor observed Resident #18 seated in the dayroom. Resident #18's [redacted] were observed in the same condition as observed on 02/18/25. During an interview with the [redacted], she stated that the resident's [redacted] needed to be [redacted] and [redacted]. The [redacted] proceeded to open Resident #18's [redacted] and a [redacted] was observed. The [redacted] then informed the surveyor that the 11:00 PM-7:00 AM shift was responsible to provide AM care to the resident and placed the resident in the [redacted] chair. The surveyor then asked the [redacted] who was responsible for providing	F0677	Continued from page 45 on nail care: - The ADL policy and the specific responsibilities for nail care during routine care. - The requirement to document all ADL care provided, including any refusals. - The process for reporting and addressing missed showers or care tasks. Nurse supervisors were instructed to complete ADL compliance checks during each shift. Certified Nursing Assistant (CNA) assignment sheets were updated to explicitly list nail care as part of the daily care routine for residents. 4. The Unit Manager or designee will audit ADL care documentation and perform visual inspections of residents' personal hygiene for 5 residents daily for two weeks, then weekly for four weeks, and monthly for three months. Compliance threshold is set at 90%. Findings below threshold will trigger immediate corrective action and re-education. Audit results will be reported at monthly QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) meetings.	04/08/2026

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

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F0677 SS = E	Continued from page 46 [redacted] care to all the residents, the [redacted] stated that the nurses were responsible for providing [redacted] care. On 02/24/26 at 11:40 AM, the surveyor interviewed the [redacted] and inquired who was responsible for providing [redacted] care. The [redacted] informed the surveyor if during medication administration, she observed a resident's [redacted] to be [redacted], she stated she could but then stated that the CNAs should be providing [redacted] care during the morning care. On 02/24/2026 the surveyor interviewed the [redacted] of [redacted]) and requested the policy for ADLs care. The [redacted] then informed the surveyor that the CNAs were responsible for providing [redacted] care. A review of the facility's policy titled, "Activities of Daily Living (ADL) last revised 1/16/25, provide on 02/24/26 at 1:37 PM, revealed the following: The Skilled Nursing Facility will assess each resident's ability to perform ADLs upon admission, quarterly, and with any significant change in condition. ADLs included bathing, dressing, grooming, toileting, transferring, ambulation, eating, nail care and incontinence care. All care provided, including the level of assistance and any refusals, will be documented accurately. On 2/24/26 at 2:54 PM, during a meeting with the survey team, the [redacted], [redacted], [redacted], [redacted], and the [redacted]) could not provide documentation that [redacted] were [redacted] and [redacted] by the resident and no additional information was provided. On 02/25/26 at 2:31 PM, the survey team met with [redacted], [redacted], [redacted] and [redacted] and the facility had no additional information to provide. NJAC 8:39-27.2(g)	F0677		04/08/2026
F0686 SS = E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F0686	1. The Director Of Nursing (DON) clarified the correct concentration with the [redacted] care Advance Practice Nurse (APN) on [redacted] to confirm that the [redacted] An immediate review of Resident #1's [redacted]	04/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
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F0686 SS = E	Continued from page 47 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a system was in place to ensure wound treatment recommendations were clarified and implemented in a timely manner. This deficient practice was identified for one (1) of three (3) residents reviewed for [redacted] (Resident #1), who had a [redacted] treatment recommended by the [redacted] on [redacted], which was implemented on [redacted] (7 days later) and the [redacted] was [redacted] by the physician until [redacted] (38 days later). The deficient practice was evidenced by the following: On 2/18/26 at 12:16 PM, the surveyor observed Resident #1 in the seated in a [redacted] in the dining room and was being [redacted] with the [redacted] by facility staff. On 2/19/26 at 8:57 AM, the surveyor observed Resident #1 sleeping in bed. At that time, the surveyor then reviewed the medical record for Resident #1which revealed the following: The Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted]	F0686	Continued from page 47 orders was completed on [redacted]. The resident's [redacted] plan was reviewed and the correct [redacted] was confirmed. 2. A review of all residents receiving wound care was completed by the Director of Nursing (DON) and the Unit Manager (UM) to identify any open wound care recommendations that had not been fully clarified, signed by a physician, or implemented within the required timeframes. There were no other residents noted to have been affected by the deficient practice. All licensed nurses were in-serviced by the Director of Nursing (DON) on: - The requirement that consultation recommendations be reviewed and physician orders obtained on the same day as the recommendation. - The obligation to clarify any incomplete or unclear orders, including dosing or concentration, before implementation. - The process for documenting physician contact and order clarification in the medical record. 3. The Director Of Nursing (DON) reviewed the wound care consultation process to require: - Consultation notes to be reviewed by the licensed nurse receiving the recommendation on the same day received. - Any incomplete order (e.g., missing dose, strength, or frequency) must be clarified with the prescribing clinician before any treatment is implemented. - The attending physician must be notified of all new wound care recommendations. 4. The Director Of Nursing (DON) or designee will audit 100% of new wound care consultation notes weekly for four weeks and monthly for three months to confirm: (1) timely implementation, (2) complete dosing information, and (3) documented physician order or clarification. Compliance threshold is 100%. Residents who verbalize discomfort during wound care will be assessed and wound care orders reviewed immediately. Audit findings will be reported to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) committee monthly.	04/08/2026

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F0686 SS = E	Continued from page 48 The comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] out of 15, which indicated Resident #1 was [redacted]. A review of Section [redacted] Conditions, reflected that the resident had one (1) [redacted] that [redacted] due to [redacted] of [redacted] by [redacted] upon admission to the facility ... The Nursing Evaluation Assessment dated [redacted], indicated that the resident had a [redacted] with a [redacted] of [redacted] ([redacted] by [redacted] by [redacted] with [redacted]. The individualized comprehensive Care Plan with an effective date of [redacted], had a Focus area for [redacted] related to [redacted] The [redacted] skilled nursing documentation reflected the resident was [redacted] on [redacted] from the hospital after a [redacted] of the [redacted]. A review of [redacted] #1's notes included the following: On [redacted] at 1:19 PM, [redacted] # 1 who provided [redacted] services at the facility, documented an initial encounter regarding a [redacted] with [redacted] of: [redacted] x [redacted] x [redacted] was a [redacted] r, had [redacted], [redacted], [redacted] ...After the [redacted] the [redacted] a [redacted] x [redacted] x [redacted] On [redacted] [untimed], [redacted] #2 a [redacted] who also [redacted] to Resident #1, while in the hospital, documented [redacted] of: [redacted] cm x [redacted] x [redacted], [redacted]) a at [redacted]. The plan was to [redacted] in [redacted], [redacted] to [redacted] with [redacted]), to [redacted], [redacted]) and to [redacted] with [redacted].	F0686		04/08/2026

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F0686 SS = E	Continued from page 49 On [redacted] at 9:44 AM, [redacted] #1 then documented [redacted] of [redacted] x [redacted] x [redacted] for [redacted] and [redacted], used a [redacted] . . . The plan included: to [redacted] with [redacted], [redacted] the [redacted] with [redacted] and [redacted] the [redacted] or as [redacted] On [redacted] [untimed], [redacted] #2's documented, on a Consultation form, [redacted] and Recommended Treatment: [redacted] x [redacted] x [redacted] and [redacted], the [redacted] was [redacted] d: [redacted] with [redacted] e, [redacted] to [redacted], [redacted] with [redacted]) [redacted]] and [redacted] with [redacted]. The Attending Physician and Consulting Physician name was left blank. A handwritten initial "noted" [redacted] initials] dated [redacted]" was reflected on the side of the document. There was no signature on the document from the either the attending or consultant Physician. There was [redacted] documented for the [redacted] on the form by [redacted] #2, or upon being "noted" by staff. The resident was administered the [redacted] on [redacted] without clarification by [redacted] #2 for the Recommendation. A review of all Physician Orders from [redacted] did not reflect a clarification of [redacted] #2's recommendation. A review of a type-written [redacted] note dated [redacted], for a Visit on [redacted] at 9:30 AM, was signed by the [redacted]) that worked under [redacted] 2. The note revealed "Current Medications and Dosages" included [redacted] A review of a type-written [redacted] note dated [redacted] for a Visit on [redacted] at 1:45 PM, was signed by the [redacted] that worked under [redacted] 2. The note revealed "Current Medications and Dosages" included [redacted] that was administered beginning on [redacted]	F0686		04/08/2026

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F0686 SS = E	Continued from page 50 A review of a type-written [redacted] note dated [redacted] for a Visit on [redacted] at 3:50 PM, was signed by the [redacted] that worked under [redacted] 2. The note revealed "Current Medications and Dosages" included [redacted] A review of a type-written [redacted] note dated [redacted], for a Visit on [redacted] at 7:00 AM, was signed by the [redacted] that worked under [redacted] 2. The note revealed "Current Medications and Dosages" included [redacted] A review of a type-written [redacted] note dated [redacted], for a Visit on [redacted] at 10:0 AM, was signed by the [redacted] that worked under [redacted] 2. The note revealed "Current Medications and Dosages" included [redacted] On 2/19/26 at 9:07 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN #1) stated that both [redacted] provided [redacted] treatment to Resident #1 once per week and also [redacted] the resident's [redacted]. and would provide new [redacted] treatment orders as needed? On 2/19/26 at 9:11 AM, the surveyor and LPN #2 reviewed the active [redacted] Treatment Administration Record (TAR) together and observed the order for [redacted] was implemented on [redacted] for [redacted] The surveyor requested the corresponding physician order for the [redacted] at that time. LPN #2 was unable to provide the surveyor with the physician order, or any documentation to show that a physician was contacted to clarify the strength of the [redacted] that was recommended by [redacted] #2 on [redacted] At that time, the surveyor observed the [redacted] treatment cart with LPN #1. A [redacted] that was labeled with Resident #1's name and dated [redacted]. There were no other [redacted] of [redacted] for Resident #1 observed and LPN #1 [redacted] that the [redacted] was what was [redacted] for Resident #1. At that time, LPN #1 and LPN #2 (the off-going shift 11:00 PM to 7:00 AM) both confirmed that neither of them had entered the [redacted] order. Both LPNs then confirmed and acknowledged that the strength	F0686		04/08/2026

