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 02/18/2025

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 Complaint NJ#s: #168894, #173918, #173951, #175914, #178822, #178987, #179080, #180737, #181135, and #183033. Survey Date: 2/18/2025 Census: 201 Sample: 35 sample + 3 closed records =38 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.	F 000		
F 550 SS=D	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	F 550		3/9/25

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

Electronically Signed | 03/09/2025

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. 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 review of other pertinent facility documents, it was determined that the facility failed to a.) treat each resident with respect and dignity in a manner that promotes their quality of life during breakfast and b.) provide privacy during med administration for 1 of 6 residents, (Resident #39), observed during medication pass administration. This deficient practice was evidenced by the following: On 2/10/25 at 8:44 AM, during the medication administration pass observation, the surveyor observed the U.S. FOIA (b) (6) prepared medications (meds) for Resident #39, and brought them inside the dining area in the [redacted] unit. The surveyor observed that there was a	F 550	F550 Resident Rights/Exercise of Rights 1. The care plan of Resident #39 was updated to reflect the resident's NJ Exec Order 26.4b1 and preference to have meds taken in the NJ Exec Order 26.4b1. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) U.S. FOIA (b) (6) were educated by the Assistant Director of Nursing (ADON) on the facility's Resident Rights Policy. 2. All active residents have the potential to be affected by with this deficient practice. 3. All licensed nurses were in-serviced	

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F 550	Continued From page 2 total of five residents inside the dining area eating their breakfast including Resident #39. The U.S. FOIA also checked Resident #39's NJ ex order 26.4b1 [redacted] After the U.S. FOIA (b administered the meds, the surveyor interviewed the U.S. FOIA outside the dining room. The surveyor asked the U.S. FOIA (b if it was appropriate to administer and check the NJ Exec Orde [redacted] of the resident inside the dining room where other residents were inside, and the resident was still eating. The U.S. FOIA responded that it was the resident's preference. The surveyor asked the U.S. FOIA if the resident's preference was in the resident's care plan (CP), and she responded that the surveyor had to ask the U.S. FOIA (b) (6) about the CP. On 2/10/25 at 8:55 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] regarding the concern with the U.S. FOIA who administered meds and checked Resident #39's Nj ex order 26.4b1 inside the dining area with other residents, and the U.S. FOIA (b) (6) responded that the resident had a Nj ex order 26.4b1 and at times some resident when they were in the dining room did not want to go back to the room to get their meds. The surveyor asked the U.S. FOIA (b) (6) if the Nj ex order 26.4b1 [redacted] were in the resident's CP, and the U.S. FOIA (b) (6) responded no. The U.S. FOIA (b) (6) further stated that she should have documented it in the CP of the resident about the NJ Exec Order 26.4b and resident's preferences. At that time, the surveyor asked the U.S. FOIA (b) (6) to print the resident's CP and eMAR (electronic Medication Administration Record).	F 550	by the Director of Nursing (DON) on the facility's Resident Rights Policy and to include the behavior of swaying hands and the resident's preference of taking their medication in the dining room in the care plan. The DON or designee audited all active residents to identify the behavior of swaying hands and preference of taking medications in the dining room to ensure the behavior and or preference to take medications in the dining room are include in the care plan. Behaviors of swaying hands and resident preferences to take medications in the main dining room will be discussed during clinical meetings. The DON or Designee will conduct an audit of 10 random charts of active residents to ensure the behavior of swaying hands and or the preference to take medications in the dining room is included in the care plan weekly x 4, then monthly x 3 months. 4. The DON will report the results of the audits in the monthly QAPI meeting x 4 months to ensure compliance and if further action is necessary.	

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F 550	Continued From page 3	F 550		

A review of the provided CP by the US FOIA (b)(6) revealed that the resident's CP did not identify resident with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . There was no documented evidence in the CP that the resident had a NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 to take meds in their room or NJ Exec Order 26.4b1 to take meds NJ Exec Order 26.4b1 .

A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Exec Order 26.4b1 .

A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of NJ ex order 26.4 under Section NJ Exec Order 26.4b1 , a brief interview for mental status (BIMS) score of NJ ex o out of 15, which reflected that the resident's NJ Exec Order 26.4b1 was NJ ex order 2 . Section NJ E for NJ Exec Orde and Section NJ for NJ Exec Order 26.4b1 was coded NJ ex , which reflected that the resident had no documented NJ Exec Order 26.4b1

A review of the Progress Notes and assessment tab in the electronic medical records revealed that there was no documented evidence that the resident had an NJ Exec Order 26.4b1 .

On 2/13/25 at 2:14 PM, the survey team met with the U.S. FOIA (b) (6)

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F 550	Continued From page 4 U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) and the surveyor notified the above findings and concerns with Resident #39. On 2/14/25 at 1:07 PM, the survey team met with the U.S. FOIA (b) (and U.S. FOIA (. The U.S. FOIA (stated that the nurse (who did not identify) interviewed the resident and Resident #39 did not mind checking their NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . The U.S. FOIA (b) confirmed that the interview of the nurse of Resident #39 was done after the surveyor's inquiry. A review of the facility's Resident Rights Policy, with a reviewed/revised date of 3/5/24, that was provided by the Regional Nurse revealed: Resident Rights: The resident has the right to a dignified existence, self-determination ... 4. Respect and dignity... Policy Explanation and Compliance Guidelines: 11. The facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the facility to properly care for its residents ... On 2/18/25 at 1:47 PM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) for an exit conference, and the US FOIA (b)(6) did not provide additional information. NJAC 8:39-4.1(a)3,12; 27.3	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident;	F 580		3/9/25

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F 580	Continued From page 5 consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility	F 580		

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F 580	Continued From page 6 that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint # NJ183033 Based on interviews, medical record reviews, and review of other pertinent facility documents, it was determined that the facility failed to ensure that the physician was consulted and notified immediately of resident's NJ ex order 26.4b1 and follow the facility's policy and protocol with regard to notification of changes. This deficient practice was identified for 1 of 3 residents, (Resident #443), reviewed. This deficient practice was evidence by the following: A review of the Admission Record (an admission summary) revealed that Resident #443 was admitted to facility with diagnoses which included but were not limited to; NJ ex order 26.4b1 [redacted]	F 580	F580 Notify of Changes (Injury/Decline/Room,etc) 1. Resident # 443 is Nj ex order 26.4b1 [redacted] 2. All active residents have the potential to be affected by this deficient practice. 3. All licensed nurses were in-serviced by the Director of Nursing (DON) on facility's Notification of Change Policy Changes in condition and provider notification will be discussed during clinical meeting and as necessary. The DON or designee will audit 10 random charts for changes in condition and ensure the provider was notified in a timely manner weekly x 4 weeks, then monthly x 3 months. 4. The DON will report the results of the audits in the monthly QAPI meetings x 4 months to ensure compliance and if further action is necessary.	

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F 580	Continued From page 7	F 580		

A review Resident #443's progress notes (PN) revealed that on NJ Exec Order 26.4b1 at approximately 3:10 PM, Resident #443's responsible party (RP) informed U.S. FOIA (b) (6) #1 (LPN#1) that the resident looked NJ Exec Order 26.4b1 The PN revealed that the resident was observed, and vital signs were obtained. The PN further revealed, "MD called at around 4:24 PM no answer and unable to leave voice message." The PN revealed that the resident was encouraged to NJ Exec Order 26.4b1

Further review of the above PN revealed no further attempts by LPN #1 to contact Resident #443's U.S. FOIA (b) (6) until 10:59 PM when the U.S. FOIA (b) (6) was notified that Resident #443 NJ ex order 26.4b1

A telephone interview was conducted with LPN #1 on 2/13/2025 at 11:38 AM. LPN #1 stated that she was NJ ex order 26.4 for Resident #443 on evening shift on NJ ex order 26.4b1, LPN #1 stated she was notified by Resident #443's RP that the resident NJ ex order 26.4b1 . LPN #1 stated that she assessed the resident, and their vital signs were NJ ex order 26.4b but the resident's NJ ex order 26.4b1 . LPN #1 further stated that she called the resident's physician to discuss the resident's NJ Exec Order 26.4 and NJ ex order 26.4b1, and to NJ ex order 26.4b1 NJ ex order 26.4b1 and U.S. FOIA #1 did not receive a call back after she called the U.S. FOIA (b) (6) and left a voice message. LPN #1 did not recall the name of the physician she attempted to contact but stated that her practice was to call the U.S. FOIA (b) (6) listed on the resident's profile. LPN #1 further stated that it was her practice to notify the U.S. FOIA (b) (6) if

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she was unable to reach a resident's physician regarding a concern.

An interview was conducted with LPN #2 on 2/13/2025 at 12:11 PM. LPN #2 stated that she was working as the [US FOI] on [NJ Exec Order 26.4b1] when Resident #443 [NJ Exec Order 26.4] LPN #2 stated that it was the expectation that nurses reported anything that was outside of a resident's baseline to the [US FOIA] the [U.S. FOIA (b) (6)] should have been called, and then any new orders followed. LPN #2 further stated that if staff was unable to reach a resident's [U.S. FOIA (b) (6)], the U.S. FOIA (b) (6) should have been called.

On that same date and time, LPN #2 stated that if a resident was [NJ ex order 26.4b1] the first steps would be to call the physician if the resident [NJ ex order 26.4b1] [NJ ex order 26.4b1]. LPN #2 stated that on [NJ ex order 26.4b1] the nurse assigned to Resident #443 attempted to contact the resident's [U.S. FOIA (b) (6)] but got no answer and left a voice message. LPN #2 stated that LPN #2 made her aware of Resident #443's condition because she was the [US FOIA] LPN #2 stated that she instructed LPN #1 to send a text message to the [U.S. FOIA (b) (6)] instead of calling but was unsure if LPN #1 was able to reach the resident's [U.S. FOIA (b) (6)] by text. LPN #2 stated that it was important that nurses reported concerns because it could lead to a resident declining if they did not get what they needed. LPN #2 further stated that was important to have clear lines of communication so that facility staff could do everything that needed to be done for residents.

An interview was conducted with the [U.S. FOIA (b) (6)] on 2/13/2025 at 1:03 PM. The [U.S. FOIA (b) (6)] stated that staff, including agency staff, were instructed to go to U.S. FOIA (b) (6) if

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F 580	Continued From page 9 they had concerns about residents, and on the weekend they should call the [US FOIA]. The [U.S. FOIA (b) (6)] stated that if a [U.S. FOIA (b)] was unable to reach a [U.S. FOIA (b) (6)], they should notify the [US FOI] who would then call the U.S. FOIA (b) (6). The [U.S. FOIA (b) (6)] reviewed the PN regarding Resident 443's RP's concern about [NJ Exec Order 26.4b1]. The [U.S. FOIA (b) (6)] stated, "It does not appear that (LPN #1) followed our process for [U.S. FOIA (b) (6)] notification when there were concerns for [NJ Exec Order 26.4b1] A review of the facility's Notification of Changes Policy, reviewed/revised 10/21/2024, revealed under Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician [...] when there is a change requiring notification. Under Definitions: the policy revealed that the need to alter treatment significantly means a need to stop a form of treatment, or commence a new form of treatment to deal with a problem. Further review of the policy revealed under Compliance Guidelines, Circumstances requiring notification include: [...] 3. Circumstance that require a need to alter treatment. This may include: a. New treatment.	F 580		
F 607 SS=D	NJAC 8:39-13.1 (d) 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,	F 607		3/9/25

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F 607	Continued From page 10 §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 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 review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure a licensed staff credentials were verified upon hire. This deficient practice was identified for 1 of 9 newly hired licensed staff reviewed. This deficient practice was evidenced by the following: On 2/11/25 at 1:30 PM, the surveyor reviewed ten randomly selected new employee files. The review for license verification/renewal for one of the new licensed employees, U.S. FOIA (b) (6) U.S. FOIA (b) revealed no license in her employee file.	F 607	F607 Develop/Implement Abuse/Neglect Policies 1. A copy of the Social Worker's (SW) original license is placed in the SW employee file. A copy of the SW's reinstated license was also placed in the employee file. 2. All active residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) [redacted] were in-serviced by the Administrator/designee on the facility's Hiring Policy	

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F 607	Continued From page 11 On 2/13/25 at 12:19 PM, the surveyor requested from the U.S. FOIA (b) (6), the US FOIA (b)(license. The U.S. FOIA (b) (6) stated, "She works NJ Exec Order 26.4 as a U.S. FOI. I think something with pending status on her license, the U.S. FOIA (b) (6) will come in and give more information." On 2/13/25 at 12:56 PM, the U.S. FOIA (b) (provided the surveyor a New Jersey Division Consumer Affairs license verification printout dated NJ ex order 26.4b1 AM, which revealed license expiration date NJ ex order 26.4b1 and license status was inactive. The U.S. FOIA (b) (provided a second printout dated NJ ex order 26.4b1 at 9:16 AM, which revealed license status "Reinstatement Pending." The verification was completed after surveyor inquiry. There was no documented evidence that the US FOIA (b)(license was verified prior to the date of hire o NJ ex order 26.4b1 At that time, the U.S. FOIA (b)(stated to the surveyor, "Her license erroneously expired," and her reinstatement was pending. The U.S. FOIA (b) (6 read an email from the Regional Human Resources (HR) Case Management dated NJ ex order 26.4b1 regarding NJ ex orde when US FOIA tried to renew her license who may have selected NJ ex order 26.4b1 versus NJ ex order 26.4b1 " The U.S. FOIA (b) (6 further stated that the HR should have gone online verified it and printed it upon hire. The U.S. FOIA (b) (also stated that "We" have HR and regional person responsible for employee file. Furthermore, the U.S. FOIA (b) (stated that the expectation was every employee should have license verified, and printed or in file upon hire. He further stated that it was important because employees need to have the correct licensing board and nothing against their license. He added	F 607	The credentials of all active licensed and certified employees were audited by Human Resources to ensure credentials are active. The Administrator or designee will audit all new hires to ensure a license verification was performed and a copy of the credential is in the employee file weekly x 4, then monthly x 4 months. 4. The Administrator will report the results of the audits in the monthly QAPI meetings x 4 months to ensure compliance and if further action is necessary.	

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	315021	A. BUILDING _____ B. WING _____	C 02/18/2025

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F 607	Continued From page 12 that, [NJ ex order 26.4b] " the previous HR did not print it, should have been followed up upon hire, the expectation was to have the license in the employee file, and it should have been checked by the HR. The [U.S. FOIA (b)] confirmed that the [U.S. FOI] was hired on [NJ Ex Order 26.4(] with no license verification in the employee file. On 2/13/25 at 2:45 PM, the surveyor notified the [U.S. FOIA (b)] and the U.S. FOIA (b) (6) , and the U.S. FOIA (b) (6) , the concern regarding [U.S. FOIA (b)] license missing in the employee file. A review of the facility's Hiring Policy, dated 12/2024, revealed, "The Human Resources Director, is responsible for maintaining and ensuring the validity and current status of individual certification/licensure." NJAC 8:39-39.2, 40.1	F 607		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625		3/9/25

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F 625	Continued From page 13 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on the interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold notices for 1 of 1 resident, (Resident #175), U.S. FOIA (b) (6) . This deficient practice was evidenced by the following: On 2/7/25 at 11:33 AM, the surveyor observed Resident #175's outside door with a posted sign for U.S. FOIA (b) (6) NJ Exec Order 26.4b1 and the resident was not inside the room. On that same date and time, the U.S. FOIA (b) (6) informed the surveyor that the resident was in NJ Exec Order 26.4	F 625	F625 Notice of Bed Hold Policy Before/Upon Transfer 1. Resident # 175 U.S. FOIA (b) (6) and U.S. FOIA (b) (6) The family was educated on the facility's Bed Hold Policy and informed a copy of the notice will be provided in the event another unplanned discharge to the hospital occurs. 2. All active residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) were in-serviced by the Administrator on the facility Bed Hold Policy.	

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F 625	Continued From page 14 The surveyor reviewed the medical records of Resident #175 and revealed: A review of the Admission Record (an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; NJ ex order 26.4b1 [redacted] A review of the Minimum Data Set (MDS), an assessment tool, revealed the following assessment reference dates (ARD) and Section A Identification Information: -ARD NJ ex order 26.4b1, NJ ex order 26.4b1 and a NJ ex order 26.4b1. -ARD NJ ex order 26.4b1, NJ ex order 26.4b1 and a NJ ex order 26.4b1. -NJ ex order 26.4b1, NJ ex order 26.4b1 and a NJ ex order 26.4b1 A review of the Progress Notes (PN) revealed the following Nurses Notes: -On NJ ex order 26.4b1, U.S. FOIA (b) (6)	F 625	The DON or designee audited all residents with an unplanned discharge to the hospital in the month of February to ensure a copy of a bed hold notice was provided to the resident and family. The Business Office Manager or designee will audit all unplanned discharges weekly x 4 weeks, then monthly x 3 months. 4. The Administrator will report the findings of the audits to the monthly QAPI meetings x 4 months to ensure compliance and if further action is necessary.	

