STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315021	A. BUILDING _____ B. WING _____	C 05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	155 HAZEL STREET CLIFTON, NJ 07011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Dates: 05/01/23 through 05/05/23 Survey Census: 179 Sample Size: 43 Supplemental Residents: 28 A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 05/01/23 through 05/05/23 and was found not to be in substantial compliance with 42 CFR 483 subpart B. On 05/04/23 at 7:15 PM, the Administrator and Director of Nursing were notified that an Immediate Jeopardy existed at F880-J Infection Control due to the failure to sanitize per manufacturer's instructions a multi-use glucometer between residents. The residents had unknown statuses for contagious bloodborne pathogens such as Hepatitis B, Hepatitis C, and/or HIV. The facility provided an acceptable Removal Plan of the Immediate Jeopardy which the survey team verified implementation and removed the Immediate Jeopardy on 05/05/23 at 12:22 PM. The deficient practice remained at a scope and severity of D (isolated for more than minimal harm) following the removal of the immediate jeopardy.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	F 640		5/31/23

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

Electronically Signed | 05/25/2023

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F 640	Continued From page 1 §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer,	F 640		

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F 640	Continued From page 2 reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and review of the facility's policy, the facility failed to provide timely "Minimum Data Set (MDS)" data submission in one (Resident (R) 343) of six residents reviewed for "MDS" transmission out of a total sample of 43 residents. Findings include: Review of R343's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R343 was admitted to the facility on [redacted] R343's admitting diagnoses included [redacted] Review on 05/02/23 of R343's MDS with an Assessment Reference Date (ARD) of [redacted] located under the "MDS" tab, indicated this "MDS" was not complete due to the majority of the "MDS" sections being colored red (in process) instead of green (completed).	F 640	F640 Resident # 343 had MDS with ARD of [redacted] completed. All residents have the potential to be affected by the same deficient practice. MDS coordinator was in-serviced by Administrator on submitting timely assessments. The Administrator or Assistant Administrator will do an audit weekly x4 & then monthly x 3 to ensure timely assessments. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	

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F 640	Continued From page 3 Review on 05/03/23, of R343's "MDS" indicated the majority of the "MDS" sections were colored yellow (in progress). Review on 05/04/23, of R343's "MDS" indicated the majority of the "MDS" sections were colored green (completed). Review on 05/04/23 of R343's "MDS" under the tracking/discharge heading indicated: Next full: ARD: 05/02/23 2 days overdue; Next ARD: 04/26/23 8 days overdue. During an interview on 05/04/2023 at 2:35 PM with the MDS Coordinator (MDSC) 2, the MDSC2 stated since 2020 she has been the only MDS Coordinator for the majority of that time. MDSC2 said the MDS department should be staffed with two full time coordinators and one per diem staff member. MDSC2 said she currently has per-diem staff to assist, but only for 16-20 hours a week. MDSC2 confirmed R343's MDS data submission was late. During an interview on 05/04/23 at 5:40 PM with the Administrator, the Administrator said timely submission of MDS information had been an ongoing issue. The Administrator agreed it was impossible for one MDS Coordinator to fulfill the MDS requirements for a facility of this size. The Administrator stated the corporate office has approved to continue to supply the MDS department with per diem staff and remote staff assistance. A review of the facility's policy titled, "Resident Assessments" revised 03/2022 indicated, "Policy Statement A comprehensive assessment of every	F 640		

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F 640	Continued From page 4 resident's needs is made at intervals designated by OBRA (Omnibus Budget Reconciliation Act of 1987) and PPS (Prospective Payment System) requirements. Policy Interpretation and Implementation ...1. The resident assessment coordinator is responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessments - conducted for all residents in the facility: (1) Admission Assessment (Comprehensive) ...b. PPS required assessment ...(1) 5-day Assessment ...2. The RAI (Resident Assessment Instrument) User's Manual (Chapter 2) provides detailed information on timing and submission of assessments. 3. A "comprehensive assessment" includes: a. completion of the Minimum Data Set (MDS) ..." A review of Centers for Medicare and Medicaid Services (CMS) Manual, "RAI Version 3.0 Manual" Chapter 2 page 2-19 stated, " ...Assessment Management Requirements and Tips for Comprehensive Assessments: The ARD (item A2300) is the last day of the observation/look back period ...For example, if the ARD is set for day 14 of a resident's admission ...while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days) ...RAI OBRA-required Assessment Summary ...MDS Completion Date ...No Later Than 14th calendar day of the resident's admission (admission date + 13 calendar days) ...01. Admission Assessment ...The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances,	F 640		

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F 640	Continued From page 5 a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home ..." NJAC 8:39-11.2(e)	F 640		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of facility policy, the facility failed provide assistance with grooming and personal hygiene in eight residents (R)292, R2, R17, R20, R136, R162, R33, and R72) from a total sample of 43 residents. This had the potential to affect the residents' physical and mental well-being. Findings include: 1. Observation on 05/03/23 at 3:07 PM revealed R292 dressed, sitting in [redacted] wheelchair with [redacted] hair uncombed. During an interview with R292 on 05/03/23 at 3:07 PM, the resident stated [redacted] had not received a shower or bath since being admitted to the facility on [redacted] R292 stated that maybe the staff would not give [redacted] shower due to the [redacted] on [redacted], but [redacted] would not mind taking whirlpool bath. R292 stated none of the staff had offered to help [redacted] take a shower.	F 677	F677 Residents # 292 received a shower and has a regular shower schedule in place, Residents #2, 17, 20, 136, 162, 72 all had their [redacted] removed, Resident #33 Had [redacted]. All residents have the potential to be affected by the same deficient practice. All residents ADL schedules regarding (Hair, Nails, shaving, showers/baths) were reviewed by the unit managers. All schedules were reviewed with the Certified Nursing Assistants and staff nurses on the unit to ensure all are aware of the ADL care specific to each resident including day/time. All licensed nurses and certified nursing assistants have been in serviced by the Director of Nursing on ADL care. The Unit Manager or Nursing Supervisor will audit 5 residents weekly for 12 weeks that the scheduled care has been rendered. Results of the audit will be submitted to the facility's quarterly QAPI	5/31/23

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F 677	Continued From page 6 Review of the resident's admission "Minimum Data Set (MDS)" with an Assessment Reference Date of [redacted], located the EMR tab for "MDS," revealed R292 was [redacted] with "Brief Interview for Mental Status (BIMS)" score of [redacted] This "MDS" revealed that R292 required physical help with [redacted] activity. Review of the physicians' orders for [redacted], located in the EMR tab for "Orders," revealed that R292 was to receive "bath/shower/nail care twice a week. Document any refusals. On Mondays and Fridays." Review of the resident's undated care plan located in the EMR tab for "Care Plans" identified thatR292 had a self-care deficit due to limited mobility and required one staff member to assist with bathing. The care plan also documented the resident was to have "shower/bath specify day and shift." Review of the unit's shower schedule, located in the unit's shower book at the nurses' station, revealed R292 was not on the list for showers. Review of the resident's [redacted] activities of daily living (ADLs) sheet, located in the EMR tab "Tasks," completed by the Certified Nursing Assistants (CNAs), revealed there was no documentation that R292 had received a shower or bath for the entire month. Continued review revealed no documentation of the resident refusing to shower or bathe. Interview with Unit Manager (UM) 4 on 05/03/23 at 4:02 PM revealed there was no problem with the R292 taking a shower or bath according to	F 677	committee for review and recommendations.	