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F0686 SS = E	Continued from page 51 should have been clarified with [redacted] #2 who documented the recommendation for the [redacted] and was also providing the [redacted] treatments for Resident #1. LPN #2 then stated she would inform the [redacted]) of the identified concerns. On 2/19/26 at 10:04 AM, after surveyor inquiry, LPN #2 then provided the surveyor with two documents: an additional "Electronically Signed" by the [redacted] note dated [redacted] at 9:26 AM [15 minutes after both LPNs confirmed they were unable to locate an order for the strength of the [redacted] the note reflected an Order Date for [redacted] was dated [redacted]. [38 days after the initial recommendation was made on [redacted]] A second document "Amendment" for Resident #1 revealed on [redacted] at 9:50 AM, the [redacted] #2 provided "Verbal taken today for the following clarification: [redacted]], and [redacted] may be [redacted]... On 2/19/26 at 10:39 AM, two surveyors observed Resident #1 in bed [redacted] to their [redacted]. Resident #1 stated they received [redacted] treatments daily, and during [redacted] treatments experienced that when the [redacted] was [redacted] the [redacted]" and stated they informed staff. On 2/19/26 at 11:32 AM, during an interview with the survey team, the [redacted] for Resident #1 stated that she deferred to the [redacted] recommendations. On 2/19/26 at 11:51 AM, the surveyor and the [redacted] reviewed Resident #1's electronic medical record (eMR) together. At that time, the [redacted] stated that the [redacted] for [redacted] was [redacted] on [redacted] and was not clarified until surveyor inquiry she clarified it on the morning of [redacted]. The [redacted] stated "we don't know that the [redacted] was clarified prior to [redacted]." The [redacted] stated when she was made aware that she clarified the [redacted] with the [redacted] for [redacted] #2 on [redacted] and they [redacted] At that time, the [redacted] also stated that the [redacted] was not implemented until [redacted] and acknowledged the order should have been clarified and implemented the same day the recommendations/order from the [redacted] #2 was obtained. The [redacted] stated that prior to [redacted] Resident #1's [redacted] was [redacted] with [redacted] from [redacted] to [redacted]. When asked why [redacted] 2's recommendation was not clarified and implemented on the day it was written, [redacted], the	F0686		04/08/2026

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F0686 SS = E	Continued from page 52 [redacted] stated she would have to speak with the [redacted]) who received the order as she did not know what occurred. The [redacted] did not respond as to why the [redacted] #2's consultation notes included a current medication for [redacted] and not [redacted] On 2/19/26 at 12:59 PM, during a telephone interview with the surveyor, [redacted] #2/[redacted] stated he did not speak with his [redacted] in that day. The [redacted] #2/[redacted] also stated that typically in his practice [redacted] was used as a [redacted], and [redacted]. When asked about potential [redacted] for using a [redacted], the [redacted] #2/surgeon stated [redacted] could be a side effect if the [redacted] was utilized. The [redacted] #2/[redacted] had not been made aware that Resident #1 had an order for [redacted] When asked about the consultation form dated [redacted] that did not have the % of the [redacted] indicated. The [redacted] #2/surveyor stated he "should have been contacted" to clarify his recommendation. On 2/19/26 at 1:16 PM, during an interview with the surveyor, the [redacted] stated that if an order did not have a strength or dose, the order should be clarified by nursing or that pharmacy whomever received the order from the prescriber. On 2/19/26 at 1:54 PM, during an interview with the survey team, the [redacted]) regarding the consultation process for a resident. The [redacted] stated, the Consultation form would be documented with the physician and/or consultant physician's name. When a resident returned from a consultation visit from a provider, the facility's [redacted] was informed of the order, "we don't take orders from the consultant" and we look to see if there were new recommendations the [redacted] would either agree or disagree with the recommendations. The [redacted] stated that this process would be completed within one hour or "no more than two." The [redacted] stated that Consultation forms were "vague" and would say continue or change. The [redacted] stated the order would be "clarified from the attending physician first." At that time the [redacted] stated that the facility's physician ordered [redacted] and confirmed she failed to document the conversation that she stated occurred with the physician regarding the order clarification. The [redacted] also stated that after a note would be written that the orders would be sent to the pharmacy. When asked if there would be any reason why this process would not be followed, she stated "no." The [redacted] was unresponsive when asked why the recommendations documented on the Consultation note dated [redacted] were not implemented until	F0686		04/08/2026

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F0686 SS = E	Continued from page 53 [redacted][8 days later]. On 2/24/26 at 2:54 PM, during a meeting with the survey team, the [redacted], [redacted] ices, [redacted] the [redacted], and the [redacted], the surveyor discussed the concern with delayed clarification, order and the resident's complaints of [redacted] during [redacted] care. At that time, the [redacted] confirmed the order was not clarified and not implemented at the time the treatment recommendation was received on [redacted]. The [redacted] also confirmed and acknowledged that the [redacted]s documentation of the [redacted] was "vague." On 02/25/26 at 2:31 PM, the survey team met with [redacted], [redacted] and [redacted] and the facility had no additional information to provide. According to the provided facility policy titled, General Guidelines Wound and Skin Care, dated 6/23/25 included that the suggested protocols may be instituted by a physician order ... According to the provided facility policy titled; Wound and Skin Care, At Risk Residents included ongoing documentation by licensed nurses in the medical record to describe the effectiveness of interventions and the resident's response to therapy. NJAC 8:39-27.1(e)	F0686		04/08/2026
F0692 SS = E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F0692	1. Resident #1's and Resident #5's [redacted] were reviewed and care plans updated. Resident #5's [redacted] requirements were communicated to all assigned Certified Nursing Assistant (CNA)s. The [redacted]) was notified and provided updated [redacted] assessments for both residents. [redacted] was in serviced on 3/20/26 by the Director Nutrition and Quality Assurance on proper review of weights and intervention implementation based on current weight policy. An inservice was conducted by the Director Of Operations and/or designee for all cooks and production staff regarding appropriate consistency and the fortified cereal recipe. Diet consistencies inservice by the RD with the kitchen staff and with nursing regarding diet consistency.	04/08/2026

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F0692 SS = E	Continued from page 54	F0692	Continued from page 54	04/08/2026

F0692 — Summary Statement of Deficiencies

maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

This REQUIREMENT is NOT MET as evidenced by:

Based on observations, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to have a system in place to ensure a) [redacted] were consistently and accurately monitored and verified a [redacted] and implemented interventions in response to a [redacted], and b) staff implemented identified [redacted] interventions appropriately and consistently. The deficient practice was identified for 2 of 2 residents reviewed for [redacted], who [redacted] (Resident #1 [redacted] in [redacted] (from [redacted] to [redacted]) and Resident #5 who had a [redacted] The deficient practice was evidenced by the following:

Refer to F804, F805

a) On 2/18/26 at 12:16 PM, the surveyor observed Resident #1 in the dining room seated in a [redacted] with [redacted] and was being [redacted] with the [redacted] by a facility staff. The [redacted] [redacted] and the [redacted]

On 2/19/26 at 8:57 AM, the surveyor observed Resident #1 was asleep in bed and the surveyor then reviewed the medical record for Resident #1 which revealed the following:

The Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted]

The comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] out of 15, which indicated Resident #1 was [redacted]. Section [redacted] indicated the resident [redacted] in [redacted] in [redacted] or [redacted] in [redacted]. On admission required [redacted] and while a resident

F0692 — Provider's Plan of Correction

2.

All residents with documented weight loss or at nutritional risk were identified for review by the Registered Dietitian (RD). A 30-day audit of weight documentation was completed for all residents to identify any significant weight losses that were not verified, reported, or acted upon. Any findings were immediately corrected. The notification process for any weight that meets the significant weight change criteria was reviewed with the RD and all nursing staff per facility policy.

All nursing staff were in-serviced by the Director of Nursing on: - The facility Resident Weights and Weight Changes policy. - The obligation to notify the RD and physician immediately upon identification of a significant weight change. - The requirement to document all notifications and follow-up in the medical record.

3.

The Director Of Nursing (DON) reviewed the weight monitoring process:

- A reweight within 48 hours of any documented weight change meeting the significant threshold criteria.

- Immediate notification to the RD and physician upon identification of a significant weight change, with documentation of the contact in the medical record.

- The RD to be included in the interdisciplinary team review for all residents with significant weight loss.

- Kitchen staff to follow standardized recipes for all fortified and modified-consistency foods; the HiCal Cream Wheat recipe was distributed to kitchen staff and posted in the kitchen.

- Certified Nursing Assistant (CNA) assignment sheets to clearly identify residents requiring full feeding assistance and document compliance at each meal.

4.