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F 625	Continued From page 15	F 625		

U.S. FOIA (b) (#1 (LPN#1) called the hospital at NJ ex order 26.4b1 and was notified that the resident would be admitted for diagnosis of NJ ex order 26.4b1

-On NJ Ex Order 26.4(b at 2:02 PM, the U.S. FOIA (b) (6) spoke with the emergency room and was notified that the resident was admitted for NJ ex order 26.4b1

-On NJ ex order 26.4b1, LPN#2 documented that the resident NJ ex order 26.4b1

Further review of the medical records revealed that there was no documented evidence that the written notifications for bed hold notices were provided to the resident or resident representative on NJ ex order 26.4b1, and NJ ex order 26.4

On 2/14/25 at 1:07 PM, the survey team met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) The surveyor notified of the concern regarding Resident #175's NJ ex order 26.4b1 notices.

On 2/18/25 at 10:40 AM, the U.S. FOIA (b) (6), in the presence of th U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) provided the two binders for NJ ex order 26.4b1 Notifications, the binders were for NJ ex order and NJ ex order 26

A review of the provided binders revealed that there were no bed hold notices for dates NJ Ex Order 26.4(b)(, NJ Ex Order 26.4(b, and NJ Ex Order 26.4

On 2/18/25 at 11:20 AM, the U.S. FOIA (b flipped over the pages in the NJ Exec Orc bed hold notices binder and the U.S. FOIA (b confirmed that there were no notices for Resident #175 for NJ Exec Order 26.4 and NJ Exec Order 26.4b1

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F 625	Continued From page 16 The U.S. FOIA (b) (confirmed also that there were no other bed hold notices in the NJ Exec Ord binder for the resident except for NJ ex order 26.4b1. Both the U.S. FOIA (b) (and U.S. FOIA (b (also confirmed that there were no other binders for bed hold notices except for the NJ Exec Ord and NJ Exec Ord binders that were reviewed in the presence of the survey team. A review of the facility's Transfer or Discharge, Facility-Initiated Policy, with a revision date of October 2022, that was provided by the US FOIA (b)(6) revealed: Notice of Transfer or Discharge (Emergent or Therapeutic Leave): 5. Notice of Facility Bed-hold and return policies are provided to the resident and representative within 24 hours of emergency transfer. 6. Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments. On 2/18/25 at 1:47 PM, the survey team met with the U.S. FOIA (b) (6), and U.S. FOIA (b) (6) for an exit conference, the U.S. FOIA (b) (did not provide additional information.	F 625		
F 637 SS=D	NJAC 8:39-4.1(a)31,32; 5.1; 5.2(a); 5.3 Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the	F 637		3/9/25

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F 637	Continued From page 17 resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure that a NJ Exec Order 26.4b1) was completed for 1 of 38 residents, (Resident #18), reviewed for Minimum Data Set (MDS). This deficient practice was evidenced by the following: According to the CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, updated October 2024 showed: An SCSA must be completed within 14 days of determining a significant change from baseline. The resident's condition is not expected to return to baseline within two weeks. Comparison with the most recent comprehensive and quarterly assessments is crucial. Criteria for SCSA include two areas of decline or improvement, or IDT (Interdisciplinary team) recommendation. Documentation of criteria met is essential in the resident's medical record. Required for various scenarios like hospice enrollment, a consistent pattern of changes, etc. On 2/7/25 at 11:49 AM, the surveyor observed Resident # 18 in the activity room behind the N	F 637	F637 Comprehensive Assessment After Significant Change 1. The U.S. FOIA (b) (6)), U.S. FOIA (b) (6) and U.S. FOIA (b) (6) conducted an interdisciplinary team meeting (IDT) related to Resident #18. Several Brief Interview for Mental Status tests were conducted on different days, times, and interviewers. An IDT note was written to reflect the latest assessments conducted by the IDT team supporting why Resident # 18 U.S. FOIA (b) (6) 2. All active residents have the potential to be affected by the deficient practice. 3. The U.S. FOIA (b) (6) , and U.S. FOIA (b) (6) were in-serviced by the Administrator on the RAI Version 3.0 Manual criteria for SCSA. The MDS Coordinator or designee audited all active residents to identify residents displaying significant weight	

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F 637	Continued From page 18 NJ Exec Or nursing station seated in a wheelchair with other residents. The surveyor reviewed the medical records of Resident #18 and revealed: A review of the Admission Record (an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; NJ ex order 26.4b1 [redacted] A review of the comprehensive MDS with an assessment reference date (ARD) of NJ ex order 26.4b1 revealed in Section NJ Exec Order 26.4b1 a brief interview for mental status (BIMS) score of NJ ex o of 15, which reflected an NJ ex order 26.4b1. Section NJ Ex NJ Exec Order 26.4b reflected that the resident's NJ Exec Order 2 was NJ ex order 26.4b1 A review of the quarterly MDS (qMDS) with an ARD of NJ ex order 26.4b1, revealed a BIMS score of NJ e of 15, which reflected that the resident's NJ Exec Order 26.4b1 status NJ ex order 26.4b1. Section NJ reflected that the resident's NJ Exec Order 2 was NJ ex order 26.4b1 A review of the qMDS with an ARD of NJ ex order 26.4b1 revealed a BIMS score of NJ e of 15, which reflected that the resident's NJ Exec Order 26.4b1 status was NJ ex order 26.4b1 [redacted] Section NJ reflected that the resident's NJ Exec Order 2 was NJ ex order 26.4b1 A review of the Dietary Assessment and Documentation (admission assessment) that was electronically signed by NJ Exec Order 26.4b1 #1 (D#1) on NJ ex order 26.4, reflected that the resident's NJ Exec Order 2 was taken on NJ ex order 26.4, and it was NJ ex order 26.4b1	F 637	changes and significant changes in the BIMs and collaborated with the U.S. FOIA (b) [redacted], and U.S. FOIA (b) ([redacted] to determine if a SCSA is needed. Significant changes in weights and BIMS will be discussed during clinical meetings. The Administrator or designee will audit the charts of 2 new admissions and 8 long term care residents to ensure a SCSA was completed if a recent decline or improvement in two areas that is not expected to return to baseline within two weeks was identified weekly x 4 weeks, then monthly x 3 months. 4. The Administrator will report the findings of the audits to the monthly QAPI meeting x 4 months to ensure compliance an if further action is necessary.	

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F 637	Continued From page 19 A review of the [NJ Exec Order 26.4b1] Assessment and Documentation (quarterly) that was electronically signed by D#2 on [NJ ex order 26.4b1], reflected that the resident's [NJ Exec Order 2] was taken on [NJ ex order 26.4b1], and it was [NJ ex order 26.4b1] A review of the [NJ Exec Order 26.4b] Notes that was electronically signed by D#3 on [NJ ex order 26.4b1] reflected that the resident's [NJ Exec Order 2] was [NJ ex order 26.4b1] noted [NJ Exec Order 26.4] on NJ ex order 26.4b1 NJ ex order 26.4b1 indicative of a [NJ Exec Order 26.4b1] NJ ex order 26.4b1 . A review of the personalized Care Plan (CP) revealed that the resident NJ ex order 26.4b1 that was identified on [NJ ex order 26.4b1], revised focus CP that was revised by D#3. Further review of the personalized CP revealed that Resident #18 NJ ex order 26.4b1 , and NJ ex order 26.4b1 that were revised on [NJ ex order 26.4b1], by Activity Director. Further review of the medical records revealed that there was no documented evidence that the Interdisciplinary Team (IDT) met and decided that the [NJ Exec Order] would not be necessary to be done due to the above two changes in the resident's status, specifically for change in [NJ Exec Order 26.4b1] status from NJ ex order 26.4b1 for two qMDS, [NJ ex order 26.4b1], and [NJ ex order 26.4b1], and [NJ ex order 26.4] than NJ ex order 26.4b1 . On 2/12/25 at 1:08 PM, the surveyor interviewed the U.S. FOIA (b) (6) who informed the surveyor that the	F 637		

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facility followed the RAI manual for MDS and that there was no separate policy for MDS. The surveyor notified the U.S. FOIA (b) (6) of the above findings and concerns. The surveyor asked the U.S. FOIA (b) (6) if she should have done a NJ ex order 26. due to the above findings, and she responded NJ ex order". The U.S. FOIA (b) (6) further stated that she would review Resident #18's records and would get back to the surveyor as to why the NJ ex order 26.4 was not done.

On 2/12/25 at 1:29 PM, the survey team met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) and the surveyor notified them of the above findings and concerns.

On 2/14/25 at 11:25 AM, the U.S. FOIA (b) (6) informed the surveyor that the resident's NJ ex order 26.4b1 and the team did not feel that it was necessary to make NJ Exec Order 26.4b1 for the two quarters after the comprehensive MDS when the BIMS score NJ ex order 26.4b1 The surveyor asked the U.S. FOIA (b) (6) if there was documentation that the team met and decided that the resident's NJ ex order 26.4b1 . The U.S. FOIA (b) (6) was unable to provide a document that the team met and decided not to proceed with NJ Exec Order 26.4b1.

At that same time, the U.S. FOIA (b) (6) further stated that it "looks like" the two quarters' BIMS scores were NJ ex order 26.4b1 . The surveyor asked the U.S. FOIA (b) (6), if the team believed it was wrong, the assessment for NJ Exec Order 26.4b1, and what the facility did to correct it, and the U.S. FOIA (b) (6) did not respond.

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F 637	Continued From page 21 On 2/14/25 at 12:56 PM, the U.S. FOIA (b) (6) informed the surveyor that the team did not feel that NJ Exec Order 26.4b1 was necessary because of the NJ ex order 26.4b1 of the resident. The U.S. FOIA (b) (6) was unable to provide documentation that the facility met and decided not to proceed with NJ Exec Order 26.4b1 for Resident#18. A review of facility provided CP by U.S. FOIA (b) (6) revealed that the CP for NJ ex order 26.4b1 after the surveyor's inquiry. On 2/18/25 at 1:47 PM, the survey team met with the U.S. FOIA (b) (6), and U.S. FOIA (b) (6) U.S. FOIA (b) (6) at an exit conference, the U.S. FOIA (b) (6) did not provide additional information. NJAC 8:39-11.2(i)	F 637		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		3/9/25

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F 640	Continued From page 22 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on interviews and record review, it was determined that the facility failed to complete and transmit the Minimum Data Set Assessment	F 640	F640 Encoding/Transmitting Resident Assessments 1. The comprehensive Minimum Data Set assessment (cMDS) for Resident # 18	

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	315021	A. BUILDING _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 640	Continued From page 23 (MDS), an assessment tool used to facilitate the management of care, within 14 days as required, for 14 of 38 residents, (Residents #13, #18, #48, #60, #68, #77, #102, #103, #121, #162, #172, #175, #180, and #187), reviewed for MDS, in accordance with federal guidelines. This deficient practice was evidenced by the following: 1. Surveyor#1 (S#1) reviewed the medical records of the following residents and their MDS and revealed: A review of Resident #18's comprehensive MDS (cMDS) with an assessment reference date (ARD) of NJ ex order 26.4b1, was completed on NJ ex order 26.4b1. A review of Resident #77's cMDS with an ARD of NJ ex order 26.4b1, was completed on NJ ex order 26.4b1. A review of Resident #162's cMDS with an ARD of NJ ex order 26.4b1 was completed on NJ ex order 26.4b1. A review of Resident #175's cMDS with an ARD of NJ ex order 26.4b1 was completed on 12/3/24. A review of Resident #180's cMDS with an ARD of NJ ex order 26.4b1 was completed on NJ ex order 26.4b1. The above MDS of Residents #18, #77, #162, #175, and #180 completion dates were presented in the electronic medical records (EMR) in red. On 2/12/25 at 1:08 PM, S#1 interviewed the U.S. FOIA (b) (6) regarding the MDS of the above residents on which completion dates were presented in red. S#1 asked the U.S. FOIA (b) (6) what the facility's	F 640	was completed on NJ ex order 26.4b1 The cMDS for Resident #77 was completed on NJ ex order 26.4b1 The cMDS for Resident #162 was completed on NJ ex order 26.4b1 The cMDS for Resident #175 was completed on NJ ex order 26.4b1 The cMDS for Resident # 180 was completed on NJ ex order 26.4b1 The cMDS for Resident # 13 was completed on NJ ex order 26.4b1 The cMDS for Resident # 60 was completed on NJ ex order 26.4b1 The cMDS for Resident # 68 was completed on NJ ex order 26.4b1 The cMDS for Resident # 102 was completed on NJ ex order 26.4b1 The cMDS for Resident # 103 was completed on NJ ex order 26.4b1 The cMDS for Resident # 187 was completed on NJ ex order 26.4b1 The cMDS for Resident # 48 was completed on NJ ex order 26 The cMDS for Resident # 121 was completed on NJ ex order 26.4b1 The qMDS for Resident # 121 was completed on NJ ex order 26.4b1 The cMDS for Resident # 172 was completed on NJ ex order 26.4b1 2. All active residents have the potential to be affected by the deficient practice. 3. The Minimum Data Set (MDS) Coordinators was educated by the Administrator/designee on completing and transmitting cMDS assessments.	

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F 640	Continued From page 24 protocol was for completing MDS and how many days the MDS should be completed, and the U.S. FOIA (b) (6) responded that she had to get back to the surveyor. At that same time, the U.S. FOIA (b) (6) informed the surveyor that the facility utilized the Resident Assessment Instrument (RAI) manual as the facility's guidelines for MDS and that the facility had no separate policy for MDS. On that same date and time, S#1 asked the U.S. FOIA (b) (6) to review the above Residents # 18, #77, #162, #175, and #180's cMDS, determine if the facility completed the assessments according to the RAI manual, and provide the transmittal reports. On 2/12/25 at 1:29 PM, the survey team met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) and S#1 notified them of the above findings and concerns regarding MDS of Residents #18, #77, #162, #175, and #180. On 2/13/25 at 1:51 PM, the U.S. FOIA (b) (6) met with S#1 and provided a CMS's RAI 3.0 Manual (October 2024 version) that included the required assessment summary and specified days when to complete and submit the MDS. The U.S. FOIA (b) (6) confirmed that the above MDS for Residents #18, #77, #162, #175, and #180 were completed beyond the required 14 days. A review of the provided documents by the U.S. FOIA (b) (6) revealed: The NJ ex order 26.4b1 cMDS of Resident #18 was completed on NJ ex order 26.4b1 The Resident was	F 640	The Regional Minimum Data Set Director or designee audited all March cMDS and qMDS assessments currently due for completion and transmission to ensure timely completion and transmission. The Regional Minimum Data Set Director or designee audited all cMDS and qMDS assessments currently due for completion and transmission weekly x 4 weeks, then monthly x 3 months to ensure compliance. 4. The Director of Nursing, Administrator, or designees, will report the findings of the audits to the monthly QAPI meetings x 4 months to ensure compliance and if further action is necessary.	

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F 640	Continued From page 25	F 640		

admitted on NJ ex order 26.4b1 MDS should have been completed by NJ ex order 26.4b1.

The NJ ex order 26.4b1 cMDS of Resident #77 was completed on NJ ex order 26.4b1. The resident was admitted on NJ ex order 26.4b1 MDS should have been completed by NJ ex order 26.4b1

The NJ ex order 26.4b1 cMDS of Resident #162 was completed on NJ ex order 26.4b1 The Resident was admitted NJ ex order 26.4b1, MDS should have been completed by NJ ex order 26.4b1

The NJ ex order 26.4b1 cMDS of Resident #175 was completed on NJ ex order 26.4b1 The Resident was admitted on NJ ex order 26.4b1, MDS should have been completed by NJ ex order 26.4b1.

The NJ ex order 26.4b1 cMDS of Resident #180 was completed on NJ ex order 26.4b1 The Resident was admitted on NJ ex order 26.4b1, MDS should have been completed by NJ ex order 26.4b1.

A review of the provided RAI Manual with an October 2024 version, that was provided by the US FOIA (b)(6) revealed that the admission (comprehensive) assessment completion date will be no later than the 14th calendar day of the resident's admission (admission date +13 calendar days).