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F 677	Continued From page 7 the resident's wishes. The UM was unaware the resident had not received a shower or bath since admission to the facility on [redacted]. Interview with CNA 49 on 05/04/23 at 10:45 AM revealed she gives R292 a complete bed bath every day. She was hesitant to put the resident in the shower due to the [redacted] on [redacted]. CNA49 stated that she had not offered the resident to sit in whirlpool bath. She also stated that it was up to the nurses to decide whether the resident received a shower or bath. CNA49 stated that she had not asked the nurses about giving the resident a shower or bath. Interview with the Licensed Practical Nurse (LPN) 48 on 05/04/23 at 10:50 AM revealed R292 could shower and she was not aware the resident had not received any showers or baths. 2. During an observation on 05/01/23 at 1:35 PM, R2 was lying in bed and R2 had [redacted] on [redacted] R2 said [redacted] could not talk as [redacted] During an observation on 05/01/23 at 3:45 PM, R2 was observed in bed with [redacted] On 05/02/23 at 11:52 AM, R2 was observed seated in the dining room. R2 was observed to have [redacted] During an observation on 05/02/23 at 1:00 PM, R2 was observed in the dining room with [redacted]. 05/03/23 at 9:19 AM, R2 was observed with [redacted]	F 677		

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F 677	Continued From page 8 Review of R2's "Face Sheet," located in the EMR under the "Resident" tab, revealed an admission date of [redacted] with medical diagnoses that included [redacted] Review of R2's annual " MDS," located in the EMR under the "RAI" tab with an Assessment Reference Date (ARD) of 02/15/23 revealed R2 required extensive physical assistance of one person for [redacted] personal hygiene needs. Review of R2's "Care Plan," located in the EMR under the "RAI" tab and last updated 02/23, revealed R2 "has an ADL self-care performance [redacted] ...requires extensive assistance by one staff with [redacted] weekly shower." In an interview with CNA1 on 05/03/23 at 10:20 AM, CNA1 said the residents receive a shower once a week. CNA1 said they take care of [redacted]. When asked about R2, CNA1 said sometimes R2 refuses. When asked where CNA1 would document refusals, CNA1 said [redacted] would tell the nurse. Review of R2's "Nurses Progress Notes" revealed no refusal of ADL care in the past 30 days. During an interview on 05/03/23 at 11:05 AM, the Registered Nurse (RN) 2 said showers were given one time a week and that the women were supposed to be shaved in the shower. 3. During an observation on 05/01/23 at 12:55	F 677		

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F 677	Continued From page 9 PM, R17 was observed to have [redacted] When asked if R17 received assistance with [redacted] ADL care needs, R17 said "I don't know,." During an observation on 05/01/23 at 3:42 PM, R17 was observed in bed asleep. The [redacted] remained. During an observation on 05/02/23 at 12:45 PM, R17 was observed in bed. The [redacted] remained on R17's [redacted] On 05/03/23 at 9:07 AM, R17 was observed, in bed, eating breakfast. The [redacted] remained on R17's [redacted] Review of R17's "Face Sheet" located in the EMR under the "Resident" tab, revealed an admission date of [redacted] with medical diagnoses that included [redacted] Review of R17's quarterly "MDS," located in the EMR under the "RAI" tab with an ARD of [redacted] revealed a "BIMS" score of [redacted] indicating R17 was [redacted]. The "MDS" revealed R17 required [redacted] for [redacted] personal hygiene needs. Review of R17's "Care Plan," located in the EMR under the "RAI" tab and last updated [redacted] read, "impaired functional ADL performance ...needs extensive assist with ADL's .. [redacted]" Review of R17's EMR, "Nurse's Progress Notes," revealed no refusal of ADL care in the past 30	F 677		

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F 677	Continued From page 10 days. 4.During an observation on 05/01/23 at 1:25 PM, R20 was observed in [redacted] wheelchair in the dining room. R20 was observed with [redacted] During an observation on 05/02/23 at 12:22 PM, R20 was observed laying in bed. R20 was observed with [redacted] During an observation on 05/03/23 at 9:14 AM, R20 was observed in [redacted] wheelchair in the dining room. R20 was observed with [redacted] Review of R20's "Face Sheet," located in the EMR under the "Resident" tab, revealed an admission date of [redacted] with medical diagnoses including [redacted]. Review of R20's quarterly "MDS," located in the EMR under the "RAI" tab with an ARD of [redacted] revealed a "BIMS" score of [redacted] indicating R20 was [redacted] The "MDS" revealed R20 required extensive assistance of one person for [redacted] ADL needs. Review of R20's "Care Plan," located in the EMR under the "RAI" tab last updated [redacted] read, "ADL self-care performance [redacted] ...requires extensive assist by one staff." Review of R20's EMR revealed only one refusal of personal hygiene care on [redacted], over the past 30 days.	F 677		

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F 677	Continued From page 11 Review of R20's EMR "Nurses Progress Notes" revealed R20 never rejected care over the past 30 days. In an interview with CNA3 on 05/03/23 at 11:07 AM, CNA3 said she liked shaving the female residents but sometimes they refuse. 5. During an observation on 05/01/23 at 1:48 PM, R136 was observed walking in the hall with two [redacted]. R136 was observed to have [redacted] During an observation on 05/01/23 at 3:46 PM, R136 was observed asleep in [redacted] wheelchair in the dining room. R136 was observed to have [redacted]. During an observation on 05/02/23 at 11:56 AM, R136 was observed seated in [redacted] wheelchair at the dining table. R136 was observed to have [redacted]. During an observation on 05/03/23 at 9:15 AM, R136 was observed in the dining room seated in [redacted] wheelchair. R136 was observed to have [redacted] Review of R136's "Face Sheet," located in the EMR under the "Resident" tab, revealed an admission date of [redacted] with medical diagnoses that included [redacted] Review of R136's quarterly "MDS," located in the EMR under the "RAI" tab with an ARD of 02/18/23, revealed a "BIMS" score of [redacted] indicating R136 had [redacted] The "MDS" revealed R136 required	F 677		