The Director Of Nursing (DON) or designee will audit weight documentation for all at-risk residents weekly

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

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F0692 SS = E	Continued from page 55 [redacted] The Nursing Admission Evaluation, dated [redacted] reflected the residen[redacted] with [redacted] and [redacted] a [redacted]. The individualized Care Plan, effective from [redacted] included a Focus of [redacted] due to [redacted], and [redacted] d for [redacted] with [redacted]. The resident [redacted] d a [redacted] and [redacted] and was at [redacted] for [redacted]. The Goals included [redacted] greater than or equal to [redacted], [redacted] and [redacted] of [redacted]. The interventions required the [redacted] to [redacted] Resident #1's [redacted], [redacted] and [redacted]. Resident #1's [redacted], [redacted] revealed the following: On [redacted], the residents documented [redacted] was [redacted] (#). On [redacted], the residents documented [redacted] was [redacted] #s. The "Notes and [redacted] column next to the [redacted] indicated # an [redacted] in [redacted] days, and [redacted] in [redacted] days This [redacted] an approximate [redacted] in [redacted] days]. On [redacted], a [redacted] was documented by the [redacted] which indicated the resident [redacted] # and an '[redacted] Note": for [redacted] and [redacted] days was [redacted] [This indicated an approximate [redacted] in [redacted]]. A review of the [redacted] Assessment reflected Resident #1 received a [redacted], [redacted], and [redacted]. On admission the resident received with [redacted], did [redacted] with [redacted] in the past and required [redacted]. The resident's [redacted] and was not [redacted] at that time. The [redacted] documented that the resident was observed not [redacted] and required [redacted] with [redacted]. The [redacted] recommended the following [redacted] interventions in response to the observation: Staff to [redacted] once a day, a [redacted] to be given with	F0692	Continued from page 55 for four weeks and monthly for three months to confirm: (1) timely reweighing, (2) documented RD and physician notification for significant weight changes, and (3) compliance with nutritional interventions. The RD will monitor meal intake for residents with active weight loss concerns. Audit findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly. Compliance threshold is set at 90%.	04/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER: ATRIUM AT NAVESINK HARBOR, THE		STREET ADDRESS, CITY, STATE, ZIP CODE: 40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701	

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F0692 SS = E	Continued from page 56 [redacted] and [redacted] and [redacted] of [redacted] [brand redacted] twice a day [redacted] and for staff to [redacted] and [redacted]. At that time, the resident had [redacted] documented [redacted] A review of the [redacted], [redacted] documented by the [redacted] reflected the resident had a [redacted], had [redacted], was [redacted], had [redacted], [redacted] and had a [redacted] of [redacted] which indicated an [redacted] but was at [redacted] for [redacted] A review of the medical record [redacted] that the [redacted] that [redacted], was [redacted] with a [redacted], and addressed by the interdisciplinary team. There was no documented evidence that the physician or [redacted] had been notified of the [redacted] A review of the following [redacted] Progress Note dated [redacted], reflected the resident was and was [redacted] facility [redacted] for a [redacted]. On 2/24/26 at 1:36 PM, the surveyor interviewed the [redacted] stated that Resident #1 experienced an [redacted] during their [redacted] period stay. The [redacted] also stated that the resident had [redacted] and she could confirm the accuracy of the admission [redacted] recorded, as their was [redacted] obtained. At that time, the [redacted] stated that she was included as part of the Interdisciplinary Team. The [redacted] stated that any staff should have alerted her of the [redacted] when it was recorded and stated "usually the nurses informed me when there was a [redacted] discrepancy". The [redacted] also stated that she was available via telephone and if she had been informed of the unplanned [redacted] she would have made additional [redacted] recommendations depending on results of the [redacted] assessments for the [redacted]. On 2/24/26 at 2:54 PM, during a meeting with the survey team, the [redacted], [redacted],	F0692		04/08/2026

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

FORM APPROVED
OMB NO. 0938-0391

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	315515	A. BUILDING B. WING	02/25/2026

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F0692 SS = E	Continued from page 57 the [redacted], and the [redacted]), the surveyor discussed the above concerns.. At that time, the surveyor inquired as what the process was regarding [redacted] upon admission. The [redacted] stated that there was "one [redacted] obtained upon admission, and then weekly [redacted] for 4 weeks." b. On 2/19/26 at 8:48 AM, the surveyor interviewed the [redacted] about Resident #5's [redacted]. The [redacted] stated the resident had [redacted], [redacted] and in response to [redacted], the [redacted] had implemented different types of [redacted] with, and between meals. On 02/19/26 at 12:38 PM, the surveyor observed Resident #5's breakfast meal tray was still in room and [redacted] was [redacted] and observed a broken muffin was observed on the plate. On 02/19/26 at 12:41 PM, Resident #5 was observed in the main dining room with a meal plate that included [redacted] and [redacted]. Resident #5 did [redacted] and there were [redacted] in [redacted] the resident. The surveyor attempted to interview the resident and the resident [redacted]. The observation [redacted] and on [redacted] at 12:49 PM [redacted] minutes after the surveyor observed the resident sitting in front of the [redacted]), a staff member [redacted] the resident and [redacted] the resident, and then brought over [redacted], [redacted], the [redacted], and [redacted] to the resident. The staff did not [redacted] with the resident or [redacted] to [redacted] the [redacted] or [redacted] an alternate option. On 2/19/26 at 2:30 PM, the surveyor reviewed the electronic medical record for Resident #5 which revealed the following: The Face Sheet (an admission summary) revealed the resident had diagnoses which included, but were not limited to [redacted], [redacted]. [redacted]	F0692		04/08/2026

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F0692 SS = E	Continued from page 58 [redacted]). The Annual Minimum Data (an assessment tool) dated [redacted] revealed the staff assessment for Mental Status was completed and the resident had [redacted] for [redacted]). The [redacted] was [redacted] days. Section [redacted] for [redacted] revealed the resident was coded as [redacted] which indicated the resident was [redacted] for [redacted]. Residents does [redacted] to complete the activity. Or, the [redacted] of [redacted] or [redacted] is required for the resident to complete the activity. The [redacted] to [redacted] to the [redacted] and [redacted] once the [redacted] before the resident). Section [redacted] revealed the resident was [redacted] and was [redacted] as had a [redacted] or [redacted] in the [redacted] or [redacted] or [redacted] in the [redacted] and was [redacted] a physician prescribed [redacted] regimen. The resident was [redacted] as being on a [redacted] Resident #5's individualized Care Plan, Effective [redacted] revealed the revealed the following: Problem: I have a [redacted] and [redacted] with my ADLs (Activities of Daily Living) …Goals: [redacted] with the [redacted] from staff …. Interventions included staff will [redacted] my [redacted]; Problem: I have [redacted], [redacted] diagnosis, [redacted]. Goals: [redacted] r than or equal to [redacted], [redacted] Interventions: "Staff will [redacted]"; [redacted] as ordered; "Provide me my [redacted]", [redacted] me my [redacted] as ordered; "Please provide me with [redacted] or [redacted] at [redacted] please [redacted] me if I [redacted]"; [redacted]; Recommend weekly [redacted] x 4 weeks [redacted]; Recommend [redacted] at [redacted]. A review of the documented [redacted] and [redacted] Nutritional Progress Notes revealed: [redacted]); [redacted] #: [redacted]; [redacted] # [redacted] # [redacted] #, [redacted] # [redacted] # ([redacted]	F0692		04/08/2026

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F0692 SS = E	Continued from page 59 [redacted]). A [redacted] Progress Note documented by the [redacted], dated [redacted] revealed resident with [redacted], "[redacted], [redacted] with [redacted] and [redacted]). [redacted] ([redacted] and [redacted]), and [redacted] if [redacted] given by nursing [redacted] (approximately [redacted], continue to [redacted], "staff to [redacted] and continue to [redacted] at [redacted], [redacted] and [redacted]". A [redacted] Progress note completed by the [redacted] and dated [redacted], revealed that [redacted] to [redacted] at [redacted] and continues on [redacted], most recent [redacted] shows [redacted]. A [redacted] Progress note completed by the [redacted] and dated [redacted], revealed [redacted] any [redacted] at [redacted], [redacted] noticed by staff- most recent [redacted] #, shows [redacted] over [redacted] days ...[redacted] and recommend [redacted] ... "resident [redacted] s a [redacted] a [redacted] ..." On 02/20/26 at 8:29 AM, the surveyor observed Resident #5 was in bed with the [redacted] in front of them and a Certified Nurse Aide (CNA #1) entered the room, assisted the room mate with the meal, then [redacted] and [redacted] the [redacted] in front of Resident #5, and the surveyor observed a plate of cut up sausage circles, with 3 pieces of French toast, syrup was opened but not poured on the French toast, milk was unopened, watery, in appearance hot cereal was also on the tray, with a beige colored beverage next to the tray in a small cup and the silverware was wrapped in a blue napkin and [redacted] to the resident. CNA #1 stated she was not assigned to Resident #5 and did not further [redacted] or [redacted] the resident. The Meal Ticket had 4 ounces orange juice, 6 ounces cream of wheat and "[redacted]" handwritten on the ticket, 8 ounces of 2 % milk, 2 ounces of "[redacted] (not on tray), and 4 ounces chilled crushed pineapple (not on tray).	F0692		04/08/2026

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F0692 SS = E	Continued from page 60 On 2/20/26 at 8:44 AM (15 minutes after the surveyor first observed the resident in the room [redacted] the [redacted] being [redacted]), a Certified Nurse Aide (CNA #2) entered the room, and stated to Resident #5, "you're not hungry?", and stood next to Resident #5 and began [redacted] the [redacted] by cutting the French toast and put the utensil in the resident's hand. The surveyor then interviewed the [redacted] about the meal ticket and asked what did the "[redacted]" mean and the [redacted] stated she was "not sure" but the resident had "sausage not [redacted]." The surveyor asked if the residen[redacted] with [redacted] and CNA #2 stated "it didn't look like [they] [redacted] it" and "[they] need [redacted]." When asked what the usual waiting time should be for a resident to be assisted with the meal, CNA #2 stated, "I don't know". When asked were you trained on that, she stated, "no, we don't have trainings on that." On 2/20/26 at 9:33, the surveyor interviewed the [redacted] and the [redacted] regarding the watery in appearance cereal on Resident #5's meal tray and asked the [redacted] if he used a recipe for the [redacted]. The [redacted] stated he would add butter and milk and did not use a recipe for the [redacted], and at that time the [redacted] was looking for a recipe. The surveyor asked the [redacted] what the purpose of the [redacted] was and he stated, "for someone to [redacted]." On 02/20/26 at 10:28 AM, the surveyor interviewed the [redacted] regarding the purpose [redacted]. The [redacted] stated it was of recent addition as an intervention due to the [redacted]. When asked if it was important to follow a recipe, the [redacted] sated, "yes, it was important, to ensure that the appropriate [redacted] and [redacted] were provided" and the surveyor asked for the recipe. On 02/20/26 at 10:47 AM, the [redacted] provided a copy of the [redacted]) recipe which revealed the recipe required Nonfat Dry Milk, Dark Brown Sugar, Whole Milk, Granulated Sugar, Butter in addition to the cream of wheat and water and if the recipe is followed a 3/ 4 cup serving would equal 360 calories and 7 grams of protein. On 2/20/20 at 12:03 PM, the surveyor conducted a telephone interview with the [redacted]) in	F0692		04/08/2026