2. Surveyor#2 (S#2) reviewed the medical records of the following residents and their MDS and revealed:

A review of Resident #13's quarterly MDS (qMDS) with an ARD of NJ ex order 26.4b1, was completed late on NJ ex order 26.4b1.

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A review of Resident #60's cMDS with an ARD of NJ ex order 26.4b1, was completed late on NJ ex order 26.4b1 and the care plan decisions were completed late on NJ ex order 26.4b1

A review of Resident #68's qMDS with an ARD of NJ ex order 26.4b1 was completed late on NJ ex order 26.4b1

A review of Resident #102's qMDS with an ARD of NJ ex order 26.4b1 was completed late on NJ ex order 26.4b1

A review of Resident #103's cMDS with an ARD of NJ ex order 26.4b1, was completed late on NJ ex order 26.4b1.

A review of Resident #187's cMDS with an ARD of NJ ex order 26.4b1 was completed late on NJ ex order 26.4b1.

On 2/14/25 at 9:43 AM, S#2 interviewed U.S. FOIA (b) (6), who stated, "We" go by the RAI manual, we complete them by 14 days from admission and the others 14 days from the ARD. She further stated that the MDSs were late because it was a big building and "I am the only one doing the subacute. Sometimes they are late, I will make sure these are a priority going forward."

On 2/14/25 at 1:39 PM, S#2 notified the U.S. FOIA (b) and the U.S. FOIA (b) (6) regarding concerns with late MDSs completion.

On 2/14/25 at 11:25 AM, the US FOIA (b)(6) provided the Final Validation Reports (CMS Submission Report) for the late MDSs which confirmed assessments were completed late.

3. A review of Resident #48's cMDS with an ARD of NJ ex order 26.4b1, was completed late on NJ ex order 26.4

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F 640	Continued From page 27 A review of Resident #121's cMDS with an ARD of [NJ ex order 26.4b1], was completed late on [NJ ex order 26.4b1]. A review of Resident #121's qMDS, with an ARD [NJ ex order 26.4b1] was completed late on [NJ ex order 26.4b1] A review of Resident #172's cMDS with an ARD of [NJ ex order 26.4b1], was completed late on [NJ ex order 26.4b1] On 2/14/25 at 1:07 PM, Surveyor #3 (S#3) notified the [U.S. FOIA (b) (] and the [U.S. FOIA (b] of the identified late completion of the MDS assessments. A review of the facility's MDS Completion and Submission Timeframes Policy, revealed, "Timeframes for completion.....is based on the current requirements published in the Resident Assessment Instrument Manual." On 2/18/25 at 1:26 PM, the survey team met with the [U.S. FOIA (b) (6)], and [U.S. FOIA (b) (6)] [redacted]. The [U.S. FOIA (b) (] did not provide additional information.	F 640		
F 641 SS=D	NJAC 8:39 - 11.1 Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the	F 641	F641 Accuracy of Assessments CFR(s): 483.20(g) 1. The Assistant Director of Nursing, Licensed Practical Nurse Unit Manager, Minimum Data Set Coordinator, and	3/25/25

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F 641	Continued From page 28 management of care, for 2 of 38 residents, (Residents #18 and #190), reviewed for MDS accuracy. This deficient practice was evidenced by the following: 1. On 2/7/25 at 11:49 AM, the surveyor observed Resident #18 in the activity room behind the NJ nursing station seated in a NJ ex order 26.4b1 with other residents. The surveyor reviewed the medical records of Resident #18 and revealed: A review of the Admission Record (AR, an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to: NJ ex order 26.4b1 , NJ ex order 26.4b1 and NJ ex order 26.4b1 A review of the quarterly MDS (qMDS) with an assessment reference date (ARD) of NJ ex order 26.4b1, revealed a brief interview for mental status (BIMS) score of NJ of 15, which reflected that the resident's NJ Exec Order 26.4b1 was NJ ex order 26.4b1. Section NJ E NJ Exec Order 26.4b reflected that the resident's NJ Exec Order 2 was NJ ex order 26.4b. A review of the qMDS with an ARD of NJ ex order 26.4b1 revealed a BIMS score of NJ of 15, which reflected that the resident's NJ Exec Order 26.4b1 status NJ ex order 26.4b1 . Section NJ reflected that the resident's NJ Exec Order 2 was NJ ex order 26.4b1 A review of the NJ Exec Order 26 Assessment and	F 641	Social Worker conducted an interdisciplinary team meeting (IDT) related to Resident #18. Several Brief Interview for Mental Status tests were conducted on different days, times, and interviewers. The Minimum Date Set (MDS) assessment for resident #190 was modified to reflect that the resident was NJ Exec Order 26.4b1 2. All residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) was in-serviced by the Administrator/designee on the Resident Assessment Instrument (RAI) Version 3.0 Manual and the criteria for a SCSA and discharge location. The Minimum Data Set Coordinator or designee audited the most recent weights of all active residents to determine if residents with NJ Exec Order 26.4b1 meet the criteria of a NJ Exec Order 26.4b1 in Status Assessment. A Modification Minimum Data Set assessment for NJ Exec Order 26.4b1 quarterly assessment for Resident #18 was completed on NJ ex order 26.4b1 to reflect the NJ ex order 26.4b1 and NJ Exec Order 26.4b1 or more NJ Exec Order 26.4b1 The Minimum Data Set Coordinator or designee audited the most recent	

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F 641	Continued From page 29 Documentation (quarterly) that was electronically signed by U.S. FOIA (b) (6) #1 (D#1) on NJ ex order 26.4b1 reflected that the resident's NJ Exec Order 2 was taken on NJ ex order 26.4b1 and it was NJ ex order 26.4b1 A review of the NJ Exec Order 26.4b Notes (NJ Exec O that was electronically by D#2 signed on NJ ex order 26.4b1, reflected that the resident's NJ Exec Order 2 was NJ ex order 26.4b1 NJ ex order 26.4b1 and NJ ex order 26.4b1 indicative of a NJ Exec Order 26.4b1 NJ ex order 26.4b1 A review of NJ Exec that was electronically signed by D#3 on NJ ex order 26.4b1 reflected that on NJ ex order 26.4b1, the weight was NJ ex order 26.4b1, on NJ ex order 26.4b1 the NJ Exec Order 2 was NJ ex order 26.4b1, on NJ ex order 26.4b1, the NJ Exec Order 2 was NJ ex order 26.4b1, and on NJ ex order 26.4b1, the NJ Exec Order 2 was NJ ex order 26.4b1 and was noted with NJ Exec Order 26.4b1 of NJ ex order 26.4b1. The NJ Exec also included that the NJ ex order 26.4 and considered NJ ex order 26.4b1 for Resident #18. On 2/12/25 at 1:08 PM, the surveyor interviewed the U.S. FOIA (b) (6) who informed the surveyor that the facility followed the RAI manual for MDS and that there was no separate policy for MDS. The surveyor notified the U.S. FOIA (b) (6) of the above findings and concerns. The U.S. FOIA (b) (6) stated that she would review Resident #18's records and would get back to the surveyor. On 2/12/25 at 1:29 PM, the survey team met with the U.S. FOIA (b) (6) and the surveyor notified them of the above findings and concerns that the qMDS ARD NJ ex order 26.4b1 Section NJ Exec Order 26.4b of NJ ex order 26.4b did not match on what the NJ Exec Order 26 Assessment and Documentation	F 641	discharge assessment to ensure the accuracy of the discharge location. Significant weight changes will be discussed during clinical meetings. The Director of Minimum Data Set or Designee will audit the accuracy of the assessments of all new admissions, discharges, and 5 long term care residents, weekly x 4 weeks, then monthly x 3 months to ensure accuracy of weights and location of discharges. 4. The Administrator or Designee will report the results of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meetings x 4 months to ensure compliance and if further action is necessary.	

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documented on [redacted] by D#1 that the [redacted] obtained on [redacted].

On 2/18/25 at 1:47 PM, the survey team met with the [redacted], and [redacted] at an exit conference, the [redacted] did not provide additional information.

2. On 2/14/25 at 9:11 AM, the surveyor reviewed the closed medical records for Resident #190.

A review of Resident #190's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] and [redacted] that [redacted].

A review of Resident #190's most recent Progress Note indicated that the resident was discharged (d/c) [redacted].

A review of Resident #190's most recent [redacted] (drna) MDS, reflected that the resident was d/c to a [redacted]. The MDS was coded incorrectly.

On 2/14/25 at 9:20 AM, the surveyor interviewed the first floor [redacted] regarding Resident #190. The first floor [redacted] stated that Resident #190 was d/c home.

On 2/14/25 at 10:04 AM, the surveyor interviewed the [redacted] regarding Resident #190. The [redacted] stated that she was not the person that coded Resident #190's drna MDS. She

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F 641	Continued From page 31 reviewed the resident's medical record and confirmed that the MDS was coded incorrectly. On 2/14/25 at 1:54 PM, the surveyor notified the U.S. FOIA (b) (and the U.S. FOIA (of the concern that Resident #190's drna MDS was coded incorrectly. On 2/18/25 at 11:50 AM, in the presence of the U.S. FOIA (b) (6), the U.S. FOIA (stated that the MDS was coded in error and that it was corrected after surveyor inquiry. The U.S. FOIA (b) (6 did not provide any additional information. The facility did not have a policy regarding MDS. N.J.A.C. 8:39-11.2, 33.2 (d)	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		3/9/25

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F 656	Continued From page 32 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint#: NJ175914 Based on observations, interviews, review of medical records, and facility documents, it was determined that the facility failed to develop and implement a comprehensive plan of care to meet residents' preferences and goals and address the resident's medical and [redacted] needs. This deficient practice was identified for 4 of 38 residents (Residents #111, #172, #180, and	F 656	F656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) 1. The following care plans for Resident # 111 have been updated to reflect an individualized focus and interventions: [redacted] The Activity Daily Living (ADL) care plan for Resident # 172 have been completed	

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(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 656	Continued From page 33 #442), reviewed for a care plan. This deficient practice was evidenced by the following: 1. On 2/7/25 at 11:26 AM, the surveyor interviewed Resident #111 who was seated in a NJ ex order 26.4b1, and stated that they had NJ ex order 26.4b1 [redacted]. Resident #111 further stated that they NJ ex order 26.4b1 and that they NJ ex order 26.4b1 and it was [redacted] The surveyor observed a NJ ex order 26.4b1 " NJ Exec Order 26.4b1 on Resident #111's [redacted] and that the resident's bed was NJ Exec Order 26.4b1 On 2/11/25 at 10:37 AM, the surveyor interviewed Resident #111's U.S. FOIA (b) (6) #1 (LPN#1) regarding the process for [redacted] assessment and [redacted] LPN#1 stated that a [redacted] risk assessment was done on admission and that it may be done by the US FOIA (b)(6) quarterly but was not sure. She added that [redacted] saw the resident within 24 hours to determine if the resident was a [redacted]. LPN#1 stated that most residents had a care plan (CP) that included risk for [redacted] with interventions that included frequent [redacted] and [redacted]. LPN#1 further stated that if a resident had a [redacted] then a risk management/incident report was done which included statements from staff. She added that an investigation for the cause was done and that the US FOIA (b)(6) would update the CP with a new intervention. A review of Resident #111's Admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to;	F 656	and individualized based on the NJ Exec Order 26.4b1 The care plan for Resident # 180 have been updated to reflect a NJ Exec Order 26.4b1 The At Risk for NJ Exec Order 26.4b1 and I have NJ Exec Order 26.4b1 care plans for Resident #442 have been updated to include the resident's risk factors and current interventions. 2. All active residents have the potential to be affected by this deficient practice. 3. The US FOIA (b)(6) [redacted] were in-serviced by the Administrator on the facility "Care Plans-Comprehensive" Policy. The Director of Nursing or designee audited all active residents at risk for skin breakdown, at risk for pain, and ADL to ensure the focus and interventions were individualized. The DON or designee audited all active resident with a Hypertension diagnosis to ensure the interventions related to the diagnosis were included in the care plan. The DON or designee audited all active residents with splints to ensure the splint and related interventions were included in the care plan. The DON or designee audited all active residents with a diagnosis of Diabetes	

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F 656	Continued From page 34 NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] A review of Resident #111's most NJ ex order 26.4b1 [redacted] return anticipated Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's NJ Exec Order 26.4b1 for decision making were NJ ex order 26.4b1 . A review of Resident #111's Progress Notes (PN) indicated that that in NJ ex order 26.4b1 the resident NJ ex order 26.4b1 [redacted] A review of Resident #111's current active CP, with an initiated date of NJ ex order 26.4b1, included the following focus areas that were not individualized to the resident and complete: NJ ex order 26.4b1 [redacted] Further review of the electronic medical record indicated that Resident #111 NJ ex order 26.4b1 [redacted] and NJ ex order 26.4b1 [redacted] on NJ ex order 26.4b1. Resident #111's active current CP did not include all of the previous focus areas or interventions that were implemented. On 2/11/25 at 12:46 PM, the surveyor interviewed the U.S. FOIA (b) (6) regarding CP. The U.S. FOIA (b) (6) stated that upon admission a	F 656	mellitus to ensure interventions related to the diagnosis were included in the care plan. New admissions will be discussed during clinical meetings to identify residents at risk for skin breakdown, at risk for pain, ADL assistance, Hypertension and Diabetes Mellitus diagnosis to ensure the applicable care plans were initiated and individualized. The DON or Designee will conduct an audit the charts of 5 new admissions and 5 long term care weekly x 4, then monthly x 3 months to ensure the perspective care plans are in place. 4. The DON will report the results of the audits in the monthly QAPI meeting x 4 months to ensure compliance and if further action is necessary.	

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baseline [redacted] was done and that the [redacted] was later updated by the supervisor, [redacted], U.S. FOIA (b) (6) [redacted] or U.S. FOIA (b) (6) [redacted] The first floor [redacted] stated that the [redacted] did not have to be closed (completed) if went to hospital and came back a couple days later but that he would have to ask MDS.

On 2/11/25 at 1:10 PM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] U.S. FOIA (b) (6) regarding CP. The U.S. FOIA (b) (6) stated that she may open the CP but that usually other departments completed them and reviewed them. The U.S. FOIA (b) (6) further stated that the CP was closed (completed) when the resident [redacted] that when they returned a new CP was opened. The surveyor asked that if the information in the completed CP should be continued in the new CP if still relevant. The [redacted] stated NJ ex order 26.4b1" The U.S. FOIA (b) (6) added that the interventions should be in place but that she was not sure if the CP had to be closed out.

On 2/12/25 at 1:43 PM, the surveyor notified the [redacted] and [redacted] the concern that Resident #111 did not have an individualized complete active CP that included all relevant focus areas that were individualized and were implemented prior to the resident's NJ ex order 26.4b1.

On 2/13/25 at 2:14 PM, in the presence of the [redacted] and [redacted], the U.S. FOIA (b) (6) [redacted] stated when Resident #111 went to the hospital the U.S. FOIA (b) (6) had canceled the CP instead of resolving it and that a new CP had to be initiated.

On 2/14/25 at 9:59 AM, the U.S. FOIA (b) (6) stated that

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apparently the CP was not supposed to have been canceled (completed) when the resident NJ ex order 26.4b1 She added that if there was a bedhold then it does not get canceled (completed). The US FOIA (b)(6) stated that for Resident #111, someone NJ ex order 26.4b1 and that now it was updated.

The [redacted] did not provide any additional information.

2. On 2/7/25 at 11:00 AM, the surveyor observed Resident #172 NJ Exec Order 26.4b1 . The resident NJ ex order 26.4b1 to the surveyor's greeting.

On 2/11/25 at 9:05 AM, the surveyor reviewed the medical records of Resident #172.

The AR revealed that Resident #172 had diagnoses that included, but were not limited to, NJ ex order 26.4b1

A review of the comprehensive MDS with an assessment reference date (ARD) of [redacted], indicated the facility assessed the resident's [redacted] and Resident #172 was coded as being NJ ex order 26.4b1 . The resident was coded NJ ex order 26.4b1 . Additionally, the resident was NJ ex order 26.4b1

A review of the resident's CP for [redacted] revealed it was not complete and individualized for Resident

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#172. The CP had an initiation date of [redacted] and a last revised date of [redacted]. The focus and interventions of the CP included areas that had been left documented "Specify" and not individualized for the resident.

On [redacted], the surveyor notified the [redacted] and the [redacted] of the above concern for Resident #172's ADL CP.

On 2/18/25 at 11:32 AM, the [redacted], the [redacted], and the [redacted] met with the survey team. The [redacted] stated Resident #172's CP was incomplete and was updated by the staff. The [redacted] also stated that re-education would be provided to their staff to ensure CPs were completed.