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F 677	Continued From page 12 extensive assistance for [redacted] personal hygiene care. Review of R136's "Care Plan," located in the EMR under the "RAI" tab and last updated [redacted] read, " ...dependent on staff with all [redacted] ADL's, required extensive to total assist of 1-2 persons." Review of R136's EMR revealed R136 never refused personal hygiene care for the past 30 days. Review of R136's EMR, "Nurses Progress Notes," revealed R136 never rejected care over the past 30 days. 6. During an observation on 05/01/23 at 3:48 PM, R162 was observed in bed in [redacted] room. R162 was observed to have [redacted] During an observation on 05/02/23 at 1:45 PM, R162 was observed to have [redacted] [redacted]. R162 was observed on 05/02/23 at 9:29 AM, while seated in [redacted] wheelchair in the dining room. R162 was observed to have [redacted] [redacted] During an observation on 05/03/23 at 9:27 AM, R162 was observed lying in bed. R162 was observed to have [redacted] Review of R162's "Face Sheet," located in the EMR under the "Resident" tab, revealed an admission date of [redacted] with medical diagnoses including [redacted]	F 677		

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ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	155 HAZEL STREET CLIFTON, NJ 07011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 13 Review of R162's quarterly "MDS," located in the EMR under the "RAI" tab with and ARD of 03/18/23, revealed R162 required extensive physical assistance of one person for [redacted] personal hygiene needs. Review of R162's "Care Plan," located in the EMR under the "RAI" tab and initiated 09/23/22, read, R162 " ...has an ADL self-care performance deficit r/t (related to) [redacted] ...shower every Thursday." In an interview with CNA2 on 05/03/23 at 10:38 AM, CNA2 said R162 can be [redacted] with [redacted] Review of R162's EMR revealed three refusals of personal hygiene care on [redacted] and [redacted] the past 30 days. Review of R162's EMR, "Nurses Progress Notes," revealed R162 never rejected care in the past 30 days. During an interview with the Director of Nurses (DON) on 05/03/2 at 11:14 AM, the DON said the residents should have their [redacted] shaved as needed, not with just showers. The DON said, "I expect them to go back again if they cannot do it during the shower." The DON said the CNA's document refusals in their notes and can go to the nurse to write a note in the record. The DON said everyone has access to document. 7. Review of the "Admission Record, " located in the profile tab of R33's EMR, documented an	F 677		

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F 677	Continued From page 14 admission date of [redacted]. R33's diagnoses included [redacted]. Review of R33's quarterly "MDS" with an ARD of [redacted] showed [redacted] mental status could not be assessed and R33 required assistance with all activities of daily living (ADLs), including grooming and eating. During an observation and interview on 05/01/23 at 11:30 AM, the R33 had long [redacted]. Family member (F)1 stated that [redacted] hair was usually combed and colored and R33 to be clean and comfortable. F1 has asked facility staff to cut [redacted] hair. During an observation on 05/02/23 at 9:49 AM, R33 was on [redacted], asleep, [redacted] was [redacted]. During an interview on 05/02/23, at 10:02 AM, CNA 51 said when a resident is up they should have their hair combed. CNA 51 stated R33 can be resistive, but usually can be reapproached later for care. During an interview on 05/02/23, at 10:05 AM, CNA 55 stated residents should be cleaned up in the morning before breakfast with hair combed, teeth brushed and check for incontinence and dressed if the resident wants. During an observation on 05/03/23 at 9:34 AM, R33 was in bed asleep. [redacted] and splayed across [redacted] pillow. During an interview on 05/04/23 at 9:47 AM,	F 677		

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F 677	Continued From page 15 RN35 said [redacted] was surprised R33's [redacted] and knew [redacted] F1 wanted the resident to have a [redacted]. 8. Review of the "Admission Record," located in the "Profile" tab of R72's EMR revealed an admission date of [redacted] R72's diagnoses included [redacted] Review of R72's quarterly "MDS" with an ARD of [redacted], revealed BIMS score of [redacted] indicating that the resident was cognitively intact and required assistance with "Activities of Daily Living" (ADLs), including bathing, dressing and grooming. During observation and interview on 05/01/23, at 1:38 PM, R72 had [redacted]. R72 stated [redacted] did not like [redacted]. [redacted] family recently visited and [redacted] had [redacted] then. During observation and interview on 05/02/23, at 10:00 AM, R72 still had the [redacted]. R72 stated [redacted] thinks the staff will [redacted] when [redacted] gets [redacted] weekly bath on [redacted]. During an interview on 05/2/23, at 10:11 AM, CNA55 said residents should be groomed when they get up for the day. CNA55 stated [redacted] did not know R72 had [redacted], which should have been removed [redacted] when [redacted] had [redacted] bath. During an interview on 05/2/23 at 10:12 AM,	F 677		

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F 677	Continued From page 16 CNA51 said residents should be cleaned up when they get up in the morning. CNA51 stated she was unaware that R72 had [redacted]. During an interview on 05/2/23 at 10:15 AM, RN15 said that all residents should be properly groomed and R72's [redacted] should be part of the assigned CNA's duties. During an interview on 05/04/23 at 4:14 PM, the DON said she expects residents to be well groomed and presentable. Females should have [redacted] removed if they wish, and hair should be combed. CNA's should be well instructed regarding transfers and safety issues for resident's if they do not know what to do they should ask questions. During an interview on 05/04/23 04:18 PM the Administrator said resident's should be dressed and groomed when they are up for the day. CNA's should receive instructions from the nurses. Review of facility policy titled, "Activities of Daily Living (ADLs)," dated 10/2022, revealed "Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care ... A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene." NJAC 8:39-4.1(a)22 NJAC 8:39-27.2(g)	F 677		
F 685	Treatment/Devices to Maintain Hearing/Vision	F 685		5/31/23