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F0692 SS = E	Continued from page 61 the presence of the [redacted] The [redacted] confirmed the resident was on a [redacted] and had a [redacted]. The [redacted] stated Resident #5 [redacted] When asked if leaving a resident for 15 minutes by themselves without [redacted] them up would that be considered queueing? The surveyor then shared the observations from the meal with the [redacted] and the [redacted] stated, "no, they should [redacted] [Resident #5] and [redacted] them up." On 2/20/26 at 12:10 PM, the surveyor reviewed the nursing assignment sheet for Resident #5 which indicated Resident #5 [redacted]. On 02/24/26 at 2:54 PM, the survey team met with the [redacted]), [redacted]), and [redacted] to discuss the above concerns. On 02/25/26 at 2:31 PM, the survey team met with [redacted], [redacted] and [redacted] and the facility had no additional information to provide. A review of the Assistance with Meals policy Revised 1/15/26 revealed Policy: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Procedure: Resident's Room: Nursing staff will feed those residents within 15 minutes of the delivery of food trays. A review of the provided facility policy, titled Resident Weights and Weight Changes revealed; Policy: Regular monitoring of weights is necessary in order to screen resident for significant weight changes, which may may indicate a resident is at nutritional risk. Residents' weights will be obtained at least monthly and recorded in the electronic medical record. "Significant weight changes will be reviewed by the dietitian and physician if indicated." Procedure: a [redacted] must be obtained within 48 hours if a [redacted] meets the following criteria: Interval: [redacted] change. The [redacted] did not indicate why a [redacted] was not [redacted] after the [redacted] was [redacted] for Resident #1 on [redacted]	F0692		04/08/2026

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F0692 SS = E	Continued from page 62 NJAC 8:39-27.1(a),27.2(a)	F0692		04/08/2026
F0726 SS = E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and record review the facility failed to assure the nursing staff had the competency and skills sets to provide nursing care to two sampled residents to provide appropriate [redacted] and ensure nursing staff were competent in a process to verify physician recommendations and clarify orders for [redacted]. The deficient practice was evidenced for 2 of 3 residents reviewed for [redacted] (Resident #1 and Resident #3) and was evidenced by the following:	F0726	1. Both staff members involved received immediate counseling and re-education by the Director of Nursing (DON). Both LPN#1 and LPN #2 had competency done with the DON regarding hand washing with soap and water, hand washing with alcohol based formulation, and clean dressing competency. 2. A review of all nursing staff competency records by the DON and Infection Preventionist (IP) will be completed by to identify gaps in wound care technique and order verification skills. Staff found to have not completed wound care competencies are going to be scheduled for mandatory training. A wound care competency assessment will be completed by the Infection Preventionist (IP) and Unit Manager/ designee for all licensed nurses. In-service education was provided by the IP to all licensed nursing staff on: (1) proper wound care setup including use of a clean barrier field; (2) hand hygiene technique per Springpoint Senior Living Policy (minimum 20 seconds); (3) the process for clarifying incomplete wound care orders prior to implementation. 3. The Director Of Nursing (DON) reviewed the wound care competency program to include: - A mandatory annual wound care competency assessment for all licensed nurses who perform wound treatments. - Competency validation to specifically include hand hygiene technique, sterile/clean field setup, and the wound care order verification process. - A formal process for licensed nurses to verify all consultation orders with the attending physician before implementing any treatment. The Facility Assessment was reviewed to include wound care competencies as a required skill set for licensed nursing staff.	04/08/2026

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F0726 SS = E	Continued from page 63 a. On [redacted] [untimed], [redacted] #2's documented, on a Consultation form [redacted] and Recommended Treatment: [redacted] x [redacted] x [redacted] and [redacted]", the [redacted] was [redacted]; [redacted] with [redacted], [redacted] to [redacted] n, [redacted] with [redacted] [twice daily] and [redacted] with [redacted]. The Attending Physician and Consulting Physician name was left blank. A handwritten initial "noted" [redacted] initials] dated [redacted]" was reflected on the side of the document. There was no signature on the document from the either the attending or consultant Physician. There was [redacted] documented for the [redacted] on the form by [redacted] #2, or upon being "noted" by staff. The resident was administered the [redacted] on [redacted] without clarification by [redacted] #2 for the Recommendation. A review of all Physician Orders from [redacted] did not reflect a clarification of [redacted] #2's recommendation. On 2/19/26 at 9:11 AM, the surveyor and LPN #2 reviewed the active [redacted] Treatment Administration Record (TAR) together and observed the order for [redacted] was implemented on [redacted] for [redacted]. The surveyor requested the corresponding physician order for the [redacted] at that time. LPN #2 was unable to provide the surveyor with the physician order, or any documentation to show that a physician was contacted to clarify the strength of the [redacted] that was recommended by [redacted] #2 on [redacted]. At that time, the surveyor observed the [redacted] treatment cart with LPN #1. A [redacted] that was labeled with Resident #1's name and dated [redacted]. There were no other strengths of [redacted] for Resident #1 observed and LPN #1 confirmed that the [redacted] was what was used for Resident #1. At that time, the [redacted] also stated that the [redacted] was not implemented until [redacted] and acknowledged the order should have been clarified and implemented the same day the recommendations/order from the [redacted] #2 was obtained. The [redacted] stated that prior to [redacted] Resident #1's [redacted] was [redacted] with [redacted] from [redacted] to [redacted]. When asked why [redacted] 2's recommendation was not clarified and	F0726	Continued from page 63 4. The Director Of Nursing (DON) or designee will observe 3 wound care treatments weekly for four weeks and monthly for three months. Observations will assess: hand hygiene compliance, clean field setup, technique, and order verification documentation. Compliance threshold is set at 90%. Findings below threshold will result in immediate re-education and competency re-validation. Results will be reported at monthly QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) meetings.	04/08/2026

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F0726 SS = E	Continued from page 64 implemented on the day it was written [redacted], the [redacted] stated she would have to speak with the [redacted] who received the order as she did not know what occurred. The [redacted] did not respond as to why the [redacted] #2's consultation notes included a current medication for [redacted] solution and [redacted] On 2/19/26 at 11:51 AM, the surveyor reviewed Resident #1's electronic medical record (eMR) with the [redacted]. At that time, the [redacted] confirmed that the [redacted] for [redacted] ordered on [redacted], was not clarified until that morning [redacted] by her, "we don't know the [redacted] was clarified" prior to that day. The [redacted] stated she clarified the [redacted] with the [redacted] Nurse after the surveyor's inquiries. On 2/19/26 at 12:59 PM, during a telephone interview with the surveyor, [redacted] stated he did not speak with his [redacted] in that day. The [redacted] #2 [redacted] also stated that typically in his practice [redacted] was used as a [redacted], and [redacted]. When asked about potentia [redacted] for using a [redacted], the [redacted] #2/surgeon stated [redacted] could be a [redacted] if the [redacted] was utilized. The [redacted] had not been made aware that Resident #1 had an order for [redacted] When asked about the consultation form dated [redacted] that did not have the % of the [redacted] indicated. The [redacted] stated he "should have been contacted" to clarify his recommendation. b. On 2/20/2026 at 11:47 AM, a surveyor observed a Licensed Practical Nurse (LPN #2) perform [redacted] to Resident #3's [redacted] and observed the following: The [redacted] washed her hands under running water for six seconds. (CDC recommendations 20 seconds away from the stream of water). Prior to performing the [redacted], the [redacted] failed to cleanse the bedside table and use a [redacted] for the supplies needed for the [redacted] treatment. The [redacted] used her lap to set up the field. On 2/20/26 at 1:07 PM, the [redacted] provided the education book utilized by the [redacted]. The surveyor asked if the Dietary department was included in any training, or competencies and she stated they were not. When asked to list all the competencies completed for the staff, the [redacted] stated, [redacted] Competencies were completed by a [redacted]. Upon review, the competencies did not include all staff, or were	F0726		04/08/2026

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER: **ATRIUM AT NAVESINK HARBOR, THE**		STREET ADDRESS, CITY, STATE, ZIP CODE: **40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701**	

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F0726 SS = E	Continued from page 65 related to order clarification. NJAC 27.1(a)	F0726		04/08/2026
F0805 SS = E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and document review it was determined that the facility failed to ensure a system was in place to ensure that a resident who required a [redacted] received appropriate meal items. The deficient practice was identified for 1 of 3 Residents reviewed fo[redacted] (Resident #5) and who required a [redacted] and had the potential to affect all residents who required a [redacted]. The deficient practice was evidenced by the following: On 2/19/26 at 8:48 AM, the surveyor interviewed the [redacted] about Resident #5's [redacted]. The [redacted] stated that the resident has had [redacted], has become [redacted], and she has added interventions in response to the [redacted] On 2/19/26 at 2:30 PM, the surveyor reviewed the electronic medical record for Resident #5 which revealed the following: The Face Sheet (an admission summary) revealed the resident had diagnoses which included, but were not limited to [redacted], [redacted]. A [redacted] Note, dated [redacted] at 10:31 AM, revealed resident was observed [redacted] during [redacted] t .. [redacted] eggs and sausage, but [redacted] it". [redacted] t a muffin and pudding. [redacted]	F0805	1. On 2/19/26 all Hot Production Staff and [redacted] were provided with inservicing by the Regional Director of Operations and/or designee on proper production of mechanical soft consistency in compliance with recipes and policy. On 3/27/26 all dining and nursing staff were in serviced and deemed competent to read and follow guidelines on tickets for presentation of all mechanically altered food items per policy. 2. All residents maintained on a mechanical soft diet are identified at risk of deficient practice. A review of all competencies and practices was implemented to ensure no further non compliant practices with those residents receiving mechanical soft diets. 3. Mechanical soft diet recipe files were reviewed with the Community Chef and cook's on 3/20/26. Education was provided to all production staff on how food should be presented to residents on a mechanical soft diet by the Regional Director of Operations and/or designee. Nursing staff were provided with additional education on reading tickets and approved abbreviations of food items on tickets for proper provision of meals to all residents on 3/26/26 Weekly audit of all mechanical soft diet food recipe compliance will be conducted by the Food Service Director or designee	04/08/2026

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	315515	A. BUILDING B. WING	02/25/2026