3. On 2/7/25 at 11:35 AM, the surveyor observed Resident #180 [redacted], and stated that they were at the facility for [redacted] and [redacted]. The surveyor observed the resident with a [redacted]

A review of Resident #180's medical records revealed:

A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; unspecified [redacted]

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NJ ex order 26.4b1 [redacted]

A review of the personalized CP revealed that there was no documented evidence that the NJ Exec [redacted] was identified and there were no interventions for care of the NJ Exec Order [redacted]

On 2/10/25 at 8:28 AM, the surveyor observed the resident in the presence of LPN#2 during medication NJ ex order 26.4b1 [redacted] LPN#2 informed the surveyor that the resident NJ ex order 26.4b1 [redacted] LPN#2 stated that the resident NJ ex order 26.4b1 [redacted]. She further stated that the resident NJ ex order 26.4b1 [redacted]

On 2/12/25 at 1:29 PM, the survey team met with the U.S. FOIA (b) (6 [redacted] and the U.S. FOIA (b) [redacted] and the surveyor notified them of the above findings and concerns regarding the NJ Exec Order [redacted]

On 2/14/25 at 1:07 PM, the survey team met with the U.S. FOIA (b) (6 [redacted] and U.S. FOIA (b) ([redacted] The U.S. FOIA (b [redacted] stated that the order and CP for the NJ Exec Ord [redacted] of Resident #180 were entered into the medical record after the surveyor's inquiry.

4. According to the AR of Resident #442, the resident was admitted to the facility with diagnoses which included but not limited to NJ ex order 26.4b1 [redacted]

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NJ ex order 26.4b1 [redacted]

A review of the most recent MDS, with a brief interview for mental status (BIMS) of [redacted] of 15, which indicated that the resident was NJ ex order 26.4b1 [redacted] Further review of the resident's MDS revealed that Resident #442 [redacted]

A review of Resident #442's CP initiated on NJ ex order 26.4b1, and revised on NJ ex order 26.4b1 revealed a focus, which indicated that Resident #442 [redacted] The resident's CP revealed [redacted]

Further review of Resident #442's CP initiated on NJ ex order 26.4b1 and revised on NJ ex order 26.4b1, revealed a Focus, which indicated that Resident #442 had DM. The resident's CP revealed no Interventions/Tasks related to the resident's diagnosis of DM.

During an interview on 2/14/2025 at 1:35 PM, the U.S. FOIA [redacted] confirmed the absence of interventions on Resident #442's CP. The U.S. FOIA [redacted] stated that the CPs purpose was to inform staff of how to care for the resident. The U.S. FOIA [redacted] stated that when CPs were not complete staff would need to rely on their basic nursing knowledge to care for a resident.

A review of the facility's Care Plans, Comprehensive Person-Centered Policy, revised March 2022, revealed under "Policy Interpretation and Implementation," that the comprehensive,

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person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. This policy section further revealed that the CP should indicate which professional services were responsible for each element of care. Further review of this section of the facility policy revealed that CP interventions should be chosen after data gathering, sequencing of events, consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.

A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.
3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. ..
11. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.
7. The comprehensive, person-centered CP:
a. includes measurable objectives and timeframes ...
b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ...
9. CP interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making ...
12. The interdisciplinary team reviews and updates the CP ...at least quarterly

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F 656	Continued From page 41 The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desire outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. On 2/18/25 at 1:47 PM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) at an exit conference, the U.S. FOIA (b)(6) did not provide additional information NJAC 8:39-11.2 (d)(e), 27.1 (a)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to ensure that a.) the monthly NJ Exec Order 26.4b1 was done routinely and accurately and b.) identified NJ Exec Order 26.4b1 were discussed with the interdisciplinary team for 1 of 5 residents, (Resident #175), reviewed for unnecessary medications, according to the standard of clinical practice and facility policy.	F 658	F658 Services Provided Meet Professional Standards 1. NJ ex order 26.4b1 Monthly Review was completed under the Progress Note section for Resident #175 summarizing the use of a NJ ex order 26.4b1 2. All resident's receiving a psychoactive medication have the potential to be	3/9/25

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F 658	Continued From page 42 This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 2/7/25 at 11:33 AM, the surveyor did not observe Resident #175 inside their room. On that same date and time, the U.S. FOIA (b) (6) informed the surveyor that the resident was in NJ Exec Order 26.4 The U.S. FOIA (further stated that Resident #17 NJ Ex Order 26.4(b)(1)	F 658	affected. 3. The Director of Nursing (DON) or designee audited all active residents who received a psychoactive medication in January to ensure a monthly psychoactive review that includes identified behaviors was written in February. The US FOIA (b)(6) were in-serviced by the Administrator on the completion of the monthly psychoactive review that includes identified behaviors. The DON or Designee will conduct an audit of 10 random charts of active resident who received a psychoactive medication anytime during the previous month weekly x 4, then monthly x 3 months to ensure a monthly psychoactive review is completed. 4. The DON will report the results of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting x 4 months to ensure compliance and if further action is necessary.	

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F 658	Continued From page 43 The surveyor reviewed the medical records of Resident #175 and revealed: A review of the Admission Record (or face sheet, an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to NJ ex order 26.4b1 [redacted] A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of NJ ex order 26.4b1, revealed in NJ Exec Order 26.4b1 Patterns, a brief interview for mental status (BIMS) score of NJ of 15, which reflected that the resident's NJ Exec Order 26.4b1 was NJ ex order 26.4b1. A review of the NJ ex order 26.4b1, and NJ ex order 26.4b1 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) with physician orders (PO) revealed: -A PO with a start date of NJ ex order 26.4b1 and NJ ex order 26.4b1 [redacted]	F 658		

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NJ ex order 26.4b1 .

NJ ex order 26.4b1 NJ Exec Order 26.4 by mouth at HS for NJ Exec Order 26.4b1

NJ ex order 26.4b1

NJ ex order 26.4b1

-A review of the NJ ex order 26.4b1 3 of 60 shifts were blanks, and 56 of 60 were documented no behaviors. For dates NJ ex order 26.4b1 were documented in the eMAR and for dates NJ Exec Order 26.4b1 were documented in the eTAR.

-A review of NJ Exec Order 26.4b1 eTAR NJ Exec Order 26.4b1 monitoring for NJ ex order 26.4b1 revealed that 1 of 93 shifts was blank, 2 of 93 shifts NJ Exec Order 26.4b1 were NJ ex order 26.4b1 and 90 of 93 shifts no NJ Exec Order 26.4b1 were documented.

A review of the NJ Exec Order 26.4b1 dated NJ ex order 26.4 which was electronically signed by the U.S. FOIA (b) (6) for the reason of evaluation was a monthly review for a NJ Exec Order 26.4b1 of NJ ex order 26.4b1 The NJ Exec reflected that NJ Exec Order 26.4b1 was identified for the period of review.

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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 658	Continued From page 45	F 658		

Further review of the above NJ Exec dated NJ ex order 26.4b1 revealed that there were no other medications (meds) listed that were reviewed except for NJ ex order 26.4b1. The NJ Exec did not reflect the documented behaviors in NJ ex order 26.4b1 and NJ ex order 26.4b1 to reflect what behaviors were monitored in the eMAR and eTAR.

Further review of the medical records revealed that there was no evidence that NJ Exec was done routinely and there was no other NJ Exec documented except NJ ex order 26.4b1.

A review of the NJ ex order 26.4b1 follow-up dated NJ ex order 26.4b1, revealed that the U.S. FOIA (b) (6) documented that there were NJ ex had been reported by the nursing.

On 2/12/25 at 1:29 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), and U.S. FOIA (b) (6) The surveyor notified the above concerns with Resident#175's NJ ex order 26.4b1, NJ Exec (monthly) not done routinely with incomplete information, and the NJ ex order 26.4b1 consult note did not reflect what were documented in the NJ ex order 26.4b1.

On 2/13/25 at 2:14 PM, the survey team met with the U.S. FOIA (b) (6), and U.S. FOIA (b) (6). The U.S. FOIA (b) (6) acknowledged that there was only one NJ Exec summary that was done, which was the NJ ex order 26.4b1. The U.S. FOIA (b) (6) stated that the reason why there was only one NJ Exec done for the resident was because the NJ ex order 26.4b1 was started on NJ ex order 26.4b1,

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F 658	Continued From page 46 which was NJ ex order 26.4b1" the NJ ex order 26.4b1 and the med was d/c. She further stated that it was "not normal practice," and the best practice was that PR should be done monthly, for example, the PR for NJ ex order 26.4b1 was for the NJ ex order 26.4b1 meds review, and if NJ ex order 26.4b1 was done, it should be for NJ ex order 26.4b1 A review of the facility's Psychotropic Med Use Policy, with a revision date of July 2022, was provided by US FOIA (b)(6) revealed: Policy Interpretation and Implementation: 2. Drugs in the following categories are considered psychotropic meds and are subject to prescribing, monitoring, and review requirements specific to psychotropic meds: a. Anti-psychotics; b. Anti-depressants ... 8. Consideration of the use of any psychotropic med is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. On 2/18/25 at 1:47 PM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) for an exit conference, the U.S. FOIA (b) (6) did not provide additional information.	F 658		
F 689 SS=D	NJAC 8:39-11.2(b) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		3/9/25

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F 689	Continued From page 47 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to ensure a) the resident's current active care plan (CP) contained the interventions that were implemented after each resident's [redacted] in order to prevent any additional [redacted] and b) ensure a [redacted] risk assessment was done quarterly in accordance with their facility policy for 1 of 2 residents reviewed for [redacted] Resident #111). The deficient practice was evidenced by the following: On 2/7/25 at 11:26 AM, the surveyor interviewed Resident #111 who was seated in a [redacted]. Resident #111 stated that they had just returned from a [redacted]. Resident #111 stated that they had [redacted] and that they [redacted]" and it was [redacted] " The surveyor observed a [redacted] on Resident #111's [redacted] and that the resident's [redacted]. On 2/11/25 at 9:58 AM, the surveyor requested from the [redacted] to provide any incidents or investigations for the last six months for Resident #111. On 2/11/25 at 10:37 AM, the surveyor interviewed Resident #111's [redacted]	F 689	F689 Free of Accident Hazard/Supervision/Devices 1. A quarterly [redacted] assessment was completed and the At Risk for [redacted] care plan of Resident # 111 was updated to contain the interventions that were implemented after each previous [redacted] 2. All active residents at risk for falls have the potential to be affected by the deficient practice. 3. The Director of Nursing in-serviced all licensed nurses, including the [redacted]), Unit Managers (UMs), and Minimum Data Set (MDS) Coordinators on Quarterly [redacted] Risk Assessment, and regarding the facility's policies: "Fall Prevention Program" and "Care Plan, Comprehensive Person Centered." The DON or designee audited all active residents at risk for falls to ensure the care plans included interventions to minimize the likelihood of falls. The Director of Nursing or designee will audit 10 random long term residents to ensure Quarterly Fall Risk Assessment are completed timely x weekly x 4 weeks,	

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F 689	Continued From page 48 regarding the process for NJ Exec Order 26.4 assessment and NJ Exec Or The U.S. FOIA (b) stated that a NJ Exec Order 26 assessment was done on admission and that it may be done by the US FOIA (b)(6) quarterly but was not sure. She added that NJ Exec Order 26.4b1 saw the resident within 24 hours to determine if the resident was a NJ Exec risk. The U.S. FOIA stated that most residents had a CP that included NJ ex order 26.4b1 that included NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The U.S. FOIA stated that if a resident NJ ex order 26.4b1 was done which included statements from staff. She added that an investigation for the cause was done and that the US FOIA (b)(6) would update the CP with a new intervention. A review of Resident #111's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ ex order 26.4b1 NJ ex order 26.4b1 A review of Resident #111's most recent NJ ex order 26.4b1 Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's NJ Exec Order 26.4b1 skills for NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1. Further review of the MDS indicated the resident had one NJ Exe with NJ Exec Order 26.4b since admission or prior assessment. A review of Resident #111's Progress Notes (PN) indicated that in NJ ex order 26.4b1, the resident was	F 689	then monthly x 3 months. The DON or Designee will audit the charts of 5 new admissions and 5 long term care residents weekly x 4 weeks, then monthly x 3 months to ensure the completion of the At Risk for Falls care plan. 4. The DON or designee will report the findings of the audits to the monthly QAPI meetings x 4 months to ensure compliance and if further action is necessary.	

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F 689	Continued From page 49 NJ Exec Order 26.4b1 and NJ ex order 26.4b1 . Further review of the PN indicated that in NJ ex order 26.4b1 . A review of Resident #111's current active CP, with an initiated date of NJ ex order 26.4b1, indicated a focus area of NJ ex order 26.4b1; a goal of NJ ex order 26.4b1 A review of the facility provided incident report of Resident #111's NJ ex order 26.4b1 included a printout of a CP with the focus area of NJ ex order 26.4b1 " which was initiated NJ ex order 26.4b1 and revised on NJ ex order 26.4b1. Further review of the printout indicated that the resident NJ ex order 26.4b1. The following interventions were added after the resident's NJ ex order: resident educated on NJ Exec Order 2 calling for NJ Exec Order 26.4b1 .; NJ Exec Order 26.4b1 .; NJ Exec Order 26.4b1 These interventions were not included in Resident #111's current active CP. Further review of the electronic medical record indicated that Resident #111 had a previous CP that included the NJ ex order 26.4b1 but that it	F 689		

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F 689	Continued From page 50	F 689		

had been completed (not active or current) on NJ ex order 26.4b. Resident #111's active current CP did not have any of the previous implemented interventions listed to attempt to prevent any NJ ex order 26.4b1

A review of Resident #111's NJ ex order 26.4b1 assessments included the following:
NJ Exec Order 26.4b1 which was included in the "NSG (nursing): Quarterly/Annual/SignificantChange Evaluation" which reflected the evaluation was "in progress," not completed.
NJ ex order 26.4b1 was listed as other not quarterly and was dated the same day as the resident's NJ Exec
NJ ex order 26.4b1 was listed as other not quarterly and was dated the same day as the resident's NJ Exec
NJ ex order 26.4b1 which was included in the "NSG: Admission/Readmission Evaluation" and listed as a readmission
There were no quarterly NJ Exe risk assessments for NJ ex order 26.4b1 and NJ ex order 26.4b1.

On 2/11/25 at 12:46 PM, the surveyor interviewed the first floor U.S. FOIA (b) (6)) regarding the process for NJ Exe risk assessment and CP related to NJ ex or and NJ ex order 26.4b. The first floor U.S. FOI stated that upon admission a NJ Exe risk assessment and a baseline CP was done and that the CP was later updated by the supervisor, U.S. FOI, U.S. FOIA (b) (6) or U.S. FOIA (b) (6)
The first floor U.S. FOIA stated that the NJ Exe risk assessment was done on admission then repeated quarterly and if something happened.
The first floor U.S. FOI stated that when a NJ Exe occurred an incident report risk management was done and that the CP would be updated with a new intervention to prevent a future NJ Exec The surveyor asked if a CP was completed when a resident

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F 689	Continued From page 51	F 689		

went to the hospital. The first floor U.S. FOIA stated that the CP did not have to be closed (completed) if went to hospital and came back a couple days later but that he would have to ask MDS. The surveyor then asked the first floor U.S. FOI to view Resident #111's active CP for NJ ex order 26.4b. The first floor U.S. FOI confirmed that Resident #111's current active CP had only one intervention for a NJ ex order 26.4b and did not mention the NJ ex ord at the facility. The first floor U.S. FOIA then confirmed that Resident #111 had a completed CP that had the NJ ex ord and NJ ex order 26.4b1 The surveyor asked if Resident #111's active current CP should have the completed CP for NJ ex ord with interventions and he stated it should be in the current CP.

On 2/11/25 at 01:10 PM, the surveyor interviewed the U.S. FOIA (b) (6) regarding CP and NJ Exc risk assessment. The U.S. FOIA (b) (6) stated that she may open the CP but that usually other departments completed them and reviewed them. The U.S. FOIA (b) (6) stated that the CP was closed (completed) when the resident NJ ex order 26.4b1 and that when they returned a new CP was opened. The surveyor asked that if the information in the completed CP should be continued in the new CP if still relevant. The U.S. FOIA (b) (6) stated "most probably." She added that the interventions should be in place but that she was not sure if the CP had to be closed out. The U.S. FOIA (b) (6) stated that she did not do anything with the NJ ex order 26.4b1.