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F 685 SS=D	Continued From page 17 CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure a [redacted] was in place in one of 43 sampled residents (Resident (R) 2) in order to maintain [redacted]. This deficient practice created a potential for a lack of communication to occur. Findings include: Review of R2's undated electronic medical record (EMR) "Face Sheet," under the "Profile" tab, revealed R2 was admitted to the facility on [redacted] Review of R2's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/15/23 revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] indicative of [redacted]. On the same annual "MDS," R2 was "able to hear with minimal	F 685	F685 Resident # 2 [redacted] was provided and placed in [redacted]. All residents have the potential to be affected by the same deficient practice. All licensed nurses and certified nursing assistants have been in serviced by the Director of Nursing on Assisted devices. The Unit Manager or Nursing Supervisor will audit 5 residents weekly for 12 weeks for appropriate placement of assisted devices. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	

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F 685	Continued From page 18 difficulty if [redacted] used." Review of R2's EMR "Orders" tab for current physician's orders included an order, dated [redacted] for [redacted] accountability every shift." Review of R2's EMR "Care Plan" tab revealed a "Care Plan," dated 03/16/23. The "Care Plan" stated R2 "has a communication problem r/t [related to] a [redacted]. [redacted] wears [redacted] to [redacted], which has been effective." R2 "is at risk for the development of a Communication deficit and for not having [redacted] needs well-known [redacted]." Additionally, the Care Plan noted "Ensure [redacted]) is in place. Insert [redacted] to [redacted]; Remove at H.S. (hour of sleep)." During an observation, on 05/01/23 at 1:35 PM, R2 was in bed. R2 pointed at [redacted] when attempts were made to converse with [redacted]. Certified Nursing Assistant (CNA2) said R2 "has a [redacted], the nurse keeps it." R2 was observed, on 05/01/23 at 3:45 PM, lying in bed with the television on and without [redacted] in [redacted] During an observation on 05/02/23 at 11:52 AM, R2 was observed seated in [redacted] wheelchair in the dining room. There was no [redacted] observed in [redacted]. R2 was observed to point at staff and a different table than where [redacted] was seated. The Nursing Supervisor (NS) said R2 wanted to sit at [redacted] usual table. R2 remained in the dining room, on 05/02/23 at 12:00 PM, eating [redacted] lunch.	F 685		

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F 685	Continued From page 19 No [redacted] was observed in [redacted] During an observation, on 05/02/23 at 1:00 PM, R2 remained seated at a dining room table. R2 was not observed to converse with anyone in the dining room. [redacted] was not observed to have a [redacted] During an observation on 05/03/23 at 9:11 AM, R2 was noted to be in bed eating [redacted] breakfast. In an attempt to talk with R2, [redacted] pointed to [redacted] An interview, on 05/03/23 at 9:19 AM, was completed by writing questions to R2 which solicited a verbal response from [redacted] R2 said the nurse had [redacted] and that [redacted] wanted to wear it. During an interview with the Registered Nurse (RN) 2 on 05/03/23 at 11:05 AM, RN2 said R2's [redacted] was kept in the medication cart. RN2 said [redacted] typically put it in R2's [redacted] after [redacted] was up. When told R2 was not observed to have [redacted], RN2 said [redacted] would put it in for R2. R2 was able to have a conversation on 05/04/23 at 8:15 AM, while in [redacted] room eating breakfast. R2 pointed to [redacted] indicating the [redacted] was in [redacted]. R2 said [redacted] wants to have the [redacted] every day." The facility's policy and procedure titled "Hearing Impaired Resident, Care of" was dated 02/2018. The policy stated "staff will assist hearing impaired residents to maintain effective communication with clinicians, caregivers, other residents and visitors.	F 685		

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F 685	Continued From page 20	F 685		
F 688 SS=D	NJAC 8:39-27.5(a) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of policy, the facility failed to consistently provide daily range of motion (ROM) services for one (Resident (R) 126) of two residents sampled for limited ROM out of a total sample of 43 residents. This failure had the potential for the resident to lose mobility and independence. Findings include: Review of the "Admission Record, " located in the	F 688	F688 RNP Program was initiated to resident #126. All residents have the potential to be affected by the same deficient practice. RNP program audited by DON/Designee to ensure all RNP referrals were addressed as appropriate. Rehabilitation and Nursing staff were re-educated by Director of Nursing on process of proper communicating to nursing department of any referrals.	5/31/23

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F 688	Continued From page 21 "Profile" tab of R126's electronic medical record (EMR), documented an admission date of [redacted]. R126's diagnoses included [redacted] Review of R126's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 03/18/23, showed a "Brief Interview for Mental Status (BIMS)" score of [redacted] indicating R126 was [redacted]. Review of R126's "Care Plan," last updated on 03/20/23, revealed that R126 was to have restorative nursing active ROM to [redacted]) of two sets with ten repetitions. Review of R126's May 2023 "Physician's Orders" revealed an order, dated [redacted], for nursing restorative active range of motion to [redacted]er [redacted] two sets with ten repetitions, as tolerated, two times per day. During interview and observation of R126 on 05/01/23 at 1:10 PM, R126 said he was not receiving any [redacted] services since his discharge from [redacted] in [redacted]. During observation and interview of R126 on 05/03/23 at 9:38 AM, R126 stated he was not sure what [redacted] was or who was supposed to be doing it with him. During an interview on 05/03/23 at 10:18 AM, Certified Nursing Assistant (CNA) 51, stated [redacted] is on the CNA assignment	F 688	The DON/ADON or Nursing Manager will audit 5 residents weekly for 12 weeks for compliance. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	

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F 688	Continued From page 22 sheets and in the computer under tasks, but CNAs usually do not have time to complete this task. CNA51 was unsure if R126 should be receiving [redacted]. During an interview on 05/03/23 at 10:21 AM, CNA55 stated [redacted] was aware CNAs do the [redacted] but did not know if R126 had ordered. During an interview on 05/03/23 at 10:36 AM, Registered Nurse (RN) 15 stated there was a restorative notebook in the nurses' station which explains the [redacted] nursing plan for the resident, including what and how often it should be done. RN15 was unable to locate the notebook. During an interview on 05/03/23 at 10:41 AM, CNA85 stated he had never heard of a restorative nursing plan for R126. CNA85 acknowledged that he was assigned to take care of R126 "yesterday and today." CNA85 stated the restorative nursing plan was neither listed on his assignment sheet nor did the nurse explain that R126 was to receive [redacted] ROM. During an interview and observation on 05/03/23 at 11:51 AM, RN15 found the [redacted] nursing notebook. Review of this notebook showed there was no current restorative plan for R126, and other residents included in the notebook were discharged from the facility, and one resident record was dated the year [redacted] During an interview on 05/04/23 at 9:33 AM, the Director of Therapy said that R126 still had an order for [redacted] in place. She could	F 688		