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F0805 SS = E	Continued from page 66 [redacted] On 02/20/26 at 8:29 AM, the surveyor observed Resident #5 was in bed with the [redacted] in front of them a Certified Nurse Aide (CNA #1) entered the room, assisted the room mate with the meal, then moved the [redacted] in front of Resident #5, and the surveyor observed a plate of cut up sausage circles, with 3 pieces of French toast, syrup was opened but not poured on the French toast, milk was unopened, watery, in appearance hot cereal was also on the tray, with a beige colored beverage next to the tray in a small cup and the silverware was wrapped in a blue napkin. CNA #1 stated she was not assigned to Resident #5 and did not further [redacted] or [redacted] the resident. On 02/20/26 at 8:43 AM, the surveyor continued the observation, as the resident did [redacted]. The meal ticket was documented [redacted] and “[redacted]” listed (not sausage). On 2/20/26 at 8:44 AM, a [redacted] entered the room, and began cutting the French toast and put the [redacted] in the resident's [redacted]. The surveyor then interviewed the [redacted] about the [redacted] and asked what does “[redacted]” meant and the [redacted] stated she was “not sure” but the resident had “sausage not [redacted].” On 02/20/26 at 8:53 AM, the surveyor interviewed Resident #5's [redacted], regarding the diet and what “[redacted]” was. The [redacted] stated she “doesn't know what that means” and asked the surveyor if she could contact [redacted] to assist. The [redacted] stated Resident #5's [redacted] was [redacted], and it meant that they could [redacted] have [redacted]. Surveyor asked the [redacted] how she would know if the resident had received the [redacted], she stated that dietary checked the tray before they sent it and the CNA's checked the tray before they gave it to the resident. The surveyor requested to speak with [redacted] Staff at that time. On 2/20/26 at 9:06 AM, the surveyor handed Resident #5's meal ticket to the [redacted] who came to Resident #5's room and observed the cut-up sausage circles on Resident #5's tray. The surveyor asked what the [redacted] meant? The [redacted] stated he needed to confirm	F0805	Continued from page 66 A weekly tray accuracy audit of 10 mechanically altered (puree/mechanical soft) trays will be conducted to ensure compliance with the diet order from the kitchen to point of service for three months. Tray accuracy audits will review consistency appropriateness/proper temperature of food and proper portion of all foods presented. All audits will be reviewed weekly with the System Registered Dietitian with updates to Plan of Correction (POC) as needed. All weekly audits will be provided to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) committee monthly Monitoring Plan: All audits will be reviewed weekly by the Food Service Director or designee for identification of areas of noncompliance All audits will be reviewed monthly with the System Registered Dietitian for identification of compliance All audits will be presented to Quality Assurance Performance Improvement (QAPI) monthly for review	04/08/2026

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F0805 SS = E	Continued from page 67 before he answered and the surveyor then asked to see the facility diet manual. On 2/20/26 at 9:13 AM, the [redacted] provided the surveyor with the [redacted] manual and stated everything was in the manual. The [redacted] stated he was still unsure of what the “GR” meant but Resident #5 should have had [redacted] instead of sausage and he would discuss with the [redacted] the meaning of [redacted] On 02/20/26 at 10:28 AM, the surveyor interviewed the [redacted] regarding what "[redacted] meant. The [redacted] stated the meat should have been [redacted] and that the [redacted] had be [redacted] to [redacted] by the [redacted]. A review of the [redacted] signed by the [redacted] on [redacted] revealed that meat or meat substitutes included "[redacted]" and the sample menu included "ground chicken salad" as an entree. On 2/20/20 at 12:03 PM, the surveyor conducted a telephone interview with the [redacted] in the presence of the [redacted]. The [redacted] stated that the "[redacted]" meant [redacted] and that Resident #5 should have had [redacted]. The [redacted] stated that the [redacted] was [redacted] due to [redacted] and stated when asked about the sausage circles that were provided "I do not think [they] would [redacted] on that." On 02/24/26 at 2:54 PM, the survey team met with the [redacted]), [redacted], and [redacted]) to discuss the above concerns. On 02/25/26 at 2:31 PM, the survey team met with the [redacted], [redacted], [redacted], and [redacted] and the facility had no additional information to provide. 8:39-17.4 (a)(1)(2)	F0805		04/08/2026
F0880 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	F0880	1. Resident #3: Licensed Practical Nurse (LPN) #2 was observed on 2/20/26 performing [redacted] care with multiple infection control breaches: hand hygiene for less than 20 seconds, failure to use a clean barrier field, placing sterile [redacted] on scrub pants, and using the same gloves for [redacted]	04/08/2026

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F0880 SS = E	Continued from page 68 a safe, sanitary and 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 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.	F0880	Continued from page 68 treatments without hand hygiene between sites. [redacted] #2 was counseled and re-educated immediately. Resident #25: LPN #1 was observed allowing the resident's [redacted] to be [redacted] on the resident's [redacted], then [redacted] the device to the medication cart surface [redacted] #1 was counseled and re-educated on the proper handling of semicritical items and the requirement to maintain a clean medication preparation surface. Second-floor dining: Certified Nursing Assistant (CNA) #1 was observed on 2/18/26 repeatedly changing gloves without performing hand hygiene between glove changes and between resident contacts. [redacted]) #1 was counseled and re-educated on the requirement to perform hand hygiene before and after each glove application and removal. 2. All residents are potentially affected by improper infection control practices. A review of current hand hygiene competencies for all direct care staff and licensed nurses was completed by the Director of Nursing (DON) and the Infection Preventionist (IP). A facility-wide hand hygiene observation audit was completed by the Infection Preventionist or designee to identify staff not following the facility's hand hygiene policy. All direct care staff and licensed nurses were in-serviced on: - Hand hygiene technique: minimum 20 seconds of friction, turning off faucet with a clean paper towel, drying with a single-use paper towel. - Glove use: hand hygiene required before donning and after removing gloves. - Clean field setup for wound care procedures. - Proper handling and disinfection of semi critical items and resident care equipment. - High-touch surface cleaning for medication carts and tray tables. 3. The following systemic changes were implemented: - The Handwashing/Hand Hygiene policy was reviewed with all staff in-service materials. - The wound care competency was reviewed to verify a specific step requiring establishment of a	04/08/2026

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F0880 SS = E	Continued from page 69 §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: Based on observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain proper infection control practices for a) hand hygiene and establishing a clean field during a [redacted] treatment b) hand hygiene during resident meal service one (1) of two (2) nurses who administered medications to one (1) of four (4) residents during the medication administration observation, to limit the potential of spreading infection. The deficient practice was evidenced by the following: Reference: According to Centers for Disease Control and Prevention, Guideline for Disinfection and Sterilization in Healthcare Facilities, dated 11/28/23, included that: Semicritical items contact mucous membranes or non-intact skin. This category included respiratory therapy… These medical devices should be free from all microorganisms. a. On 2/20/2026 at 11:47 AM, the surveyor observed Licensed Practical Nurse (LPN #2) perform a treatment for Resident #3 in the resident's bathroom. Prior to performing the treatment LPN #2 was observed performing hand hygiene. LPN#2 turned on the faucet, wet her hands, applied soap and lathered for six seconds. LPN #2 then placed her hands under the running water and then removed her hands from the running water and lathered for 10 more seconds and rinsed hands. LPN #2 turned off facet with wet hands. LPN #2 then dried her hands with paper towel and applied gloves. LPN #2 observed Resident #3's [redacted] and then	F0880	Continued from page 69 clean barrier field using the bedside table (not personal clothing or surfaces), prior to any dressing application. - A protocol for handling semi critical items was developed and distributed to all licensed nurses. The protocol requires cleaning and disinfection of any semi critical item before returning it to a shared or common area. - Medication cart cleaning was added to the licensed nurse shift responsibilities, with a cleaning log implemented. - The Dressing a Wound competency was updated and re-dated. 4. The Infection Preventionist or designee will conduct hand hygiene observation audits for a minimum of five staff members per shift weekly for four weeks and monthly for three months. Wound care technique will be directly observed by the Director Of Nursing (DON) or designee for 3 of wound care treatments monthly. Medication cart cleanliness will be audited weekly. Compliance threshold is set at 90%. Findings below threshold will result in immediate re-education and competency re-validation. Wound treatment and medication cart audit results will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The committee will determine whether further monitoring or action is necessary.	04/08/2026

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F0880 SS = E	Continued from page 70 [redacted] Resident #3 with [redacted]. LPN#2 performed hand hygiene. She turned on the faucet, wet her hands, applied soap and lathered for 10 seconds. LPN #2 placed her hands under the running water and then removed her hands from the running water and lathered for 7 more seconds and rinsed hands. LPN #2 turned off facet with wet hands. LPN #2 then dried her hands with paper towel and applied gloves. LPN#2 kneeled her right knee down on the bathroom floor and kept her left knee bent. She opened the packages o[redacted] and placed the [redacted] on her [redacted] scrub pants. There was no [redacted] observed. LPN#2 [redacted] to the [redacted] and [redacted] the [redacted], then [redacted] to the [redacted]. The LPN #2 did not perform hand hygiene and proceeded to perform the same treatment on the [redacted] the [redacted]. After completing the treatment, LPN#1 performed hand hygiene. She turned on the faucet, wet her hands, applied soap and lathered for 8 seconds. LPN #1 placed her hands under the running water and then removed her hands from the running water and lathered for 7 more seconds and rinsed hands. LPN #1 turned off facet with wet hands. LPN #1 then dried her hands with paper towel and applied gloves. On 2/20/26 at 11:58 AM, the surveyor discussed the concerns with LPN #1. LPN #1 stated that she should have washed her hands for the length of singing the happy birthday song 2 times or 20 seconds. Stated that she placed her hands under the running water to "make them more wet." She acknowledged that she should have rinsed her hands and dried them with a clean paper towel and then turned off the faucet with a clean paper towel. In addition, she acknowledged that the opened [redacted] should not have been placed on her scrubs. She stated, " I should have left them in the packet." She stated, "I didn't perform hand hygiene and change my gloves between treatments because I was under the impression it was one treatment." On 02/24/2026 11:14 AM Interview with the [redacted]) and [redacted], the surveyor discussed the concerns regarding hand hygiene and treatment observation	F0880		04/08/2026