On 2/12/25 at 11:42 AM, the first floor U.S. FOI stated that the quarterly nursing assessment usually contained the NJ ex order 26.4b1

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F 689	Continued From page 52 On 2/12/25 at 1:43 PM, the surveyor notified the U.S. FOIA (b) (and U.S. FOIA (the concern that Resident #111 did not have a current active CP that included the interventions implemented prior to the resident's U.S. FOIA (b) (6) and that the resident did not have quarterly NJ Exe risk assessments done. On 2/13/25 at 2:14 PM, in the presence of the U.S. FOIA (b) (and U.S. FOIA (, the U.S. FOIA (b) (6) stated that in regards to the quarterly risk assessment that because of the different changes of positions that it was unclear with MDS and nursing who was initiating the quarterly assessment NJ Ex Order 26.4(b)(1)) and that now the U.S. FOIA (b) (6) would be providing assessment dates and nursing would follow the risk assessment based on the dates provided. The RDCS stated that when Resident #111 went to the hospital the U.S. FOIA (b) (6) had canceled the CP instead of resolving it and that a new CP had to be initiated. On 2/14/25 at 9:59 AM, the U.S. FOIA (b) (6) stated that apparently the CP was not supposed to have been canceled (completed) when the resident NJ ex order 26.4b1 unless they are there for 30 days. She added that if there was a bedhold then it does not get canceled (completed). The U.S. FOIA (b) (6 stated that for Resident #111, someone canceled the CP by accident and that now it was updated. The US FOIA (b)(6) stated that nursing was supposed to do the quarterly nursing assessment. The U.S. FOIA (b) (6 did not provide any additional information. A review of the facility provided policy titled, "Fall Prevention Program" with a reviewed/revised date of 10/16/24, included the following:	F 689		

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F 689	Continued From page 53 Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls ... Policy Explanation and Compliance Guidelines: 1. The facility utilizes a standardized risk assessment for determining a resident's fall risk .... 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate on the (specify location) the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk .... 5. Low/Moderate Risk Possible Protocols: ... g. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes ... 9. When any resident experiences a fall, the facility will: ... e. Review the resident's care plan and update as indicated ... A review of the facility provide policy titled, "Care Plans, Comprehensive Person-Centered" with a revision date of March 2022, included the following: 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. .. 11. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition;	F 689		

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F 689	Continued From page 54 b. when the desire outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. N.J.A.C. 8:39-27.1 (a)	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to NJ Exec Order 26.4b1 administration to assure the NJ Exec Order 26.4b1 administered was in	F 693	F693 Tube Feeding Mgmt/Restore Eating Skills 1. The physician order related to the NJ ex order 26.4b1 for Resident # 172 was	3/9/25

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F 693	Continued From page 55 accordance with physician's orders. This deficient practice was identified for 1 of 1 resident, (Residents #172), reviewed for NJ ex order 26.4b1 [redacted]. This deficient practice was evidenced by the following: On 2/7/25 at 10:45 AM, the surveyor observed Resident #172 NJ Exec Order 26.4b1 [redacted]. The resident ha NJ ex order 26.4b1 [redacted]. On 2/11/25 at 9:05 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #172. A review of the Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, NJ ex order 26.4b1 [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of NJ ex order 26. [redacted], indicated that resident's NJ ex order 26.4b1 [redacted]. In Section NJ Exec Order 26.4b1 [redacted]), Resident #172 NJ ex order 26.4b1 [redacted] A review of the physician's order (PO) dated NJ ex order 26.4b1 [redacted] indicated the resident was NJ Exec Order 26.4b1 [redacted]	F 693	corrected to reflect the NJ Exec Order 26.4b1 [redacted] is administered in accordance with the physician's orders. 2. All active residents receiving tube feed orders have the potential to be affected by the deficient practice. 3. All licensed nurses and US FOIA (b)(6) [redacted] were in-serviced by the Director of Nursing on the facility's Enteral Tube Feeding via Continuous Pump Policy and the Enteral Feed Batch order set to ensure the total volume to be infused are documented in resident's medication administration record as per physician's order. The DON or designee audited all residents with tube feed orders to ensure the physician orders reflect the correct total volume to be administered. The DON or designee will audit all active residents with physician orders for tube feed to ensure the order reflects the correct total volume to be administered weekly x 4 weeks, then monthly x 3 months. 4. The DON will report the findings of the audits to the monthly QAPI meetings x 4 months to ensure compliance and if further actions is necessary.	

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A review of the PO dated [redacted], indicated every day (7AM to 3PM) shift to document the [redacted] was completed.

A review of the PO dated [redacted], indicated to NJ ex order 26.4b1 [redacted]

A review of the resident's care plan (CP) included a CP with a focus on NJ Exec Order 26.4b1. An intervention of the CP indicated the resident needed to be provided NJ Exec Order 26.4b1 and to view the PO.

A review of the NJ ex order 26.4b1 Medication Administration Record (MAR) revealed for [redacted] days the documented NJ ex order 26.4b1 was less than order NJ ex order 26.4b1 [redacted]. The entries revealed the following:

On [redacted], the nurse documented the NJ ex order 26.4b1 as [redacted]
On [redacted], the nurse documented the NJ ex order 26.4b1 as [redacted]
On [redacted], the nurse documented the NJ ex order 26.4b1 as [redacted]
On [redacted], the nurse documented the NJ ex order 26.4b1 as [redacted].
On [redacted], the nurse documented the NJ ex order 26.4b1 as [redacted]
On [redacted] the nurse documented the NJ ex order 26.4b1 as [redacted]

A review of the progress notes revealed there was no documentation that indicated why the [redacted] which was the ordered NJ ex order 26.4b1 to the resident.

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F 693	Continued From page 57	F 693		

On 2/13/25 at 11:57 AM, the surveyor interviewed a U.S. FOIA (b) (6) about NJ Exec Order 26 and nursing documentation. The U.S. FOIA stated an NJ Exec Order 26.4b1 for a resident was administered according to the PO and the total NJ Exec Order 26.4b1 depended on the PO. The U.S. FOIA further explained the administration and NJ Exe was documented in the MAR.

On 2/13/25 at 1:24 PM, the surveyor interviewed the U.S. FOIA (b) (6) about NJ Exec Order 26.4b1 administration and NJ Exe documentation. The U.S. FOIA (b) (6) stated PO were entered in the EMR and there was a set of orders for NJ Exec Order 26.4b1. The U.S. FOIA (b) (6) further explained a resident's NJ Exec Order 26.4b1 was administered per PO and the nurses documented the NJ Exe of the NJ Exec Order 26.4b1 to be NJ Exec Order 26 in the MAR.

The surveyor reviewed with the U.S. FOIA (b) (6) the documented NJ ex order 26.4b1 MAR. The U.S. FOIA (b) (6) could not speak to why the nurses documented NJ ex order 26.4b1 and would follow up with the nurses to provide additional information.

On 2/13/25 at 2:18 PM, the surveyor notified the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) of the above concern for the documented NJ Exec Order 26.4b1 which differed from the prescribed NJ Exec Order 26.4b1 to be administered to the resident.

On 2/14/25 at 1:07 PM, the U.S. FOIA (b) (and the U.S. FOIA (b) met with the survey team. The U.S. FOIA (b) stated some of the U.S. FOIA (b) (6) were NJ Exec Order 26.4b1 about the NJ Exec Order 26 to document and were documenting the NJ Exec O on their shift. The U.S. FOIA (b added that

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F 693	Continued From page 58 in-service education was initiated. There was no additional information provided by the facility. A review of the facility's Enteral Tube Feeding via Continuous Pump Policy, with a last revised date of November 2018. Under Preparation it specified, "1. Verify that there is a PO for this procedure ..." Under Documentation indicated the person performing the procedure should record information in the resident's medical record which included, "3. Amount and type of enteral feeding ...5. All assessment data obtained during the procedure ..." NJAC 8:39-25.2(c)2; 27.1 (a)	F 693		
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: REPEAT DEFICIENCY Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to, a.) maintain the necessary [redacted] care and services of residents and b.) develop	F 695	F695 Respiratory/Tracheostomy Care and Suctioning 1. Resident # 187 NJ ex order 26.4b1 [redacted] 2. All active residents who have a	3/9/25

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F 695	Continued From page 59 an individualized care plan in accordance with professional standards of practice for one 1 of 4 residents, (Resident #187), reviewed for NJ ex order 26.4b1 This deficient practice was evidenced by the following: On 2/7/25 at 11:00 AM, the surveyor observed the Resident #187 NJ Exec Order 26.4b1, NJ ex order 26.4b1 and not in the bag. The resident stated they placed the NJ ex order 26.4b1 and did not NJ ex o . The plastic bag was dated NJ ex order 26.4b1 The resident stated, NJ ex order 26.4b1 A review of the Admission Record (an admission summary) revealed diagnoses which included but not limited to; NJ Exec Order 26.4b1 , presence of NJ Exec Order 26.4b1 , and NJ Exec Order 26.4b1 . A review of the Order Summary Report (OSR) revealed: NJ ex order 26.4b1 . Do not NJ Ex Order 26 ordered on NJ ex order 26.4 completed on NJ ex order 26.4b1 NJ ex order 26.4b1 . Further review of the OSR revealed that there was no order for NJ Exec Order 26.4b1 .	F 695	physician order for nebulizer services has the potential to be affected by this deficient practice. 3. All licensed nurses were in-serviced by the Director of Nursing (DON) or designee on the facility's Nebulizer Therapy and Care Plan policies. The DON or designee audited all active residents with physician orders for nebulizer services to ensure there is a physician order to change the nebulizer tubing as ordered and a care plan addressing the nebulizer is in place. The DON or designee will audit all active residents who have a physician order for nebulizer services to ensure a care plan addressing the nebulizer and order is in place to change the nebulizer tubing as ordered weekly x 4 weeks, then monthly x 3 months. 4. The DON will report the findings of the audits to the monthly QAPI meetings x 3 months to ensure compliance and if further actions are necessary.	

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F 695	Continued From page 60	F 695		

A review of the comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of [NJ Exec Order 26.4] revealed Brief Interview of Mental Status (BIMS) score of [NJ ex] out of 15 indicating [NJ Exec Order 26.4b1].

A review of the Care Plans (CP) reflected that the resident was NJ ex order 26.4b1 [redacted]

Further review of the CP revealed that there were no goals or interventions for NJ ex order 26.b1 and no individual CP for [NJ Ex Ord]

On 2/14/25 at 10:00 AM, the surveyor interviewed the U.S. FOIA (b) (6) [U.S. FOIA (b) (6)] [redacted], and the [U.S. FOIA] stated, "Everyone's [NJ ex order 26.b] and [NJ ex order 26.b1], the [U.S. FOIA (b) (6)] change every week on Wednesday night and dated. Everyone NJ ex order 26.b1 [redacted] and is dated, and changed every week." The [U.S. FOI] confirmed that the Resident #187 should have an NJ ex order 26.b1 [redacted]

On 2/14/25 at 10:15 AM, the [U.S. FOI] confirmed with the surveyor by looking in the Electronic Health Record, NJ ex order 26.4b1 [redacted] The [U.S. FOI] further stated that there was no CP, it was started but it did not have goals, interventions or anything about the [NJ ex orde] The [U.S. FOI] also stated that the CP was initiated by the admitting nurse and "I'm" supposed to go back and ensure everything was in place. The [U.S. FOI] further stated 'NJ ex order 26.b1 [redacted]"

On 2/14/25 at 1:39 PM, the surveyor notified the

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F 695	Continued From page 61 U.S. FOIA (b) (6) and the US FOIA (b)(6) U.S. FOIA (b) (6) regarding concerns with the care of the NJ ex order 26.4b1 and CP. A review of the facility's Nebulizer Therapy Policy, dated 4/16/24, revealed, "Care of the equipment.... change neb tubing as ordered" and a policy on "CP, Comprehensive Person-Centered" revealed, "...describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being....." NJAC 8:39-25.2(c)3	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to, a.) ensure a resident's medication, NJ Exec Order 26.4b1 check, and times were adjusted to accommodate their NJ ex order 26.4b1 schedule for 2 of 3 residents (Residents #77 and #121) and b.) clarify duplicate orders for 1 of 3 residents, (Resident #77), reviewed for NJ ex order 26.4b1 according to facility's policy and standard of clinical practice.	F 698	F698 Dialysis 1. The physician orders for Resident #77 NJ ex order 26.4b1 The duplicate orders for NJ ex order 26.4b1 The physician orders for Resident # 121 were adjusted to accommodate the resident□s NJ ex order 26.4b1 .	3/9/25

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F 698	Continued From page 62 The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 2/7/25 at 10:29 AM, Surveyor #1 (S#1) observed Resident#77 seated in a NJ ex order 26.4b1 in the day room in a group activity. Surveyor #2 (S#2) reviewed the medical records of Resident #77. A review of the Admission Record (AR, admission	F 698	2. All active residents who are receiving hemodialysis services have the potential to be affected by this deficient practice. 3. All licensed nurses have been educated by the Director of Nursing (DON) on the facility's Hemodialysis Policy; All licensed nurses were in-serviced by the Director of Nursing on discontinuing duplicate orders to ensure compliance with the physician's order. The DON or designee audited all residents who are receiving hemodialysis services to ensure the physician orders are adjusted to accommodate the resident's dialysis days and times. The Director of Nursing or designee will audit all active residents receiving hemodialysis services to ensure physician orders are adjusted to accommodate the resident's dialysis days daily x one week, then weekly x 3 weeks, then monthly x 3 months. The Director of Nursing or designee will audit all active residents receiving hemodialysis services to ensure no duplicate orders in resident charts daily x one week, then weekly x 3 weeks, then monthly x 3 months. 4. The DON will report the findings of the audits to the monthly QAPI meetings x 4 months to ensure compliance and if further actions are necessary.	

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F 698	Continued From page 63	F 698		

summary) reflected that Resident #77 was admitted to the facility with a diagnosis that included but was not limited to NJ ex order 26.4b1 [redacted]

A review of the most recent comprehensive Minimum Data Set (cMDS), an assessment tool, with an assessment reference date (ARD) of NJ ex order 26.4b1 revealed in Section NJ Exec Order 26.4b1 with a BIMS (Brief Interview for Mental Status) score of NJ ex of 15, which reflected that the resident's NJ Exec Order 26.4b1 NJ ex order 26.4b1 The cMDS revealed that the resident was NJ ex [redacted]

A review of the NJ ex order 26.4b1 electronic Medication Administration Record (eMAR) revealed:

Start date of NJ ex order 26.4b1 without NJ ex order 26.4b1 [redacted].

Start date NJ ex order 26.4b1 [redacted]

Further review of the above NJ ex order 26.4b1 eMAR revealed that on NJ ex order 26.4b1 was coded NJ ex ord on NJ ex order 26.4b1 on NJ ex order 26.4b1 and NJ ex order 26.4b1 [redacted]

On 2/11/25 at 11:56 AM, S#2 interviewed the U.S. FOIA (b) (6) who informed the surveyor that she was the U.S. FOIA (b) of Resident # 77 who was currently not at the facility and was at

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the [NJ Exec Order 26] center. The [U.S. FO] stated that the resident was picked up today at around [NJ ex order 26] [NJ ex order 26.4b1] and [NJ ex order 26.4b1] The [U.S. FOIA] also stated that the resident [NJ ex order 26.4b1], and [NJ ex order 26.4b1] depending on days when the resident [NJ ex order 26.4b1]

At that same time, S#2 asked the [U.S. FOIA] regarding the resident's [NJ Exec Order 26.4b1] eMAR. S#2 asked the [U.S. FO] why there were [NJ ex order 26.4b1], one early morning and the other one before meals and at HS without coverage for both. S#2 also asked what was the code [NJ ex o] on [NJ ex order 26.] and [NJ ex order 26.4b1], and the [U.S. FO] had no response. The [U.S. FO] confirmed that the [NJ Exec] was not applicable.

On 2/11/25 at 12:02 PM, the [U.S. FOIA (b) (6)] informed S#2 that she was aware of the concerns of the surveyor about duplicate orders and the [NJ Exec Order 26.4b1]) coding that was not according to the resident's [NJ Exec Order 26] timing and that she corrected it after the surveyor's inquiry. She further stated that the nurse should have picked it up when the resident came back from hospitalization and followed the correct order and plotting of orders according to [NJ ex order 26.4b] time and days.