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F 688	Continued From page 23 not find the written copy of R126's plan in the restorative notebook. [redacted] was unsure how [redacted] orders are communicated to nursing, but that each nurses' station should have a restorative notebook. During observation and interview on 05/04/23 at 9:47AM, RN35 showed a printed copy of the restorative checklist for CNAs for R126. The boxes for the AM and PM shifts were checked. She stated she initialed the daytime checks for the CNAs, and the evening nurse checks the PM boxes. RN35 stated she was unaware if the CNAs actually completed the [redacted]. Review of the facility policy dated 6/23/22 included the following: It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Definition: the "Restorative nursing program" refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently as possible. "Restorative nursing program" refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. Policy Explanation and Compliance Guidelines: Cognitive and physical functioning of all residents will be assessed in accordance with the facility's assessment protocols. The interdisciplinary team, with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision-making regarding services to maintain or improve resident's abilities in accordance with the	F 688		

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F 688	Continued From page 24 resident's comprehensive assessment, goals, and preferences. Nursing personnel are trained on basic, or maintenance nursing care that does not require the use of a qualified therapist or licensed nurse oversight. Assisting residents with range of motion exercises, performing passive range of motion for residents who lack active range of motion ability. The Restorative Nurse and restorative aides receive additional training on restorative nursing program and activities upon hire and as needed. NJAC 8:39-27.1(a) NJAC 8:39-27.2(m)	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to obtain physician orders and develop a care plan with interventions for one of two residents (Resident (R) 292) reviewed for [redacted] from a total sample of 43 residents. Findings include:	F 695	F695 An order was received from the physician for Resident # 292, for administration of [redacted] and the care plan was updated. All residents have the potential to be affected by the same deficient practice. Residents receiving [redacted] were reviewed for appropriate orders and care plans. All licensed nurses were in	5/31/23

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F 695	Continued From page 25 Observation on 05/02/23 at 9:57 AM revealed R292 in bed receiving morning care. R292 was wearing a [redacted] with an [redacted] at bedside. There was a portable tank of oxygen observed on the back of R292's wheelchair. Observation 05/03/23 at 3:07 PM revealed R292 sitting up in [redacted] wheelchair with [redacted] in place. The [redacted] concentrator for set two liters per minute. The humidifier jar had a date of 05/03/23. Review of R292's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] located in the electronic medical records (EMR) "MDS" tab, assessed R292 had "Brief Interview for Mental Status (BIMS)" score of [redacted] which indicated [redacted].. Further review of this "MDS" for special treatments and procedures documented that R292 was receiving [redacted] Review of the resident physician's active orders summary, dated [redacted] and located in the EMR "Orders" tab, revealed no orders for R292 to receive [redacted]. Review of R292's undated care plan, located in the EMR tab "Care Plans," revealed there was no care plan with interventions developed for the resident's use of [redacted]. During an interview on 05/03/23 at 3:07 PM, R292 stated tha[redacted] was utilizing [redacted] before admission to the facility due to a diagnosis of [redacted]. R292 stated [redacted] wears the	F 695	serviced by the Director of Nursing on obtaining orders for [redacted] use and care planning for [redacted] use. The DON/ADON or Nursing Manager will audit 5 residents on Oxygen for correct orders weekly for for 4 weeks and then monthly x2 for compliance. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	

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ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	155 HAZEL STREET CLIFTON, NJ 07011

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F 695	Continued From page 26 [redacted] continuously. Interview with the Unit Manager (UM) 4 on 05/03/23 at 4:02 PM revealed that she was not aware that R292 was on [redacted]. She stated there should be an order for the [redacted] indicating the flow rate and how often the resident [redacted] level should be monitored to ensure the resident is maintaining an adequate [redacted] level. UM 4 further stated a care plan with interventions should have been developed. UM4 stated that the floor nurses and unit manager are responsible for developing and revising the care plans. Review of facility policy titled "Oxygen Administration," with a revision date of October 2021, revealed the following ..." Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess any special needs for the resident." NJAC 8:39-11.1 NJAC 8:39-11.2 NJAC 8:39-25.2(c)4	F 695		
F 756 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.	F 756		5/31/23

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F 756	Continued From page 27 §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, 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 record review, interview, and policy review, the facility failed to ensure a medication regimen review was completed by a pharmacist at least once a month in one resident (Resident (R) 150) out of five residents reviewed for	F 756	F756 Resident #150 had medication reviewed by pharmacist and reported to the attending physician. All residents have the potential to be	

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F 756	Continued From page 28 unnecessary medications out of a total sample of 43 residents. Findings include: Review of R150's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R150 was admitted to the facility on [redacted]. R150's admitting diagnoses included [redacted]. Review of R150's EMR under the "Orders" tab indicated R150's ordered medications included: [redacted] times day; [redacted] oral tablet, one tablet every [redacted] hours fo[redacted]; [redacted] give [redacted] tablet [redacted] every [redacted] as needed for [redacted] for 14 days; [redacted] at bedtime for [redacted] - give [redacted] during night shift for [redacted] (2 AM); [redacted] R ([redacted]) tablet [redacted] tablet in evening for [redacted] one time day; insulin [redacted]) inject [redacted] at bedtime. Review of R150's EMR did not reveal a "Medication Regimen Review"(MMR) completed by a pharmacist for R150.	F 756	affected by the same deficient practice. Licensed Nursing staff were re-educated by Director of Nursing regarding Drug regimen review. Administrator confirmed with Pharmacist Consultant that reviews were being done. The DON/ADON or Nursing Manager will audit 5 residents weekly for 4 weeks and then monthly x2 for compliance. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	

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F 756	Continued From page 29 During an interview on 05/04/23 at 6:50 PM with the Director of Nursing (DON), the DON said she was able to locate a MRR for January and April of 2023, but could not locate reviews for the months of February and March of 2023 for R150. The DON stated the facility's Pharmacist should complete monthly MRRs for all of the facility's residents. Review of the facility's policy titled, "Medication Regimen Review" dated 06/23/22, indicated, "Policy: The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. Policy Explanation and Compliance Guidelines: 1. Medication Regimen Review (MRR) ...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 ...4. The pharmacist shall document, either manually or electronically, that each medication regimen review has been completed. a. The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities ...6. Written communications from the pharmacist shall become part of the resident's medical record ..."	F 756		
F 758 SS=D	NJAC 8:39-29.3(a) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		5/31/23

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F 758	Continued From page 30 processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758		