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F0880 SS = E	Continued from page 71 for LPN#2 [redacted] and [redacted] acknowledged that hand washing should be done for 20 seconds, and the faucet should have been shut off using a clean paper towel. The [redacted] stated, "the Nurse should have shut off the faucet using a paper towel if not she would have contaminated her hands." The [redacted] and [redacted] acknowledged that the Nurse should have performed hand hygiene in between the two treatments and that LPN #2 should not have [redacted] the [redacted] on her [redacted] scrub pants and that should not have been used for the [redacted] "because it is contaminated." The surveyor reviewed facility provided policy, "Infection Control Policies and Procedures Handwashing/Hand Hygiene", revised 3/12/25 which included: Purpose: The facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: Washing Hands 3. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) away from the stream of water. 5. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. The surveyor reviewed facility provided competency, "Dressing a Wound", undated which included: Title- Supplies Description- Assemble supplies on a protective barrier on the bedside table. Rationale- Allows for efficiency and prevents disruption of the procedure. On 2/18/26 at 12:27 PM, the surveyor observed lunch in the second-floor dining room. A Certified Nurse Aide (CNA #1) was observed wearing gloves and with gloved hands assisted a resident to perform hand hygiene with a hand towelette. CNA #1was observed to remove her gloves, put on a clean pair of gloves, without performing hand hygiene and with gloved hands poured soup for another resident. CNA #1 then removed her gloves, did not perform hand hygiene, assisted a third	F0880		04/08/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F0880 SS = E	Continued from page 72	F0880		04/08/2026

resident with a can of soda with her bare hands, and then put on a clean pair of gloves without performing hand hygiene. With gloved hands, she then assisted a fourth resident to perform hand hygiene using a hand towelette. She then removed her gloves and without performing hand hygiene she assisted a fifth resident with a can of soda with her bare hands. CNA #1 then put on a clean pair of gloves without performing hand hygiene. The surveyor asked CNA #1 if hand hygiene was needed before and/or after gloving and she stated she did not need to perform hand hygiene if she assisted residents with hand towelettes, she then stated, "I probably should have performed hand hygiene".

On 2/24/2026 at 2:53 PM, the survey team met with the [redacted] along with the [redacted]), the [redacted], the [redacted], and the [redacted] and discussed the above concerns.

On 02/25/2026 at 10:18 AM, the [redacted] confirmed that hand hygiene was needed between different pairs of gloves.

The surveyor reviewed facility provided policy, "Infection Control Policies and Procedures Handwashing/Hand Hygiene", revised 3/12/25 which included:

Purpose: The facility considers hand hygiene the primary means to prevent the spread of infections.

Procedure:

2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents. and visitors.

7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations:

f. Before donning (putting on) gloves;

m. After removing gloves;

p. Before and after assisting a resident with meals

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F0880 SS = E	Continued from page 73 Apply and Removing Gloves Perform hand hygiene before applying gloves When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove Perform hand hygiene NJAC 8:39-19.4(a) b. On 2/20/26 at 8:41 AM, the surveyor observed Licensed Practical Nurse (LPN #1) prepare medications (meds) for Resident #25 on the surface of the medication cart. The meds included a physician's order dated [redacted], for [redacted]) [redacted] mcg [redacted]r for [redacted] application [redacted]] with [redacted] device one time a day for [redacted] On 2/20/26 at 8:46 AM, LPN #1 entered the resident's room, followed by the surveyor and observed the administration of the meds to the resident. At 8:50 AM, LPN #1 [redacted] to the resident that they had to [redacted] and [redacted] the [redacted] their [redacted]. At 8:51 AM, the surveyor observed the resident [redacted] their [redacted]] and placed it on their tray table [a high touch surface; frequently touched area], LPN #1 handed the glass of [redacted] to the resident, to [redacted] and [redacted] At that time, LPN #1 [redacted] the [redacted] device from the tray table, [redacted] to the medication cart, [redacted] the [redacted]r on the medication cart, unlocked the medication cart, grabbed the carton, was going to place the medication device into the carton, which was stored in the medication cart. On 2/20/26 at 8:54 AM, the surveyor discussed the	F0880		04/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER **ATRIUM AT NAVESINK HARBOR, THE**		STREET ADDRESS, CITY, STATE, ZIP CODE **40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701**	

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F0880 SS = E	Continued from page 74 concern that the [redacted] device was placed on the resident's tray table, a high touch surface, was placed on the medication cart, where medications were prepared for other residents and was to be returned into the medication cart without any cleaning of the top of the medication cart or medication device. At that time, LPN #1 acknowledged and confirmed that she should have cleaned the device and should not have placed the [redacted] on the medication cart. On 2/24/26 at 2:54 PM, during a meeting with the survey team, the [redacted], the [redacted], the [redacted], and the [redacted], the surveyor discussed the concern with the [redacted] device, a semicritical item was placed on the tray table, a high touch surface, without a barrier, and disinfection in between, then placed on top of the medication cart where other resident's medications for administration were prepared, and placed into the boxed manufacturer's container which was to be stored in the medication cart with other resident's medications. On 2/25/26 at 10:19 AM, during a meeting with the survey team, the [redacted], the [redacted], and the [redacted], the [redacted] stated he had spoken with the [redacted]) and was advised that the manufacturer's recommendation does not require storage of the inhaler in a plastic bag and the [redacted] cover was sufficient. On 2/25/26 at 2:18 PM, during an interview with the surveyor, the [redacted]) stated that a tray table was a high touch area and required cleaning 3 to 4 times a day to prevent spread of disease, germs, bacteria and overall infection control. The [redacted] stated that med carts were cleaned by the nurses. A review of the provided facility's communication with the [redacted] dated [redacted] included: Medication carts/med prep areas should be clean and free from contaminated equipment... No further information was provided.	F0880		04/08/2026

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F0880 SS = E	Continued from page 75 A review of the provided facility policy for Cleaning and Disinfection of Resident-Care Items and Equipment, dated 3/1/17, included that Resident-Care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendation for disinfection and the OSHA Bloodborne Pathogens Standards. Under, Procedure for semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin. Such devices should be free from all microorganisms.	F0880		04/08/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F0582	1. Residents #12 and #46 were identified as having received the required Skilled Nursing Facility Advance Beneficiary Notice and Notice of Medicare None Coverage notifications outside of the required timeframes. Both residents and/or their responsible parties were contacted to ensure they were informed of their rights under Medicare coverage. 2. Social Services will review all current residents who will be discharged from Medicare part A to ensure that the residents will receive timely beneficiary notices. Social Services staff were notified of the requirement for timely issuance Skilled Nursing Facility Advance Beneficiary Notice and Notice of Medicare None Coverage. 3. The Licensed Nursing Home Administrator reviewed and revised the facility process for issuance of Skilled Nursing Facility Advance Beneficiary Notice and Notice Of Medicare None Coverage to include: - A tracking log for all Medicare Part A admissions with anticipated last covered day. - A two-day advance alert process for issuing required notices. - Social Services inserviced on the required notice timeframes and documentation requirements. 4. The Social Worker Or designee will audit 100% of	04/08/2026

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

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F0582 SS = D	Continued from page 76 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and document review, it was determined that the facility failed to issue the required Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN) and Notice of Medicare Non-Coverage (NOMNC) in the proper time frame for 2 of 3 residents (Resident #12, and Resident #46) reviewed for Beneficiary Protection Notification. This deficient practice was evidenced by the following: On 2/18/26 at 1:36 PM, the surveyor reviewed the facility provided list of residents who were discharged from [redacted] covered [redacted] in the last six months and randomly chose three residents and requested the Beneficiary Notices from the [redacted]). On 2/21/26 at 1:55 PM, the surveyor reviewed the Beneficiary Notices provided which revealed the following: Resident #12 had a [redacted] episode that began on [redacted] and a last covered day of [redacted]. An email provided by the facility revealed the SNF ABN and the NOMNC were both sent to the Resident #12's [redacted] on [redacted] at 4:06 PM.	F0582	Continued from page 76 residents with a change in Medicare coverage status weekly for four weeks and monthly for three months. Compliance threshold is set at 100%. Audit findings will be reported to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) committee monthly until substantial compliance is achieved.	04/08/2026

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F0582 SS = D	Continued from page 77 Resident #46 had a [redacted] episode that began on [redacted] and a last covered day of [redacted] The SNF ABN and NOMNC provided by the facility were both signed by Resident #46's [redacted] and dated [redacted] On 2/24/2026 at 2:53 PM, the survey team met with the [redacted], along with the [redacted], the [redacted], the [redacted], and the [redacted]. The surveyor notified the facility management of the above concerns regarding the Beneficiary Notices. On 2/25/26 at 10:18 AM, the [redacted] stated that she had no further information to provide. NJAC 8:39 - 5.1(a)	F0582		04/08/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F0756	1. The Consultant Pharmacist (CP) was notified of the identified concern on 2/19/26 and provided education on the regulatory expectation for monthly Treatment Administration Record review as part of the Medication Regimen Review (MRR). 2. A review of all current Treatment Administration Records was completed to identify any orders lacking required elements such as dose, strength, or frequency. Any incomplete orders were immediately brought to the attention of the Director Of Nursing (DON) and the prescribing physician for clarification. The CP was directed to complete a review of all active TARs as part of the next monthly MRR cycle. 3. The Licensed Nursing Home Administrator and Director of Nursing (DON) met with the CP to review the facility's MRR policy and expectations under 42 CFR 483.45(c). The CP was instructed to: - Review the TAR as part of every monthly MRR cycle, not on a 6–12 month schedule. - Document all identified irregularities on a separate written report submitted to the attending physician, Medical Director, and Director of Nursing (DON).	04/08/2026

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

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	315515	A. BUILDING B. WING	02/25/2026