On 2/12/25 at 1:29 PM, the survey team met with the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] S#2 notified the above concerns with Resident#77's [NJ ex order 26.4b1]

On 2/18/25 at 1:47 PM, the survey team met with

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F 698		F 698		

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the U.S. FOIA (b) (6), U.S. FOIA (b) (6) of U.S. FOIA (b) (6) [redacted], and U.S. FOIA (b) (6) [redacted] for an exit conference, the U.S. FOIA (b) [redacted] did not provide additional information.

2. On 2/7/25 at 10:21 AM, S#1 observed Resident #121 NJ Exec Order 26.4b1 [redacted]. The resident did not respond to the surveyor's greeting.

On 2/13/25 at 9:04 AM, S#1 reviewed the medical records of Resident #121.

A review of the AR documented the resident had diagnoses that included but were NJ ex order 26.4b1 [redacted]

A review of the quarterly MDS, with an ARD of NJ ex order 26.4b1 [redacted] indicated a BIMS score of NJ ex [redacted] out of 15, which indicated the resident had NJ ex order 26.4b1 [redacted]

A review of the physician's order (PO) dated NJ ex order 26.4b1 [redacted] indicated change medications and treatment timing from facility's medication (med) and treatment administration time to accommodate NJ ex order 26.4b1 [redacted].

A review of PO dated NJ ex order 26.4b1 [redacted], indicated the resident NJ ex order 26.4b1 [redacted]

A review of progress notes revealed the nurses documented that the resident returned to the facility from NJ ex order 26.4b1 [redacted], and NJ ex order 26.4b1 [redacted] on

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NJ ex order 26.4b1.

A med administration note dated NJ ex order 26.4b1 NJ ex ord indicated that the NJ ex order 26.4b1 Pt[Patient] NJ ex order 26.4b1

A review of NJ ex order 26.4b1 and NJ ex order 26.4b1 eMAR revealed the following:

An entry with a start date of NJ ex order 26.4b1 for NJ ex order 26.4b1 which was scheduled to be administered to the resident at NJ ex order 26.4b1 and NJ ex order 26.4b1

The NJ ex order 26.4b1 were signed as administered at NJ ex order 26.4b1 by the nurses on NJ ex order 26.4b1, and NJ ex order 26.4b1, was signed NJ ex which indicated NJ ex order 26.4b1."

On 2/13/25 at 11:42 AM, S#1 asked the U.S. FOIA (b) (6) about care for NJ ex order 26.4b residents. The U.S. FOIA stated that a resident's med should be scheduled around their NJ Exec Order 26 sessions. The U.S. FOIA further explained that if there was a med scheduled for when the resident was not in the facility, the nurse should call the physician to clarify the order.

On 2/13/25 at 2:18 PM, S#1 notified the U.S. FOIA (b) (6) the U.S. FOIA (b), and the US FOIA (b)(6) about the concern of Resident #121's NJ ex order 26.4b1 med scheduled time not being adjusted to accommodate when the resident was out of the facility to NJ Exec Order 26.4

On 2/14/25 at 1:07 PM, the U.S. FOIA (b) and the U.S. FOIA (b

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F 698	Continued From page 67 met with S#1. The [U.S. FOIA (b)] acknowledged the [NJ Exec] [redacted] should have been clarified by the nurses. The [U.S. FOIA (b)] stated the [NJ ex order 26.4b1] was clarified and education would be provided to the nursing staff. A review of the facility's Hemodialysis Policy that was provided by the [U.S. FOIA (b)] on 2/7/25 at 2:49 PM, revealed that the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental and psychosocial needs of residents receiving hemodialysis. NJAC 8:39-11.2(b), 27.1(a)	F 698		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced	F 711		3/18/25

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(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 711	Continued From page 68 by: Based on interviews and review of other facility documentation, it was determined that the facility failed to ensure that the physicians must review the residents' total program of care including medications and treatments, and write, sign, and date progress notes at each visit. This deficient practice was identified for 14 of 35 residents, (Residents#10, #13, #16, #18, #50, #60, #68, #102, #103, #121, #131, #149, #175, and #180), reviewed for physician services. This deficient practice was evidenced by the following: 1. On NJ ex order 26.4b1, Surveyor #1 (S#1) observed Resident #18 in the activity room behind the [redacted] nursing station seated in a [redacted] with other residents. The surveyor reviewed the medical record of Resident #18 and revealed: A review of the Admission Record (AR, an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; NJ ex order 26.4b1 [redacted] A review of the Progress Notes (PN) and Assessment tabs in the electronic medical records (EMR) revealed that there was no evidence that Physician #1 (P#1) wrote, signed, and dated PN and documented in the assessment tab from NJ ex order 26.4b1 [redacted] his visit notes.	F 711	F711 Physician Visits-Review Care/Notes/Order 1. Resident # 10, # 13, #16, #18, # 50, # 60, #68, #102, #103, #121, #131, # 149, #175, #180 were all scheduled to be seen by the provider with visit progress notes written timely in the electronic health record (EHR). The monthly physician orders from [redacted] through [redacted] for Resident # 10, # 13, #16, #18, # 50, # 60, #68, #102, #103, #121, #131, # 149, #175, #180 were signed by the physician. Physicians # 1 and #2 were in-serviced on the facility's policy Physician Visits Policy and the timely documentation of visit notes and monthly physician orders. 2. All active residents have the potential to be affected by this deficient practice. The Director of Nursing conducted a facility wide audit of all active residents currently due for a physician visit and ensured timely visits with documentation and review of current monthly physician monthly orders occurred. 3. All active Physicians, Nurse Practitioners, and Physician Assistants were in-serviced by the Director of Nursing/Administrator and/or designee, on the facility's Physician Visits Policy and the timely documentation of visit notes and monthly physician orders. The Director of Nursing or designee will	

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F 711	Continued From page 69 Further review of the EMR revealed that Nurse Practitioner #1 (NP#1) documented on NJ ex order 26.4b1 that the reason for a visit was due to an NJ ex order 26. and that the SNF (Skilled Nursing Facility) NJ Exec Order 26.4b1 NJ ex order 26.4b1 A review of the monthly U.S. FOIA (b) (6) orders (MPO) revealed that on NJ ex order 26.4b1 the orders were NJ ex ord for P#1 to sign. 2. On 2/7/25 at 11:28 AM, S#1 interviewed the U.S. FOIA (b) (6) who informed the surveyor that Resident # 175 NJ ex order 26.4b1 gown, gloves when providing direct care. S#1 reviewed the medical records of Resident #175 and revealed: A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; NJ ex order 26.4b1 NJ ex order 26.4b1 is a type of NJ ex order 26.4b1	F 711	audit 10 random charts to ensure monthly physician visits occur, timely documentation of the monthly visits, and the signage of the monthly physician orders weekly x 4 weeks, then monthly x 3 months 4. The Director of Nursing will report findings of the audits to the monthly QAPI meetings x 4 months to ensure compliance or if further necessary actions are necessary.	

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F 711	Continued From page 70 A review of the PN and Assessment tabs in the EMR revealed that there was no evidence that Physician #2 (P#2) wrote, signed, and dated PN and documented it in the assessment tab from NJ ex order 26.4b1 his visit notes. Further review of the EMR revealed that Nurse Practitioner #2 (NP#2) documented on NJ ex order 26.4b1, that the reason for a visit was due to a NJ ex ord A review of the MPO revealed that on NJ ex order 26.4b1 for P#2 to sign. 3. On NJ ex order 26.4b1 AM, S#1 observed Resident #180 NJ Exec Order 26.4b1, and stated that they were at the facility for NJ ex order 26.4b1 and had to go back to the doctor to NJ ex order 26.4b1 The surveyor observed the resident with a NJ ex order 26.4b1 S#1 reviewed the medical records of Resident #180 and revealed: A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; NJ ex order 26.4b1 and	F 711		

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F 711	Continued From page 71	F 711		

NJ ex order 26.4b1 [redacted]

A review of the PN and Assessment tabs in the EMR revealed that there was no evidence that P#2 wrote, signed, and dated PN in a timely manner from NJ ex order 26.4b1 [redacted] and NJ ex order 26.4b1 were all created on NJ ex order 26.4b1. There was no documented evidence that P#2 wrote his visit notes in the assessment tab of EMR NJ ex order 26.4b1 [redacted]

Further review of the EMR revealed that there was U.S. FOIA (b) (6) wrote and signed the PN and the Assessment tab.

A review of the MPO revealed that on NJ ex order 26.4b1 the orders were 69 days overdue for P#2 to sign.

On 2/12/25 at 1:29 PM, the survey team met with the U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6)), and S#1 notified them of the above findings and concerns regarding U.S. FOIA (b) (6) services for Residents #18, #175, and #180.

On 2/13/25 at 2:14 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6) [redacted], and U.S. FOIA (b) (6). The U.S. FOIA (b) (6) stated that as far as physician services with no U.S. FOIA (b) (6) notes, "we" did reach out to the U.S. FOIA (b) (6) and had been periodically reaching out. The U.S. FOIA (b) (6) acknowledged it was an ongoing problem with regard to U.S. FOIA (b) (6) services signing orders and writing their visit notes.

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On 2/18/25 at 11:25 AM, the survey team met with the [redacted], [redacted], and [redacted]. The surveyor asked what the facility's standard of practice was for signing orders and visits, and the [redacted] stated that the [redacted] visits would be done monthly for the 1st 90 days and then convert to every 60 days thereafter. She further stated that the signing of orders should be signed off monthly by the [redacted] in the EMR and the [redacted] had 10 days from the due date.

4. A review of the medical record for Resident #10, revealed the resident's [redacted] had not hand signed or electronically signed the MPO for [redacted], and [redacted]

5. A review of the medical record for Resident #13, revealed the resident's [redacted] had not hand signed or electronically signed the MPO for [redacted].

A review of the [redacted] PN (PPN) for Resident #13, revealed that the [redacted] did not conduct face to face visits and did not write PN for the month of [redacted]

6. A review of the medical record for Resident #50, revealed the resident's [redacted] had not hand signed or electronically signed the MPO for [redacted] and [redacted]

A review of the PPN for Resident #50, revealed

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F 711	Continued From page 73 that the U.S. FOIA (b) (6) did not conduct face to face visits and did not write PN for the month of NJ ex order [redacted] and NJ ex order 26.4b1 7. A review of the medical record for Resident #60, revealed the resident's U.S. FOIA (b) (6) had not hand signed or electronically signed the MPO for NJ ex order 26.4b1. 8. A review of the medical record for Resident #68, revealed the resident's U.S. FOIA (b) (6) had not hand signed or electronically signed the MPO for NJ ex order 26.4b1. A review of the PPN for Resident #68, revealed that the U.S. FOIA (b) (6) did not conduct face to face visits and did not write PN for the month of NJ Exec Order 26.4b1, a late entry was created on NJ Exec Order 26. [redacted], and back dated for NJ Exec Order 26.4b1. 9. A review of the medical record for Resident #102, revealed the resident's U.S. FOIA (b) (6) had not hand signed or electronically signed the MPO for NJ ex order 26.4b1, NJ ex order 26.4b1, NJ ex order 26.4b1, and NJ ex order 26.4b1 A review of the PPN for Resident #102, revealed that the U.S. FOIA (b) (6) did not conduct face to face visits and did not write PN for the month of NJ ex ord [redacted], and NJ ex order 26.4b1 10. A review of the medical record for Resident #103, revealed the resident's U.S. FOIA (b) (6) had not hand signed or electronically signed the MPO for NJ ex order 26.4b1 and NJ ex order 26.4b1	F 711		

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F 711	Continued From page 74	F 711		

A review of the PPN for Resident #103, revealed that the U.S. FOIA (b) (6) did not conduct face to face visits and did not write PN for the month of NJ ex order 26.4b1 and NJ ex order 26.4b1 a late entry was created on NJ ex order 26.4b1, and back dated for NJ ex order 26.4b1 and NJ ex order 26.4b1

On 2/14/25 at 10:00 AM, Surveyor #2 (S#2) interviewed the US FOIA (b)(6) who stated, "I know they're supposed to come in once a month, I have to review the policy. After they see the patient, they usually write a PN in Electronic Health Record (EHR). I'm not sure about signing orders, I have to review it, but I believe it's once a month. They document under the PPN."

11. On 2/13/25 at 9:04 AM, Surveyor #3 (S#3) reviewed Resident #121's medical records.

The AR documented that Resident #121 had diagnoses that included but were not limited, type NJ ex order 26.4b1

A review of the PN revealed a PN written by P#2, the resident's primary U.S. FOIA (b) (6), with effective dates of NJ ex order 26.4b1, and NJ ex order 26.4b1 were written on NJ ex order 26.4b1, after the surveyor's inquiry.

A review of the order review history revealed P#2 last signed orders for the resident on NJ ex order 26.4b1.

12. On 2/13/25 at 9:28 AM, S#3 reviewed Resident #16's medical records.

The AR documented that Resident #16 had

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F 711	Continued From page 75 diagnoses that included but were not limited, left NJ Ex Order 26.4(b)(1) [redacted] A review of the PN revealed the following: NP #2 wrote a PN on NJ Ex Order 26.4(b) [redacted] NP #1 wrote PN on NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4 [redacted] There were no PN written by P#3, the resident's primary physician, from NJ Ex Order 26.4(b)(1) [redacted] A review of the order review history revealed the last signed orders for the resident was on NJ Ex Order 26.4([redacted] by P#3. 13. On 2/13/25 at 9:36 AM, S#3 reviewed Resident #149's medical records. The AR documented that Resident #149 had diagnoses that included but were not limited, NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b) [redacted] A review of the PN revealed P#3, the resident's primary physician, wrote PN with effective dates of NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)([redacted]. There were no PN written by P#3 in NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1) [redacted]. A review of the order review history revealed the last signed orders for the resident was on NJ Ex Order 26.4([redacted]	F 711		

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F 711	Continued From page 76	F 711		

by P#3.

14. On 2/13/25 at 9:36 AM, S#3 reviewed Resident #131's medical records.

The AR documented that Resident #131 had diagnoses that included but were not limited, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

A review of the PN revealed there were no PN written by P#3, the resident's primary physician, from NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1

A review of the order review history revealed the last signed orders for the resident was on NJ Exec Order 26.4b1 by P#3.

On 2/13/25 at 2:18 PM, S#3 notified the U.S. FOIA (b)(6), the U.S. FOIA (b)(6), and the U.S. FOIA (b)(6) of the concerns with PPN, review, and signing of orders for residents.

A review of the facility's Physician Visits Policy, with a revision date of April 2013, that was provided by the U.S. FOIA (b) (6) revealed that the attending physician must make visits in accordance with applicable state and federal regulations.

Policy Interpretation and Implementation:
1. The attending physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone.
2. The attending physician must visit his/her patients at least once every 30 days for the 1st 90

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F 711	Continued From page 77 days following the resident's admission, and then at least every 60 days thereafter. 3. Non-physician practitioners (physician assistant, NP) may perform required visits (initial and follow-up), sign orders, and sign certifications/re-certifications as permitted by state and federal regulations ... NJAC 8:39-11.2(1); 23.2(b)(d)	F 711		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		3/9/25

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F 732	Continued From page 78 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the accurate Nursing Home Resident Care Staffing Report daily for 2 of 7 days in a prominent place within the facility readily accessible and visible to the residents and the visitors. This deficient practice was evidenced by the following: 1. On 2/7/25 at 8:47 AM, upon entry to the facility, Surveyor #1 (S#1) observed the Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the main lobby. The NHRCSR posted was dated 2/6/25 for the [7:00 AM to 3:00 PM] day shift. There was no NHRCSR for 2/7/25 posted. On 2/7/25 at 9:20 AM, S#1 interviewed the receptionist by the main lobby, who stated, "I am responsible for posting the staffing. I know it's the wrong date, I was waiting on the U.S. FOIA (b) (6) [redacted] to come in, she's running late. She will usually give me the numbers and I will correct it on the paper. I am the one printing out the staffing."	F 732	F732 Posted Nurse Staffing Information 1. The Nursing Daily Staffing Sheets for 2/7/25, 2/8/25, and 2/9/25 were updated to reflect the correct census. 2. All active residents have the potential to be affected by this deficient practice. 3. TheUS FOIA (b)(6) [redacted] were in-served by the Administrator/designee regarding the facility's Nurse Staffing Positing Information The Administrator/designee will audit the Nursing Daily Staffing Sheet to ensure it is posted at the beginning of the shift with the correct census daily x 1 week, then weekly x 3 weeks, then monthly x 3 months. 4. The Administrator/designee will report the findings of the audits to the monthly Quality Assurance Performance Improvement (QAPI) meetings x 4 months to ensure compliance and if further actions are necessary.	