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F 758	Continued From page 31 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure [redacted] medication efficacy was monitored for one of five residents (Resident (R) 15) reviewed for unnecessary medications. This failure had the potential to affect the ability for a physician to prescribe the lowest possible effective dose of medication. Findings include: Review of R157's printed "Admission Record," from the electronic medical record (EMR) "Profile" tab, showed an admission date of [redacted] with medical diagnoses that included [redacted]. Review of R157's printed "Order Summary," from the EMR "Orders" tab, showed the following orders: atypical [redacted] (mg) daily at bedtime for [redacted], with an order to monitor behavior for [redacted] an [redacted] at bedtime for [redacted], with an order to monitor [redacted] for [redacted]; and a mood stabilizing medication [redacted], but	F 758	F758 Behavior monitoring was placed for Resident #157[redacted] medication. All residents have the potential to be affected by the same deficient practice. Licensed Nursing staff were re-educated by Director of Nursing regarding Psychotropic drug use. The DON/ADON or Nursing Manager will audit 5 residents weekly for 4 weeks and then monthly x2 for compliance. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	

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F 758	Continued From page 32 no order for [redacted] monitoring was found. During an interview on 05/04/23 at 2:49 PM regarding [redacted] monitoring for R157, the Director of Nursing (DON) stated, "There is one [redacted] for the [redacted], but I do not see one for the [redacted]." In an interview on 05/04/23 at 2:59 PM regarding the [redacted] monitoring for the [redacted] medication, Unit Manager (UM) 3 reviewed R157's medication and treatment administration record, and stated, "I did it for the [redacted] and [redacted] [brand name for [redacted]], I don't know how I missed it unless I thought it was for [redacted]. I need to update it; I'll go update it now." UM3 confirmed [redacted] when used as a [redacted] should be monitored for [redacted] like the other [redacted] meds. Review of the facility policy titled "Psychotherapeutic Drug Management," revised August 2022, revealed: ". . . XIII. Nursing Responsibility A. Consider other factors that may be causing expressions or indications of distress before initiating a psychotropic medication, such as an underlying medical condition (e.g., urinary tract infection, dehydration, delirium), environmental (lighting, noise) or psychosocial stressors. i. Monitoring should also include evaluation of the effectiveness of non? pharmacological approaches prior to administering PRN medications. . . . C. Will monitor the presence of target behaviors on a daily basis charting by exception (i.e.,	F 758		

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F 758	Continued From page 33 charting only when the behaviors are present) . . . " NJAC 8:39-29.3(a) NJAC 8:39-33.2(c)2	F 758		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and 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 §483.70(e) 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	F 880		5/6/23

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F 880	Continued From page 34 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. §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:	F 880		

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F 880	Continued From page 35 Based on observation, interview, record review, and policy review, the facility failed to sanitize glucometers between uses for one (Resident (R) 111) of two residents (R152 and R111) observed receiving blood glucose testing out of a total sample of 43 residents. The failure to sanitize glucometers between residents resulted in an Immediate Jeopardy (IJ) at F880-J: Infection Control due to the increased likelihood to cause serious harm due to the potential of cross-contamination of [redacted] pathogens. On 05/04/23 at 7:15 PM, the Administrator and Director of Nursing (DON) were notified of the IJ at F880-K: Infection Control. The Immediate Jeopardy began on 05/03/23 when the survey team identified glucometers were not being sanitized between uses for R111. The facility provided an acceptable Removal Plan which included retraining and ensuring competency of all Licensed Practical Nurses (LPN) and Registered Nurses (RN) on the use and sanitization of glucometers. Through interviews with facility staff, observations of glucose testing, and review of staff in-services, the survey team verified implementation and removed the Immediate Jeopardy on 05/05/23 at 12:22 PM. The deficient practice remained at a scope and [redacted] ([redacted]) following the removal of the immediate jeopardy. Findings include: Review of R111's "Admission Record" from the	F 880	F880 Resident #111 was immediately assessed no issues noted. Resident #111 vitals were monitored q shift for 72 hours, no issues noted. Resident #152 has no known [redacted]. The nurse identified was immediately in-serviced by Director of Nursing on the proper procedures for glucometer disinfection. All residents requiring finger stick glucose monitoring have the potential to be affected. No other residents noted to have been affected. The facility retained on site services from an ICP consultant to develop and implement the POC and RCA. All licensed nursing staff were in-serviced by Director of Nursing and Nursing Supervisor as of May 5 2023 on the facility's Glucometer Disinfection policy. New staff will be in serviced IP or Nursing Supervisor prior to start of shift. The DON or IP Nurse will complete random competency checklist for nurses performing glucometer disinfection weekly for 4 weeks and then monthly x2 for compliance. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	

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F 880	Continued From page 36 electronic medical record (EMR) "Profile" tab showed a facility admission date of [redacted] with a medical diagnosis of [redacted]. Review of R111's "Order Summary" from the EMR "Orders" tab showed an order for [redacted] reading] If 151-200=1unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; 401-450=6 units; 451-500=7 units; [redacted] [physician]" Review of R152's "Admission Record" from the EMR "Profile" tab showed a facility admission date of [redacted] with a medical diagnosis of [redacted] Review of R152's May 2023 "Medication Administration Record (MAR)" from the [redacted] "Humalog [redacted]) Inject as per sliding scale: If 151 -200=2units: 201 -250=4units; 251 -300=6 units; 301-350=8 units; 351 - 400 = 10 units, subcutaneously before meals and at bedtime for [redacted] call MD."	F 880		

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F 880	Continued From page 37 During the observation of blood glucose monitoring on 05/03/23 at 10:50 AM, LPN1 took the glucometer from the zippered case (LPN1 stated she had sanitized the glucometer before she put it away; and stated there was only one and all residents share it) and entered R152's room and performed a blood glucose check. LPN1 placed the glucometer back into the zippered case and returned it to the cart. At 10:59 AM, LPN1 retrieved the zipper case, entered R111's room, performed hand hygiene, took an alcohol wipe from the zipper case, and cleaned the glucometer, (LPN1 verified it was an alcohol wipe) let it dry and performed a blood glucose test on R111. The glucometer was placed back into the zipper case and returned to the medication cart. During an interview on 05/03/23 at 4:41 PM, in response to a query regarding the facility policy for sanitizing the glucometer, LPN1 stated, "When you want to use the glucometer you clean after each resident with an alcohol wipe before the using it on the next resident." In an interview on 05/04/23 at 1:28 PM, the Director of Nursing (DON) stated, "[Nurses] are supposed to use the guidelines according to the manufacture - that's my expectation, not supposed to use alcohol. If they don't have the right product, they can request it from central supply." Review of the facility policy titled "Blood Glucose Monitoring," revealed: " . . . 3. The nurse will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacturer's	F 880		