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F0756 SS = D	Continued from page 78 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to identify medication irregularity from 1/13/26 to 2/19/26, during the monthly Medication Record Review (MRR) of the [redacted] for one (1) of three (3) residents (Resident #1) reviewed for [redacted]. The deficient practice was evidenced by the following: On 2/18/26 at 12:16 PM, the surveyor observed Resident #1 in the dining room seated in a [redacted] with [redacted] and was [redacted] by a facility staff. On 2/19/26 at 8:57 AM, the surveyor observed Resident #1 asleep on their back [redacted] by the surveyor's voice [redacted] was [redacted] and legs were covered with a blanket. The surveyor reviewed the medical record for Resident #1. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] out of 15, which indicated Resident #1 was [redacted]. A review of	F0756	Continued from page 78 - Flag any medication orders that lack required dose, strength, or frequency information as irregularities requiring timely resolution. 4. The Director Of Nursing (DON) or designee will review CP monthly MRR reports within five business days of receipt to confirm: (1) the TAR was reviewed, (2) any identified irregularities were documented and reported, and (3) physician follow-up was obtained and documented. A 100% review of MRR reports will be conducted for three consecutive months. Findings will be reported to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) committee monthly.	04/08/2026

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F0756 SS = D	Continued from page 79 Section [redacted] Conditions, reflected that the resident had [redacted] that was [redacted] due to [redacted] of [redacted] by [redacted]) upon admission to the facility and [redacted] a [redacted] device on the [redacted] and [redacted]. A review of the [redacted] [time note included] [redacted] note included [redacted] treatment: [redacted] the [redacted] with [redacted] to [redacted], [redacted] with [redacted] %) [redacted] twice a day with [redacted]. A small handwritten initial dated [redacted], was reflected on the side. A review of the [redacted] order entry made by the [redacted] included to [redacted] with [redacted]. The [redacted] was not documented on the "new wound order." On 2/19/26 at 9:11 AM, the surveyor and LPN #2 reviewed the active [redacted] Treatment Administration Record (TAR) together and observed the order for [redacted] was started on [redacted] for [redacted] At that time, LPN #2 could not show that the physician was contacted to clarify the [redacted], a recommendation made by [redacted] #2 or [redacted] A review of the CP's MRR from 1/1/26 to 1/25/26 included that Resident #1's chart was reviewed sometime during the specified period and did not require any recommendations. On 2/19/26 at 1:16 PM, during an interview with the surveyors, the [redacted] stated that he reviewed the Treatment Administration Record (TAR) every 6 to 12 months. On 2/24/26 at 2:54 PM, during a meeting with the survey team, the [redacted], [redacted], the [redacted], the [redacted], and the [redacted], the surveyor discussed the concern that missing [redacted] for the [redacted] was not identified during the CP's MRR.	F0756		04/08/2026

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F0756 SS = D	Continued from page 80 At that time, the [redacted] stated that the expectation was that all medication be reviewed monthly. A review of the provided facility policy, titled Medication Regimen Review (MRR), dated 3/5/35 included that MRR or Drug Regiment review is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. NJAC 8:39- 29.1(b), 29.3 (a)(1)	F0756		04/08/2026
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:	F0849	1. The Licensed Nursing Home Administrator contacted Hospice #1 to obtain a current, signed written agreement. A current agreement with the updated Hospice name was obtained and signed by 2/25/26. 2. A review of all residents receiving hospice services was completed to identify each hospice provider and confirm that a current, signed written agreement is on file for each. No missing or outdated agreements were identified. 3. The Licensed Nursing Home Administrator (LNHA) established a process to track all hospice agreements and renewal dates. A hospice contract log was created to document each active hospice provider, the effective date of the agreement, and the date of the next scheduled review. The Licensed Nursing Home Administrator will be responsible for ensuring a current agreement is on file before any new hospice provider begins services at the facility. 4. The Licensed Nursing Home Administrator or designee will review the hospice contract log monthly to confirm all active hospice agreements are current and signed. A 100% review of all hospice provider agreements will be conducted quarterly. Any lapsed or missing agreement will be addressed within 24 hours. Findings will be reported to the	04/08/2026

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F0849 SS = D	Continued from page 81 (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed	F0849	Continued from page 81 Quality Assurance Performance Improvement (QAPI) committee monthly for three months.	04/08/2026

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F0849 SS = D	Continued from page 82 therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice:	F0849		04/08/2026

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F0849 SS = D	Continued from page 83 (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and document review, it was determined that the facility failed to have a current written agreement between the Medicare-certified [redacted] and the facility for 1 of 1 resident (Resident #28) reviewed for [redacted] of [redacted]. The deficient practice was evidenced by the following: On 2/20/2026 at 9:23 AM, the surveyor observed and interviewed Resident #28 who was in their room. On 2/24/26 at 10:20 AM, the surveyor reviewed the resident's hard chart (paper chart) which revealed the following: The Face Sheet revealed the resident had diagnoses including but not limited to: [redacted]	F0849		04/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER: **ATRIUM AT NAVESINK HARBOR, THE**		STREET ADDRESS, CITY, STATE, ZIP CODE: **40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0849 SS = D	Continued from page 84 [redacted]). The physician's orders included an order dated [redacted] for [name redacted #1][redacted]. A review of Resident #28's electronic medical record (EMR) revealed the following: The quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted] included a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated [redacted]. A review of the individual comprehensive care plan (ICCP) included a focus area that the resident was [redacted] with [redacted] #1 for "[redacted] and per my [redacted] for diagnosis of [redacted]". A review of the hospice communication book, kept behind the nursing station, revealed Resident #28 was admitted to [redacted] #1 in [redacted] for a diagnosis of [redacted]. On 2/24/26 at 2:06 PM, the surveyor reviewed the facility provided [redacted] contract, with an effective date of [redacted], between the facility and [name redacted #2][redacted] ([redacted] #2). The surveyor then asked the [redacted] for the contract with [redacted] #1 as identified in Resident #28's medical record and she stated the [redacted] changed names. On 2/24/2026 at 2:53 PM, the survey team met with the [redacted], along with the [redacted], the [redacted], the [redacted], and the [redacted]. The surveyor notified the facility management of the above concerns regarding the [redacted] contract. On 2/25/26 at 10:18 AM, the [redacted] provided the surveyor with a social service note dated [redacted] which indicated the [redacted] with Resident #28's [redacted]), who had [redacted] to make a [redacted] referral to H #1. On 2/25/26 at 2:00 PM, the facility administration had no further information to provide. NJAC 8:39-27.1(a)	F0849		04/08/2026

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031304	A. BUILDING B. WING	02/25/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Survey Date: 2/25/26 Census: 32 Sample: 12 + 2 closed records The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S0000		04/08/2026
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of other facility documentation, it was determined that the facility failed to have a system in place to ensure that employees received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to the first day of employment or upon employment. This deficient practice was identified for 7 of 56	S1405	1. Upon identification of this deficiency, the Human Resources Director (HRD) and Director of Nursing (DON) immediately reviewed the files of all seven employees identified: Employee #1 (hired [redacted] Employee #4 (hired [redacted]), Employee #5 (hired [redacted]), Employee #19 (hired [redacted], Employee #22 (hired [redacted]), Employee #24 (hired [redacted] - no employee with this hire date was found, and Employee #25 (hired [redacted]). For each employee currently active, an expedited appointment for a physical examination by a Physician, APN, or Licensed PA was arranged and the completed, signed Physical Exam Form obtained and filed. For any employee no longer employed, a written notation was placed in the file documenting the gap in compliance and the status of the record. 2. A retrospective audit of all employee files for staff hired since 9/19/2024 (the last recertification survey date) was initiated by the Human Resource Director (HRD) to identify any additional employees with missing or incomplete physical examination documentation. Any employee found without a completed Physical Exam Form was immediately scheduled for examination or, where applicable, had a documented nursing assessment and physician	04/08/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER: ATRIUM AT NAVESINK HARBOR, THE		STREET ADDRESS, CITY, STATE, ZIP CODE: 40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S1405	Continued from page 1 employee files reviewed and was evidenced by the following: On 2/18/2026 at 9:40 AM, the surveyor requested a list of all employees, including contracted employees, that had been hired since [redacted] (last recertification survey date) and included employee name, date of hire, title, and date of separation (if applicable) from the Human Resources Director (HRD). A review of employee files revealed the following: Employee # 1 was hired on [redacted]; there was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 4 was hired on [redacted]; there was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 5 was hired on [redacted]; there was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 19 was hired on [redacted]; there was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 22 was hired on [redacted]; there was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 24 was hired on [redacted]; there was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. Employee # 25 was hired on [redacted] there was no Physical Exam Form signed by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant. A review of facility policy "Hiring Policy: Employment Application & Pre-Employment Checks", revised April 2025 included: Policy: [Facility Name], Inc. (SSL) is an equal opportunity employer and believes in the fair treatment of all applicants… Applicants for certain	S1405	Continued from page 1 follow-up arranged within the required 30-day window. All findings identified during the audit were corrected and education by the Regional Human Resources Director was provided to the Human Resources staff and hiring supervisors involved. 3. The facility's pre-employment onboarding checklist was revised to include the Physical Exam Form (signed by a Physician, APN, or Licensed PA) as a mandatory clearance item that must be completed and filed in the employee record prior to the employee's hire date. A facility-wide Human Resources (HR) tracking log was implemented to monitor the status of physical exam documentation for all new hires, with weekly review by the DON or designee for the first 90 days post-implementation. The facility hiring policy, "Hiring Policy: Employment Application & Pre-Employment Checks," was reviewed and updated to explicitly define the required examination timeline, acceptable clinician types, and supervisory sign-off requirements confirming documentation receipt prior to hire. The Administrator and Human Resource Director (HRD) provided mandatory in-service education to HR staff and hiring managers on the requirements of NJ 8:39-19.5(a), including documentation standards and consequences of non-compliance. Education was documented with a sign-in sheet. 4. The Human Resource Director (HRD) or designee will audit 100% of new hire employee files within seven days of each hire date to confirm receipt and filing of a completed Physical Exam Form. Audits of new hire files will be conducted weekly for four weeks, followed by monthly audits for three months, or until such time as substantial compliance is achieved. Compliance thresholds are set at 90%; any rate below this threshold will trigger an immediate review and corrective action plan. Findings will be reported at the monthly Quality Assurance and Performance Improvement (QAPI) meetings, and corrective actions will be documented and monitored.	04/08/2026