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F 732	Continued From page 79 On 2/11/25 at 1:15 PM, S#1 interviewed the SC in the presence of the US FOIA (b)(6) [redacted]. The SC stated, "[Name Redacted] or whoever is on the front desk is responsible for posting the staffing. I am the one who gives the numbers, the number of nurses, Certified Nursing Assistants (CNAs), and the census. I will email or text the census, for it to be corrected on the form. The person on the front desk prints the NHRCSR. The corrected one was printed out after you guys arrived." The SC confirmed that [Name Redacted] did not print out the NHRCSR correctly for 2/7//25. The US FOIA (b)(6) [redacted] confirmed, "Usually it gets posted at the beginning of the shift, 7AM, 3PM, and 11PM." On 2/11/25 at 1:46 PM, the US FOIA (b)(6) [redacted] for the 4th floor provided the facility Policy and Procedure titled, "Nurse Staffing Posting Information" dated 2/5/25, which revealed, "The facility will post the Nurse Staffing Sheet at the beginning of each shift." On 2/13/25 at 2:17 PM, S#1 notified the US FOIA (b)(6) [redacted], the US FOIA (b)(6) [redacted], and the US FOIA (b)(6) [redacted] regarding incorrect posting of the NHRCSR. The US FOIA (b)(6) [redacted] stated, "The expectation is, it's due on the receptionist desk when he comes in the beginning of the shift." 2. On 2/10/25 at 6:30 AM, Surveyor #2 (S#2) entered the facility and met with the US FOIA (b)(6) [redacted], who informed the surveyor that she was from 7:00 AM-3:00 PM shift US FOIA (b) [redacted] and assigned to check the staffing for nursing. The surveyor observed the posted sign for	F 732		

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(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 732	Continued From page 80 NHRCSR dated 2/9/25, Evening Shift 3:00 PM-11:00 PM with the census of 205. On 2/10/25 at 8:02 AM, the U.S. FC provided the Nursing Daily Staffing Sheet for the date 2/9/25, with handwritten information on the side of the paper of the following: Friday 202 3 bed Saturday 203 2 bed Sund 203 3 bed At that same time, the surveyor asked the U.S. FC what those handwritten notes in blue ink pen were that the U.S. FC provided. The U.S. FC stated that on Friday, 2/7/25, the census was 202, with a 3-bed hold, on Saturday, 2/8/25, the census was 203, with a 2-bed hold, and on Sunday, 2/9/25, the census was 203, with a 3-bed hold. The U.S. FC stated that the posted staffing that the surveyor observed today for 2/9/25, was for Sunday, and the census was wrong. A review of the facility Policy and Procedure titled "Nurse Staffing Posting Information" dated 2/5/2025 revealed, "The facility will post the Nurse Staffing Sheet at the beginning of each shift."	F 732		
F 806 SS=D	N.J.A.C. 8:39-41.2 (a)(b)(c)(d) Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;	F 806		3/9/25

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	315021	A. BUILDING _____ B. WING _____	C 02/18/2025

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

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F 806	Continued From page 81 §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to ensure a resident's NJ Exec Order 26.4b1 were honored for 1 of 1 resident, (Resident #48), reviewed for NJ Exec O [redacted] This deficient practice was evidenced by the following: On 2/7/25 at 10:41 AM, the surveyor observed Resident #48NJ Exec Order 26.4b1 [redacted] The resident was NJ Exec Ord and NJ Exec Order 26.4b1. Resident #48 NJ Exec Order 26.4b1 [redacted]. The resident stated that they NJ Exec Order 26.4b1 [redacted] they wanted and did not get what was requested most of the time. The resident further explained that if they received a NJ Exec O item they did not request, the staff would call the kitchen, and the resident would "just get what's available ...whatever they have left" at the time. Resident #48 stated they did discuss with kitchen and U.S. FOIA (b) (6) [redacted] about not getting NJ Exec O items requested and the issue still occurs. On 2/11/25 at 9:35 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #48. A review of the Admission Record (admission summary) documented the resident had diagnoses that included but were not limited to	F 806	F806 Resident Allergies, Preferences, Substitutes 1. The US FOIA (b)(6) [redacted] immediately interviewed Resident # 48 clarified NJ Exec Order 26.4b1 and was provided with selected choices. 2. All active residents have the potential to be affected by the deficient practice. 3. The US FOIA (b)(6) [redacted] and all dietary staff were in-serviced by the Administrator/designee regarding the clarification of resident meal preferences to confirm accurate data entry into the dietary software. The Food and Nutrition Services Director or designee will audit 5 random food trays to compare against the dietary ticket and the resident's selected menu x 7 days for one week, then weekly x 3 weeks, then monthly x 3 months. 4. The Administrator will report the findings of the audits to the monthly QAPI meetings x 4 months to ensure compliance and if further actions are necessary.	

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NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 .

A review of the comprehensive Minimum Data Set (MDS), an assessment a tool, with an assessment reference (ARD) of NJ ex order 26.4b1 indicated a Brief Interview Mental Status (BIMS) score of NJ ex o out of 15, which indicated the resident was NJ ex order 26.4b1 .

A review of the physician's order dated NJ ex order 26.4b1 revealed the resident had a NJ Exec Order 26.4b1 .

A review of the resident's care plan (CP) included a CP for nutrition with an initiation dated of NJ ex order 26.4b1 and a revision dated of NJ ex order 26.4b1 An intervention of the CP indicated NJ ex order 26.4b1 with an initiation date of NJ ex order 26.4b1

On 2/11/25 at 1:10 PM, the surveyor observed Resident #48 sitting at a table in the dining area of their unit. The resident had a NJ Exec Order 26.4b1 only and there was NJ Exec Order 26.4b1 for the resident on the table. The surveyor asked Resident #48 about their meal. The resident replied that they had received NJ Exec Order 26.4b1 instead of the NJ Exec Order 26.4b1 that they had requested. The resident stated that they told staff in dining area who called the kitchen. Resident #48 further explained that the staff informed them that there was NJ Exec Order 26.4b1 and Resident #48 asked for a NJ Exec Ord which NJ Exec was waiting to receive.

The surveyor interviewed the Medical Record Staff (MRS) who had followed up with the kitchen

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F 806	Continued From page 83	F 806		

for Resident #48. The MRS stated that Resident #48 NJ Exec Order 26.4b1 , the kitchen was called, they did not have any more NJ Exec Order 26.4b1, and the resident selected a NJ Exec Order

On 2/11/25 at 1:22 PM, the surveyor interviewed the U.S. FOIA (b) (6) The U.S. FOIA stated the menu schedule was available on the units for all the residents to review and for staff to inform residents of available options. The U.S. FOIA (b further explained three-week cycle selective menus were provided to some of the residents so that they could choose their preference for each NJ Exec Orde The U.S. FOIA (b acknowledged NJ Exec Order 26.4b1 of residents should be honored.

The U.S. FOIA confirmed that Resident #48 was provided a NJ Exec Order 26.4b1 for each NJ Exec Orde The surveyor informed the U.S. FOIA (b of the concern that the resident ordered a NJ Exec Order 26.4b1 for lunch and did not receive it on their lunch tray. The U.S. FOIA stated that sometimes residents changed their mind and would want the alternative option that was being served to other residents. The surveyor requested the meal ticket for the resident's lunch today and the resident's NJ Exec Order 26.4b1. The U.S. FOIA provided the selective menu and the meal ticket.

The U.S. FOIA reviewed with the surveyor the selective menu for Resident #48. For today's lunch meal the resident crossed out NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1" option remained. The U.S. FOIA confirmed that the resident selected the roasted NJ Exec Order 26.4b1 indicated the resident NJ Exec Order 26.4b1 item.

The surveyor reviewed with the U.S. FOIA (b the

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F 806	Continued From page 84 resident's NJ Exec Order 26.4b1, which revealed listed NJ Exec Order 26.4b1 [redacted]. The U.S. FOIA [redacted] could not speak to why the resident received NJ Exec Order [redacted] when the resident had ordered the NJ Exec Ord NJ Exec Order 26.4b1 [redacted]. The U.S. FOIA [redacted] stated she would follow up to determine what happened. On 2/13/25 at 2:18 PM, the surveyor notified the US FOIA (b)(6) [redacted] U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) [redacted] of the above concern for Resident #48's NJ Exec Order 26.4b1 not being honored. On 2/14/25 at 1:07 PM, the U.S. FOIA (b) [redacted] and the U.S. FOIA (b [redacted] met with the survey team. The U.S. FOIA (b) [redacted] stated the facility investigated and that it was the unclear writing of 'NJ Exec Order 26.4b1 the dietary staff. The surveyor showed the NJ Exec Order 26.4b1 of Resident #48 where NJ Exec Order 26.4b1 was crossed out in ink and 'NJ Exec Order 26.4b1" in typed format remained. The U.S. FOIA (b) [redacted] and the U.S. FOIA (b [redacted] stated they would in-service staff that moving forward staff were to clarify anything that was unclear. The surveyor reviewed the facility provided policy titled, "Nutritional Management" with a last review date of 4/9/24. Under CP Implementation indicated: "The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care." Under Monitoring/revision of the policy indicated: " ...Interviewing the resident and/or resident representative to determine if their personal goals and preferences are being met ..."	F 806		

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F 806	Continued From page 85 NJAC 8:39-17.4 (e); 27.1 (a)	F 806		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		3/9/25

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F 842	Continued From page 86 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ173918 Based on interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete, available, accurate, and readily accessible medical records. This deficient practice was identified for 4 of the 38 residents reviewed, (Residents #131, #162,	F 842	F842 Resident Records - Identifiable Information 1. Late entry U.S. FOIA (b) (6) notes were written from NJ ex order 26.4b1 for Resident #162. The NJ Exec Order 26.4b1 Sign was moved from the door to under the	

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F 842	Continued From page 87 #175, and #493). This deficient practice was evidenced by the following: 1. On 2/7/25 at 11:47 AM, the surveyor observed Resident #162 U.S. FOIA (b) (6) outside their room with U.S. FOIA (b) (6) The surveyor reviewed the medical records of Resident #162, and revealed the following: The Admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ ex order 26.4b1 [redacted] A review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool, with an assessment reference date (ARD) of NJ ex order 26.4b1 under Section NJ Exec Order 26.4b1 revealed a brief interview for mental status (BIMS) score of NJ of 15, which reflected that the resident had NJ Exec Order 26.4b1 . A review of the Progress Notes (PN) revealed that the physician's visit notes were all late entries, created on NJ ex order 26.4b1 for an effective date from NJ ex order 26.4b1 . On NJ ex order 26.4b1, the survey team met with	F 842	resident's name tag for Resident # 175. The NJ ex order 26.4b1 [redacted] and NJ ex order 26.4b1 consent forms were uploaded in the electronic health record system for Resident #175. The care plan for Resident # 131 to reflect the NJ ex order 26.4b1 [redacted] to the resident. Resident #493 NJ ex order 26.4b1 [redacted] 2. All active residents have the potential to be affected by this deficient practice. 3. All active providers were in-serviced by the Administrator/designee regarding the facility's Physician Visits Policy. The Director of Nursing (DON) or designee audited all active residents were seen at least monthly for the 1st 90 days and then every 60 days. The DON or designee audited all active residents with physician order for Enhanced Barrier Precautions to ensure the signage is placed under the resident's name tag. The DON or designee audited all active residents to ensure a completed Influenza, Pneumococcal, Covid-19 Vaccine and Psychoactive consent forms are completed and uploaded in the resident's electronic health record within 5	

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F 842	Continued From page 88 the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) and the surveyor notified them of the concerns above regarding late entries of the physician. On 2/18/25 at 11:25 AM, the survey team met with the U.S. FOIA (b) (6), and the U.S. FOIA (b) (6) The U.S. FOIA (b) (6) stated that the monthly physician visit notes should be done within the 1st 90 days and then every 60 days thereafter. 2. On 2/7/25 at 11:33 AM, the surveyor observed Resident #175's outside door with a posted sign for NJ ex order 26.4b1 were measures implemented in healthcare settings to NJ ex order 26.4b1, particularly in situations where standard precautions alone may not be sufficient) and the resident was not inside the room. On that same date and time, the U.S. FOIA (b) (6) informed the surveyor that the resident NJ ex order 26.4b1. The U.S. FOIA (further stated that Resident #175 NJ ex order 26.4b1, and NJ ex order 26.4b1. The surveyor reviewed the medical records of Resident #175 and revealed: A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; NJ ex order 26.4b1	F 842	days of admission and or start of a psychoactive medication. All active licensed nurses and certified nurse aides were in-serviced by the Infection Preventionist about the placement of the Enhanced Barrier Precaution Signs. All licensed nurses were in-serviced by the DON about the facility's Smoking Policy and types of smoking cessation. All active licensed nursed and certified nurse aides were in-serviced by the DON about the facility's Incontinence Policy and the importance of bowel and bladder documentation. All active licensed nurses were in-served by the Infection Preventionist about offering, completing, and uploading the Influenza, Pneumococcal, Covid-19 vaccine and Psychoactive consent forms within 5 days of admission and/or as needed. The Infection Preventionist will audit 10 random charts to ensure the Enhanced Barrier Precaution Sign is placed under the name tag weekly x 4 weeks, then monthly x 3 months. The Infection Preventionist or designee will audit all new admission and 5 long term care charts to ensure the Influenza, Pneumococcal, Covid-19 vaccine and psychoactive consent forms are completed and uploaded weekly x 4 weeks, then monthly x 3 months.	

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F 842	Continued From page 89 NJ ex order 26.4b1 [redacted] A review of the most recent comprehensive MDS (cMDS), with an ARD of [redacted], revealed a BIMS score of [redacted] of 15, which reflected that the resident's [redacted] status was NJ ex order 26.4b1 The cMDS also reflected that Resident #175 [redacted] A review of the NJ ex order 26.4b1 and NJ ex order 26.4b1 electronic Medication Administration Record (eMAR) with U.S. FOIA (b) (6) orders (PO) revealed: -A PO with a start date of [redacted] and NJ ex order 26.4b1 [redacted] -A PO with a start date of [redacted] and d/c on [redacted] for NJ ex order 26.4b1 [redacted] -A PO with a start date of NJ ex order 26.4b1 [redacted] -A PO with a start date of NJ ex order 26.4b1	F 842	The DON or designee will audit 10 random charts to ensure Bowel and Bladder documentation compliance daily x 7 days, then weekly x 3 weeks, then monthly x 3 months. 4. The DON will report the findings of the audits to the monthly Quality Assurance Performance Improvement (QAPI) meetings x 4 months to ensure compliance and if further actions are necessary.	

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NJ ex order 26.4b1 [redacted]

Further review of the medical records revealed that there was no documented evidence that NJ ex order 26.4b1 [redacted] were offered and declined by the resident or by the Resident Representative (RR) or education was provided. There was no evidence that the consent was offered and signed by the resident or the RR to start on NJ ex order 26.4b1 [redacted].

On 2/10/25 at 9:22 AM, the surveyor discussed with the U.S. FOIA (b) (6), and U.S. FOIA (b) (6) [redacted]) regarding the expectation that the survey team must have access to residents' medical records as part of the survey process and the facility to provide asked documents timely, and the U.S. FOIA (b) ([redacted] acknowledged.

On 2/10/25 at 11:18 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager #1 (LPN/UM#1) in the 1NJ Exec Order 26.4b1 about Resident #175's NJ Exec Order 26.4b1 status and consent forms. LPN/UM#1 showed the packet that was being given to the resident and/or RR for consent as part of the admission packet.

At that same time, LPN/UM#1 was unable to locate the resident's NJ Exec Order 26.4b1 consent forms and NJ ex order 26.4b1 signed consent. LPN/UM#1 had checked the resident's paper chart and electronic medical records and stated that he did not find evidence that the consent for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 were done. LPN/UM#1 had no response when asked why the resident NJ ex order 26.4 [redacted].