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F 880	Continued From page 38 instructions and in accordance with the facility's glucometer disinfection policy. 4. If possible, glucometers should not be shared between residents, but if this is not possible, the nurse is responsible for cleaning and disinfection of the machine between residents following the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy." Review of the manufacturer's user guide for the Even care G3 Blood Glucose Monitoring System User's Guide, page 46-47, showed: "Cleaning and Disinfecting Procedures for the Meter The [redacted] Meter should be cleaned and disinfected between each patient. The meter is validated to withstand a cleaning and disinfection cycle of ten times per day for an average period of three years. The following products have been approved for cleaning and disinfecting the [redacted] Meter: o Dispatch® Hospital Cleaner Disinfectant Towels with Bleach (EPA Registration Number: 56392-8) o Medline Micro-Kill+ (Trademark) Disinfecting, Deodorizing, Cleaning Wipes with Alcohol (EPA Registration Number: 59894-10) o Clorox Healthcare® Bleach Germicidal and Disinfectant Wipes (EPA Registration Number: 67619-12) o Medline Micro-Kill (Trademark) Bleach Germicidal Bleach Wipes (EPA Registration Number: 37549-1) . . ." Materials needed: o [redacted] Meter o Gloves o A validated disinfecting wipe . . . Step 5. To disinfect your meter, clean the meter	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315021	A. BUILDING _____ B. WING _____	C 05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	**155 HAZEL STREET CLIFTON, NJ 07011**

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F 880	Continued From page 39 surface with one of the approved disinfecting wipes. Other EPA registered wipes may be used for disinfecting the [redacted] system, however, these wipes have not been validated and could affect the performance of the meter. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. Wipe all external areas of the meter including both front and back surfaces until visibly wet. Avoid wetting the meter test strip port. Wipe meter dry, or allow to air dry . . . " NJAC 8:39-19.4(a)1	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031601	A. BUILDING: _____ B. WING _____	C 05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIR	155 HAZEL STREET CLIFTON, NJ 07011

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was identified for CNA staffing for residents on 31 of 42-day shifts. The findings were as follows: Reference: New Jersey Department of Health (DOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	S560 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. During the annual survey it was determined that the facility failed to ensure that minimum staffing ratios were adequately met. No residents were identified nor immediately affected by the failure to provide minimum staffing levels. All residents have the potential to be affected by this deficient practice. The facility made over 10 CNA hires this past year to bolster staffing ratios. In addition, contracts with 3 different agencies have been signed, so that the facility may supplement agency staff when	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 7/02/22 to 7/23/22, and 10/16/22 to 11/05/22, revealed the staffing to resident ratios did not meet the minimum requirement for one CNA to eight residents for the day shift as documented below: 1. For the 3 weeks of staffing (07/03/2022 to 07/23/2022), the facility was deficient in CNA staffing for residents on 15 of 21 day shifts as follows: -07/03/22 had 18 CNAs for 160 residents on the day shift, required 20 CNAs. -07/04/22 had 18 CNAs for 160 residents on the day shift, required 20 CNAs. -07/06/22 had 18 CNAs for 160 residents on the day shift, required 20 CNAs. -07/07/22 had 18 CNAs for 160 residents on the	S 560	needed. Sign on bonuses, as well as referral bonuses were offered in order to assist in recruitment of CNAs, as well as the addition of shift differentials being paid for evening shifts. The staffing coordinator will inform DON or designee of any call out(s) that result in insufficient staffing levels. This will be reported as soon as possible. Any staffing deficiencies will be filled prior to the start of the shift with other associates or agency as needed. The Administrator or Assistant Administrator will audit 5 shifts weekly for 4 weeks and then monthly x2 for compliance. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 day shift, required 20 CNAs. -07/09/22 had 16 CNAs for 162 residents on the day shift, required 20 CNAs. -07/10/22 had 15 CNAs for 162 residents on the day shift, required 20 CNAs. -07/13/22 had 19 CNAs for 162 residents on the day shift, required 20 CNAs. -07/14/22 had 19 CNAs for 164 residents on the day shift, required 20 CNAs. -07/15/22 had 19 CNAs for 164 residents on the day shift, required 20 CNAs. -07/17/22 had 17 CNAs for 166 residents on the day shift, required 21 CNAs. -07/18/22 had 15 CNAs for 166 residents on the day shift, required 21 CNAs. -07/19/22 had 20 CNAs for 166 residents on the day shift, required 21 CNAs. -07/20/22 had 17 CNAs for 166 residents on the day shift, required 21 CNAs. -07/22/22 had 20 CNAs for 168 residents on the day shift, required 21 CNAs. -07/23/22 had 20 CNAs for 168 residents on the day shift, required 21 CNAs. 2. For the 3 weeks of staffing (10/16/2022 to 11/05/2022), the facility was deficient in CNA staffing for residents on 16 of 21 day shifts as follows: -10/16/22 had 18 CNAs for 185 residents on the day shift, required 23 CNAs. -10/17/22 had 20 CNAs for 184 residents on the day shift, required 23 CNAs. -10/18/22 had 20 CNAs for 184 residents on the day shift, required 23 CNAs. -10/19/22 had 22 CNAs for 184 residents on the day shift, required 23 CNAs. -10/20/23 had 18 CNAs for 183 residents on the day shift, required 23 CNAs.	S 560		

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S 560	Continued From page 3 -10/21/22 had 19 CNAs for 182 residents on the day shift, required 23 CNAs. -10/22/22 had 18 CNAs for 181 residents on the day shift, required 23 CNAs. -10/23/22 had 16 CNAs for 180 residents on the day shift, required 22 CNAs. -10/24/22 had 17 CNAs for 180 residents on the day shift, required 22 CNAs. -10/25/22 had 20 CNAs for 180 residents on the day shift, required 22 CNAs. -10/26/22 had 21 CNAs for 180 residents on the day shift, required 22 CNAs. -10/27/22 had 22 CNAs for 182 residents on the day shift, required 23 CNAs. -10/30/22 had 18 CNAs for 174 residents on the day shift, required 22 CNAs. -10/31/22 had 18 CNAs for 174 residents on the day shift, required 22 CNAs. -11/02/22 had 20 CNAs for 174 residents on the day shift, required 22 CNAs. -11/03/22 had 20 CNAs for 174 residents on the day shift, required 22 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
031601 Y1	Y2	6/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	155 HAZEL STREET CLIFTON, NJ 07011

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/31/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON 5/5/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 05/02/23. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/02/23 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Atlas Rehabilitation and Healthcare at Daughters of Miriam is a Five - story building that was built in the 1950's, It is composed of Type II 222 protected construction. The facility is divided into 19 - smoke zones. The generator does approximately 75 % of the building as per the Maintenance Director. The current occupied beds are 180 of 209.	K 000		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.	K 281		5/31/23