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **031304**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/25/2026**
NAME OF PROVIDER OR SUPPLIER **ATRIUM AT NAVESINK HARBOR, THE**		STREET ADDRESS, CITY, STATE, ZIP CODE **40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S1405	Continued from page 2 positions will also be required to pass a fitness for duty test, take tuberculosis/PPD & Covid screening tests. If the candidate does not successfully complete the fitness for duty exam by the date of hire, a registered professional nurse must perform a nursing assessment on the date of hire with the physician completing a physical examination and health history within 30 days of the date of hire. On 2/25/26 at 2:31 PM, during an exit conference held with the Regional Corporate Nurse (RCN), Regional Director of Operations (RDO), Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), no further information was provided. NJ 8:39-19.5(a.)	S1405		04/08/2026
S1410	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(b)(1) (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of pertinent facility documentation it was determined that the facility failed to have a process in place to ensure all newly hired employees completed the required [redacted] screening upon hire. The deficient practice was identified for 7 of 56 employee files reviewed and was evidenced by the following:	S1410	1. Upon identification of this deficiency, the Director of Nursing (DON) and Infection Preventionist(IP) immediately reviewed the [redacted] screening status of all seven employees identified: Employee #1 (hired [redacted]), Employee #4 (hired [redacted]), Employee #5 (hired [redacted]), Employee #19 (hired [redacted]), Employee #22 (hired [redacted], Employee #24 (hired [redacted])- no employee with this hire date was found, and Employee #25 (hired [redacted]. For each currently active employee without documented [redacted] screening, a [redacted] or approved IGRA alternative ([redacted]) was arranged, administered, and results documented in the employee file. Where a valid exception existed, supporting clinical documentation was obtained and placed in the file. For employees no longer employed, a notation documenting the gap was added to the record. 2. A retrospective audit of all employee files for staff hired since 9/19/2024 was completed by the Human Resources Director (HRD) and Infection Preventionist to identify any additional employees missing TB screening documentation. All active employees identified as lacking documentation were scheduled for screening. Any exceptions were documented with supporting evidence in accordance with NJ 8:39-19.5(b). Findings identified during the audit were corrected and education was provided to Human Resources (HR) staff and Infection Preventionist by the Area Human Resources Director. 3.	04/08/2026

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031304	A. BUILDING B. WING	02/25/2026

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

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S1410	Continued from page 3 On 2/18/2026 at 9:40 AM, the surveyor requested a list of all employees, including contracted employees, that had been hired since [redacted] (last recertification survey date) and included employee name, date of hire, title, and date of separation (if applicable) from the Human Resources Director (HRD). A review of employee files revealed the following: Employee # 1 was hired on [redacted] There was no documentation in the file to indicate that a [redacted] was completed upon hire. Employee # 4 was hired on [redacted]; There was no documentation in the file to indicate that a [redacted] was completed upon hire. Employee # 5 was hired on [redacted]; There was no documentation in the file to indicate that a [redacted] was completed upon hire. Employee # 19 was hired on [redacted]; There was no documentation in the file to indicate that a [redacted] was completed upon hire. Employee # 22 was hired on [redacted]; There was no documentation in the file to indicate that a [redacted] completed upon hire. Employee # 24 was hired on [redacted] There was no documentation in the file to indicate that a [redacted] was completed upon hire. Employee # 25 was hired on [redacted] There was no documentation in the file to indicate that a [redacted] was completed upon hire. A review of facility policy "Hiring Policy: Employment Application & Pre-Employment Checks",	S1410	Continued from page 3 The facility's pre-employment onboarding checklist was revised to include a mandatory TB screening documentation item, confirming completion of the two-step Mantoux or an approved alternative prior to the employee's first scheduled shift, unless a valid documented exception applies. Exceptions must be supported by written clinical documentation filed in the employee record. The TB screening requirement was incorporated into the HR new hire monitoring log established in conjunction with the S1405 corrective action, with weekly review by the (Director of Nursing) DON or designee for the first 90 days. The facility's infection control and hiring policies were reviewed and updated to clearly define required screening methods, acceptable alternatives, documentation of valid exceptions, and the required timeline for two-step completion — with Step 2 administered one to three weeks after Step 1 when the first result is less than 10mm induration. The DON and Infection Preventionist provided mandatory in-service education to HR staff, hiring managers, and nursing leadership on NJ 8:39-19.5(b)(1) requirements. Education was documented with a sign-in sheet. 4. The HRD or designee will audit 100% of new hire employee files within seven days of each hire date to confirm TB screening documentation. Audits will be conducted weekly for four weeks, followed by monthly audits for three months, or until such time as substantial compliance is achieved. Compliance thresholds are set at 90%; any rate below this threshold will trigger an immediate review and corrective action plan. TB screening documentation compliance will be included as a standing audit item for all new hires and reviewed at the monthly QAPI meetings. Any trends or recurring deficiencies will trigger further education or systems adjustments.	04/08/2026

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER **ATRIUM AT NAVESINK HARBOR, THE**		STREET ADDRESS, CITY, STATE, ZIP CODE **40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701**	

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S1410	Continued from page 4 revised April 2025 included: Policy: [Facility Name,] Inc. (SSL) is an equal opportunity employer and believes in the fair treatment of all applicants… Applicants for certain positions will also be required to pass a fitness for duty test, take tuberculosis/PPD & Covid screening tests. If the candidate does not successfully complete the fitness for duty exam by the date of hire, a registered professional nurse must perform a nursing assessment on the date of hire with the physician completing a physical examination and health history within 30 days of the date of hire. On 2/25/26 at 2:31 PM, during an exit conference held with the Regional Corporate Nurse (RCN), Regional Director of Operations (RDO), Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), no further information was provided. NJ 8:39-19.5(b.)	S1410		04/08/2026

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **315515**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 04/14/2026 in relation to the 02/25/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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.

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/14/2026

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

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 04/14/2026 in relation to the 02/25/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **315515**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN (2ND ...** B. WING	(X3) DATE SURVEY COMPLETED **02/25/2026**

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

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 02/20/2026 and The Atrium at Navesink Harbor was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The Atrium at Navesink Harbor is a 12-story building that was built in 1965. Skilled Nursing is located on the second and third floors of the building. It is composed of Type I protected construction. The facility is divided into four-smoke zones. The generator powers approximately 50% of the building as per the U.S. FOIA (b)(6). The current occupied beds were 32 out of 43.	K0000		03/04/2026
K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS	K0222	1. The following actions were taken immediately upon identification of the deficiency: On 02/20/2026, upon confirmation of the malfunction, an emergency work order was placed with the door hardware vendor to repair the delayed-egress locking mechanism on both second-floor horizontal exit doors. Both doors were repaired on 3/4/26 and verified to open in accordance with NFPA 101 §7.2.1.6.1. Repair documentation is on file. The Maintenance Director conducted a full walk-through of all egress doors, horizontal exits, and delayed-egress locking devices throughout the facility. No additional malfunctions were identified. 2.	03/04/2026

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 reverse for further 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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN (2ND ...** B. WING	(X3) DATE SURVEY COMPLETED **02/25/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0222 SS = E Bldg. 01	Continued from page 1 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure two of two horizontal exit access doors with signs reading "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" would open in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.6.1.1 (4). This deficient practice	K0222	Continued from page 1 All 18 residents on the second floor at the time of survey were potentially affected. Both doors were repaired and verified by the Maintenance Director (MD) to open in accordance with NFPA 101 §7.2.1.6.1 within 24 hours of survey completion. Repair documentation is on file. 3. The Preventive Maintenance (PM) Policy has been revised by the Director of Risk Management (DRM) to include a formal monthly operational testing protocol for all delayed-egress locking devices throughout the facility, consistent with NFPA 101 §7.2.1.6.1 and manufacturer specifications. A Delayed-Egress Door Inspection Checklist has been developed and implemented by the DRM. The checklist documents the date of testing, door location, pass/fail result, and technician signature. The [redacted] and all maintenance staff have been educated by the DRM on proper testing procedures for delayed-egress devices and documentation requirements. Nursing staff on the second floor received in-service education from the MD on fire egress procedures and manual evacuation assistance protocols. A licensed life safety contractor has been engaged to conduct annual inspections and certify all delayed-egress and special locking devices throughout the facility. 4. Monthly delayed-egress door testing results will be reviewed by the Administrator and Maintenance Director. Any failed test will result in an immediate work order and corrective action within 24 hours. Completed inspection checklists will be submitted to the Safety Committee by the MD and reviewed at the monthly Environment of Care/Safety Meeting.	03/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315515	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN (2ND ... B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER: ATRIUM AT NAVESINK HARBOR, THE		STREET ADDRESS, CITY, STATE, ZIP CODE: 40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0222 SS = E Bldg. 01	Continued from page 2 had the potential to affect all 18 residents who resided on the second floor of the facility and was evidenced by the following: Observations on 02/20/26 at 2:00 PM of all the facility's horizontal exit cross corridor doors across from the living room to the assisted living section on the second floor revealed the doors were provided with signs on both doors that read "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS." Further observation at this time revealed both doors did not open when pushed with significant force by the U.S. FOIA (b)(6). During an interview at the time of observation, the U.S. FOIA (b)(6) confirmed the double horizontal exit doors on the second floor did not open when pushed on. NJAC 8:39-31.1(c), 31.2(e)	K0222	Continued from page 2 The Safety Committee will audit compliance with the testing protocol on a quarterly basis for a minimum of twelve (12) months, with results reported to the Quality Assurance Performance Improvement (QAPI) Committee. QAPI oversight of this corrective action plan will continue until three (3) consecutive months of 100% compliance are documented.	03/04/2026

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **315515**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/25/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 02/20/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		03/11/2026

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 reverse for further 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.

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **315515**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN (2ND ...** B. WING	(X3) DATE SURVEY COMPLETED **04/12/2026**
NAME OF PROVIDER OR SUPPLIER **ATRIUM AT NAVESINK HARBOR, THE**		STREET ADDRESS, CITY, STATE, ZIP CODE **40 RIVERSIDE AVENUE , RED BANK, New Jersey, 07701**	

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 4/12/2026 in relation to the 2/25/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		04/13/2026

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 reverse for further 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.

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