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

Electronically Signed | 05/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 281	Continued From page 1 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switch in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 180 residents. Findings include: An observation on 05/02/23 at 04:15 PM revealed emergency lighting was not present at the emergency generator transfer switch located in the electrical room. The Maintenance Director who was present at the time of the observation confirmed the emergency lighting was not present. NJAC 8:39-31.2(e) NFPA 99, 110	K 281	K281 There is a battery powered light above the ATS. All residents have the potential to be affected by the same deficient practice. Director of Maintenance was in-serviced by Administrator on the requirement for battery powered lights and how to identify. The Director of Maintenance / maintenance Tech will check operation of battery powered light monthly x 3. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this	K 311		5/31/23

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K 311	Continued From page 2 box. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to maintain the vertical openings, 15 of 28 stairway exit doors on the 1st, 3rd, and 4th floors were missing latches that holds the doors closed in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.1.7. and one of the 28 doors in the vertical openings is a wood door with no fire rating in accordance with NFPA 101 Life safety Code (2012 Edition) Section 19.3.1.1 This deficient practices had the potential to affect 180 residents. Findings include: An observation on 05/02/23 from 02:10 PM to 04:25 PM revealed that the stairway doors were equipped with magnetic locks which deactivates when the fire alarm is activated, the latches were removed and replaced with steel plates keeping the doors from latching when closed. An observation on 05/02/23 at 03:53 PM revealed that stairway door 1-E near room [redacted] was a wood door with no fire rating. This door is required to have a minimum of one-hour fire rated assembly. At the time of the observation, the Maintenance Director verified the latches were missing from the stairway doors and the doors would not latch. The Maintenance Director also verified that the wooden door 1-E did not have a fire rating.	K 311	K311 Latches were installed on all fire doors and a contractor was hired to install new 60 minute rated fire door near room [redacted]. All residents have the potential to be affected by the same deficient practice. Maintenance department was in-serviced by administrator on vertical openings. The Director of Maintenance / maintenance Tech will check fire doors for proper latching monthly x 3. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	
K 341	NJAC 8:39-31.2(e) Fire Alarm System - Installation	K 341		5/31/23

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K 341 SS=E	Continued From page 3 CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a manual fire alarm box was located within 60 inches of the exterior exit doors from the auditorium in accordance with NFPA 72 (National Fire Alarm and Signaling Code) 17.14.6. This deficient practice had the potential to affect 95 residents. Findings include: An observation on 05/02/23 at 1:43 PM revealed there was not a manual fire alarm box located within 60 inches of the front exit. The nearest manual fire alarm box was located in the main lobby.	K 341	K341 Facility contracted fire alarm vendor to install pull station near exit door in auditorium. All residents have the potential to be affected by the same deficient practice. Maintenance department was in-serviced by administrator on Fire alarm system. The Director of Maintenance / maintenance Tech will check fire pull stations monthly x 3. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	

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K 341	Continued From page 4 At the time of the observation, the Maintenance Director confirmed a manual fire alarm box was not located within 60 inches of the front exit. The NFPA 72 code 17.14.6 requires "Manual fire alarm boxes shall be located within 60 in. (1.52 mm) of the exit doorway open at each exit on each floor." NJAC 8:39-31-1(c), 31.2(e) NFPA 70, 72	K 341		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 14.4.5.3.2. This deficient practice had the potential to affect all 180 residents. Findings include: An observation of the facility smoke detectors on 05/02/23 from 02:10 PM to 04:25 PM revealed	K 345	K345 Facility received sensitivity test report from fire alarm vendor. All residents have the potential to be affected by the same deficient practice. Maintenance director was in-serviced by administrator on importance of having sensitivity report in the facility. The Director of Maintenance will check maintenance binder monthly x 3. to ensure documentation of fire alarm system including sensitivity testing. Results of the audit will be submitted to	5/31/23

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K 345	Continued From page 5 smoke detectors were located in the corridors at the smoke barriers, and other concealed areas throughout the building. A review of the facility binders provided by the Maintenance Director, contained inspection and testing reports for the fire alarm system for the calendar year 2021 and 2022. A review of the facility fire alarm "Inspection and Testing Reports" dated 08/03/22 revealed no reference to a smoke detection sensitivity test. The Maintenance Director, who was present at the time of the observation, confirmed the sensitivity testing was not performed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	the facility's quarterly QAPI committee for review and recommendations.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure Ground Fault Circuit Interruption	K 511	K511 A licensed electrician checked the outlets	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315021	A. BUILDING **01** B. WING _____	**05/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	**155 HAZEL STREET** **CLIFTON, NJ 07011**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 6 (GFCIs) were provided within six feet of a sink in accordance with NFPA 70 National Electrical Code (2011 Edition) Section 210 (B) (5). This deficient practice had the potential to affect 95 residents. Findings include: An observation on 05/02/23 at 02:17 PM revealed two electrical outlets located within six feet of a sink without GFCI protection within the kitchen in the auditorium on the West wall. The Maintenance Director was present at the time of observation and verified that outlets were not protected by GFCI outlets or breakers. NJAC 8:39-31.2(e) NFPA 70	K 511	and confirmed they are on a GFCI breaker. All residents have the potential to be affected by the same deficient practice. Maintenance department was in-serviced by administrator on electric NFPA 70. The Director of Maintenance / maintenance Tech will check outlets near sinks monthly x 3. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced	K 761		5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315021	A. BUILDING **01** B. WING _____	**05/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	**155 HAZEL STREET** **CLIFTON, NJ 07011**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 7 by: Based on observation and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 180 residents. Findings include: An observation of the facility's fire doors on 05/02/23 from 02:10 PM to 04:25 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. The Maintenance Director was present at the time of the observation and confirmed the fire doors were not inspected annually. NJAC 8:39-31.2(e) NFPA 80	K 761	K761 All fire doors were inspected by a qualified inspector. All residents have the potential to be affected by the same deficient practice. Maintenance department was in-serviced by Administrator on annual fire door inspection. The Director of Maintenance / maintenance Tech will check fire door inspection monthly x 3. Results of the audit will be submitted to the facility's quarterly QAPI committee for review and recommendations.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315021 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	155 HAZEL STREET CLIFTON, NJ 07011

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	05/31/2023	LSC K0311	05/31/2023	LSC K0341	05/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	05/31/2023	LSC K0511	05/31/2023	LSC K0761	05/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/5/2023	☐ YES ☐ NO