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F 842	Continued From page 91 A review of the electronic medical records revealed that the NJ ex order 26.4b1 [redacted] Later, LPN/UM#1 stated that the U.S. FOIA (b) (6) [redacted] would "probably" have the NJ Exec Order 26.4b1 consent forms. Both the surveyor and LPN/UM#1 went to the IPN's office. In the U.S. FOIA's office, the U.S. FOI stated that she only had a few in her binder of NJ Exec Order 26.4b1 consent forms that were signed because some of them were on the "residents' charts." The U.S. FOI further stated that it was the responsibility of the admission nurse to get consent as part of their admission packet. The U.S. FOI showed the binder and confirmed that there was no consent for Resident #175. The U.S. FOI further stated that the vaccines should be offered to all residents. On 2/10/25 at 1:05 PM, LPN/UM#1 informed the surveyor that he found the NJ Exec Order 26.4b1 and NJ ex order 26.4b1 consents of Resident #175 in the copying machine because the admission person scanned it during admission and "probably" forgot it in the copying machine when they were scanning it. On 2/18/25 at 1:47 PM, the survey team met with the U.S. FOIA (b) (6) and LPN/UM#1 for an exit conference, the U.S. FOIA (b) (6) did not provide additional information. 2. On 2/10/25 at 1:07 PM, the surveyor observed Resident #131 NJ Exec Order 26.4b1 . The resident was NJ ex order 26.4b1 [redacted] The resident stated that NJ ex order 26.4b1 [redacted] and that the facility was now a NJ Exec Order 2	F 842		

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free facility. Resident #131 stated that NJ ex order 26.4b1 [redacted] and had NJ Exec Order 26.4b1 with the facility.

On 2/10/25 at 1:15 PM, the surveyor interviewed LPN#2, who was assigned to care for Resident #131. LPN#2 stated Resident #131 NJ ex order 26.4b1 prior to update of NJ Exec Order 26.4b1 facility policy and that the resident did NJ Exec Order 26.4b1 anymore. LPN#2 verbalized NJ Exec Order 26.4b1 for the resident.

On 2/10/25 at 1:26 PM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] who stated that Resident #131 did NJ Exec Order 26.4b1 anymore after the implementation of the NJ Exec Order 26.4b1 policy. The U.S. FOIA (b) (6) stated the interdisciplinary team (IDT) met with the resident to inform and educate the resident of the update policy, and the resident was NJ Exec Order 26.4b1

On 2/13/25 at 9:49 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #131.

A review of the AR documented that the resident had diagnoses that included but were not limited to, NJ Exec Order 26 and NJ Exec Order 26.4b1 [redacted].

A review of the qMDS with an ARD of NJ ex order 26.4b1 indicated a BIMS score of NJ ex out of 15, which indicated the resident was NJ ex order 26.4b1.

On 2/13/25 at 11:31 AM, the surveyor interviewed the U.S. FOIA (b) (6) about documentation about the IDT meeting with the resident about the facility's updated NJ Exec Order 26.4b policy and the resident agreeable. The U.S. FOIA (b) (6) stated that the documentation should be found in the resident's

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medical records. The surveyor notified the U.S. FOIA (b) (6) that documentation and agreement was not found in Resident #131's medical records. The U.S. FOIA (b) (6) stated she would ask the U.S. FOIA (b) (if they had a copy.

On 2/13/25 at 11:51 AM, the U.S. FOIA (b) (6) stated that the U.S. FOIA (b) (6) had the agreement and would provide to the surveyor.

On 2/13/25 at 12:46 PM, the surveyor interviewed the U.S. FOIA (b) (who stated that the IDT had a meeting with Resident #131 about the facility's updated policy in NJ Exec Order 26.4b1. The U.S. FOIA (b) (provided copy of a progress note for the IDT meeting.

A team care plan meeting note dated 10/9/24, indicated the IDT meeting with Resident #131 which documented that the resident was educated on the updated facility policy of being NJ Exec Order 26.4b1 and verbalized NJ Exec Order 26.4b1 Resident #131 was NJ Exec Order 26.4b1 NJ ex order 26.4b1 , and expressed NJ ex order 26.4b1 The note documented that nursing/IDT would follow up.

The surveyor asked the U.S. FOIA (b) (about follow up on the NJ Exec Order 26.4b1 with NJ ex order 26.4b1 The U.S. FOIA (b) (stated NJ ex order 26.4b1, and NJ ex order 26.4b1 to the resident. The U.S. FOIA (b) (was to provide additional information regarding the follow up for the NJ Exec Order 26.4b1 with NJ ex order 26.4b1 .

On 2/13/25 at 2:18 PM, the surveyor notified the U.S. FOIA (b) (, the U.S. FOIA (, and the US FOIA (b)(6) of the concern of the care planning of NJ Exec Order 26.4b and there being no documentation of cessation interventions in chart.

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F 842	Continued From page 94 On 2/14/25 at 1:07 PM, the surveyors met with the U.S. FOIA (b and the U.S. FOIA (b) (6. The U.S. FOIA (b) (provided an untitled document letter dated NJ Exec Order 26.4b1 which indicated the resident had NJ Exec Order 26.4b1 interventions. The surveyor asked the U.S. FOIA (b) (where the document was located and if it was in the resident's medical record. The U.S. FOIA (b) (replied the document was not in the medical record and stated it was filed in his office. There was no additional documentation provided by the facility. 3. A review of the facility AR revealed that Resident #493 was admitted with diagnoses which included but were not limited to; NJ ex order 26.4b1 [redacted] and NJ ex order 26.4b1 [redacted]. A review of the MDS, revealed Resident #493 had a BIMS score of NJ ex o of 15, which indicated NJ Exec Order 26.4b1 and Resident #493 NJ ex order 26.4b1 [redacted]. A review of Care Plan (CP), initiated NJ ex order 26.4b1 included at NJ ex order 26.4b1 related to (r/t) NJ ex order 26.4b1 [redacted] Interventions included but were not limited to NJ ex order 26.4b1 [redacted] and NJ ex order 26.4b1 [redacted] A review of CP initiated on NJ ex order 26.4b1 included at NJ ex order 26.4b1 [redacted]	F 842		

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F 842	Continued From page 95 day and describe amount, color, and consistency. A review of Resident #493's NJ Exec Order 2 Certified Nurse Aide (CNA) Intervention/Task Report sheet for NJ Exec Order 26.4b1 revealed that Resident #493's assigned CNA(s) did not document, on each shift, whether Resident #493 had NJ Exec Order 2 , NJ e NJ Exec Order 26.4b1 NJ ex order 26 NJ Exec Order 26.4b1 not rated due to NJ ex order 26.4b1 , NJ - NJ Exec Order 26.4b1 not rated due to NJ ex order 26.4b1 , NJ - NJ Exec Order 26.4b1 not rated due to NJ ex order 26.4b1 The NJ Exec Order 26.4b1 intervention had missing signatures for NJ ex order 26.4b1 for NJ ex order 26.4b1. NJ Exec Order 26.4b1 signatures were missing fo NJ ex order 26.4b1 for NJ ex order 26.4b1. The NJ Exec Order 26.4b1 intervention/task had missing signatures for NJ ex order 26.4 and NJ ex order 26 for NJ ex order 26.4b1 Further review of the above revealed a total of 35 missed opportunities out of 93. A review of Resident #493's NJ Exec Order 2 Certified Nurse Aide (CNA) Intervention/Task Report sheet for NJ Exec Order 26.4b1 revealed that Resident #493's assigned CNA(s) did not document, on each shift, whether Resident #493 NJ ex order 26.4b1 - NJ Exec Order 26.4b1 2- NJ ex order 26.4b1 3- NJ Exec Order 26.4b1 not rated due to NJ ex order 26.4b1 NJ Exec Order 26.4b1 = NJ -None, NJ ex or NJ Exec Order 2 NJ ex or NJ Exec Order 26.4b1 NJ ex or NJ Exec Order 2 NJ Exec Order 26.4b1 = NJ e - NJ Exec Order 26.4b1 , NJ ex or NJ ex order 26.4b1 NJ e - NJ ex order 26.4b1 , NJ ex or NJ ex order 2 NJ Exec Order 26.4b1 intervention/task had missing signatures for NJ ex order 26.4b1 ,	F 842		

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NJ ex order 26.4b1 for NJ ex order 26.4b1. NJ Exec Order 26.4b1 intervention/task had missing signatures for NJ ex order 26.4b1 for NJ ex order 26.4b1 shift. NJ Exec Order 26.4b1 intervention/task had missing signatures for NJ ex order 26. and NJ ex order. for NJ ex order 26.4b1 shift.

A review of the above revealed a total of 35 missed opportunities out of 93.

During interview with the surveyor on 2/13/2024 at 12:29 PM, with current LPN/UM#1 on NJ Exec Order 2, confirmed that there were missing signatures for the dates mentioned and stated that it was important that there were no blanks because resident's NJ ex order 26.4b1 for example NJ Exec Order 26.4b1 and to ensure resident was NJ Exec Order 26.4b1. LPN/UM#1 further stated that it was also important to sign and check for resident's NJ Exec O also stated that he did not know what the "NJ Exec meant.

During an interview with the surveyor on 2/13/204 at 1:30 PM, with assigned Licensed Practical Nurse/Unit Manager #2 (LPN/UM#2) during the mentioned time on NJ Exec Order 2, confirmed that there were blanks and that it was important that there were no blanks to ensure the tasks were completed. LPN/UM#2 further stated that if the resident is not checked then NJ ex order 26.4b1, and resident can attempt to NJ Ex Order 26 which could lead to a NJ Exec LPN/UM#2 stated that she does not know what the "NJ Ex meant.

During an interview with the surveyor on 2/14/204

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F 842	Continued From page 97 at 1:29 PM, with the [redacted], she confirmed that there were blanks and stated that there should not be any blanks. She further stated that it was important to sign to show that the care was provided and that it was very concerning. The [redacted] stated that she did not know what the "[redacted] meant. During an interview with the surveyor on 2/18/204 at 11:53 AM, with the [redacted], the [redacted] confirmed that there were blanks, she stated that there should be no blanks on the [redacted] sheets. She further stated that it was important to document so we know the type of care that was provided. A review of a facility's Incontinence Policy, reviewed/revised 12/3/24, revealed: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Resident that are incontinent of bladder or bowel will receive appropriate treatment ... NJAC 8:39-23.2 (a)(b); 27.1, 35.2 (a)(c)(d) 4,5,6,13	F 842		
F 880 SS=D	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	F 880		3/9/25

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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

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F 880	Continued From page 99 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: Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene, use of personal protective equipment (PPE) practices, and use of disinfecting wipes for 3 of 6 staff (1 Certified Nursing Aide and 2 Nurses) and b.) ensure that the NJ Exec Order 26.4b1 was posted and ensure the physician order for NJ Exec Order 26.4b1 was followed for 1 of 1 resident, (Resident #292), and follow appropriate infection control practices, to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand	F 880	F880 Infection Prevention & Control 1. The U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) were immediately removed from the floor and in-serviced by the U.S. FOIA (b) (6) with the facility's Hand Hygiene and Protective Personal Equipment (PPE) Policy. A hand hygiene and PPE competency was conducted with the U.S. FO and U.S. FOIA (. The U.S. FOIA (b) (6)) was immediately in-serviced by the Infection Preventionist about ensuring the lids of disinfection wipes are closed when not in use. The signage for the NJ Exec Order 26.4b1 was immediately moved from the inside of the door to under the name tag of Resident # 292.	

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F 880	Continued From page 100 Hygiene for Healthcare Workers dated 2/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ... Before moving from work on a soiled body site to a clean body site on the same patient ... After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. On 2/10/25 at 6:54 AM, during the incontinence tour, the surveyor observed the U.S. FOIA (b) (6) come out of the elevator with a surgical mask not covering the nose and mouth. The U.S. FOIA (informed the surveyor that she was one of the CNAs in the unit and confirmed that "almost all" residents in her assignments were NJ Exec Order 26.4b1 of both NJ Exec Order 26.4b1 . On that same date at 6:57 AM, both the surveyor and U.S. FOIA (went inside room NJ Exec O The U.S. FOIA (stated that the resident in the room by the door, Resident # 93 was her resident and the resident was NJ Exec Order 26.4b1 Inside the resident's room, the U.S. FOIA (did not perform hand hygiene before and after touching her surgical mask. The surveyor observed the U.S. FOIA (adjusted her mask to cover her nose with the same surgical mask, took a pair of gloves inside her pocket sweater, and donned (put on) gloves. The U.S. FOIA (did not perform hand hygiene before donning gloves. After the U.S. FOIA (checked the resident's NJ Exec Order 26.4b1 , the U.S. FOIA (immediately doffed (removed) off the used gloves and disposed of to the garbage receptacle inside	F 880	2. All active residents have the potential to be affected by the deficient practice. 3. All licensed nurses and certified nursing assistants were in-serviced by the Infection Preventionist on the facility's Hand Hygiene, Personal Protective Equipment ("PPE") and Transmission Based Precaution ("TBP") policies and on the proper use of disinfecting wipes and following the manufacturer guidelines. The Infection Preventionist audited all disinfecting wipes to ensure lids are closed when not in use. The Infection Preventionist or designee will audit 5 random staff to ensure compliance on use of disinfection wipes x 7 days for 1 week, then weekly x 3 weeks, then monthly x 3 months. The Infection Preventionist audited all active residents with a physician order for TBP to ensure the TBP sign was placed under the resident's door name tag. The Infection Preventionist or designee will audit 5 random staff to ensure compliance with hand hygiene and the use of PPE daily x 7 days, then weekly x 3 weeks, then monthly x 3 months. The Infection Preventionist or designee will audit 5 residents with a physician order for a TBP to ensure the signage is placed under the resident's name tag weekly x 4 weeks, then monthly x 3	

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F 880	Continued From page 101 the resident's room. The U.S. FOIA (did not perform hand hygiene after the removal of gloves and before exiting the resident's room. Outside the resident's room, the U.S. FOIA (pulled down her surgical mask below her nose and did not perform hand hygiene after touching her mask. The surveyor asked the U.S. FOIA (about her surgical mask not covering her nose and the doffing off gloves without performing hand hygiene. The U.S. FOIA (b stated that at times the mask fell off because she could not breathe. After the surveyor notified the U.S. FOIA (of the concerns with hand hygiene and the use of gloves, the U.S. FOIA (went to wash her hands in another room. The surveyor observed the U.S. FOIA (b) open the faucet and take soap from the dispenser without wetting her hands first. The U.S. FOIA (performed handwashing (scrubbing) under the stream of water for 22 seconds. At that same time, the U.S. FOIA (acknowledged that she scrubbed her hands under the stream of water and stated that it was the appropriate way of washing hands. On 2/10/25 at 7:00 AM, the surveyor and the U.S. FOIA (b) (6) went to room NJ Exec O The surveyor observed the U.S. FOIA (b) (6) donned gloves without performing hand hygiene and checked Resident #97's NJ Exec Order 26.4b1. The U.S. FOIA (b) (6) did not perform hand hygiene after doffing gloves and before exiting the resident's room. Outside the room, the surveyor notified the U.S. FOIA (b) (6) of the concern regarding the CNA's hand hygiene and use of gloves. The U.S. FOIA (b) (6) stated that the U.S. FOIA (should have washed hands before	F 880	months. 4. The Director of Nursing will report the findings of the audits to the monthly QAPI meetings x 4 months to ensure compliance and if further actions are necessary.	

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and after the use of gloves and not stored gloves in the pocket. She further stated that the [redacted] should wear the mask properly which was to cover both mouth and nose.

Afterward, the surveyor notified the [redacted] of the concerns that she did not perform hand hygiene before and after the use of gloves as well.

2. On 2/10/25 at 8:16 AM, during medication (med) administration pass, the surveyor observed the [redacted] used the disinfecting wipes for cleaning the [redacted] before and after use. The surveyor observed the [redacted] after the use of disinfecting wipes left the cover lid open and went to other resident without covering the disinfecting wipes container.

On 2/10/25 at 8:40 AM, the surveyor interviewed the [redacted] after med administration pass observation of two residents and discussed the concern that from 8:16 AM to 8:40 AM, the disinfecting wipes container was left open. The [redacted] responded that because she was not finished with the med administration pass to all residents in her assignment that was why she did not close the cover of the disinfecting wipes. The [redacted] acknowledged that it was depicting the purpose of the disinfectant wipes if the container lid was left open for some time.

On 2/10/25 at 11:37 AM, the surveyor interviewed the [redacted] and notified of the concerns with the [redacted] and the [redacted]. The [redacted] stated that [redacted] and [redacted] should have done hand hygiene before and after gloves use, and surgical masks should be worn properly to cover the mouth and nose.

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 02/18/2025

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 880	Continued From page 103 The U.S. FOIA also stated that hand hygiene should not be under a stream of running water. She further stated that the U.S. FOIA (b) should have closed the container of disinfecting wipes to keep them wet. On 2/14/25 at 1:07 PM, the survey team met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) and the surveyor notified them of the above findings and concerns. The U.S. FOIA (b) stated that the U.S. FOIA (b) should follow the facility's policy and protocol about the storage of PPE, proper use of masks, and hand hygiene, as well as the U.S. FOIA (b) (6). She further stated that the facility was taking seriously the concerns of the surveyor with regard to infection control and in-service ongoing. A review of the facility's Safety Data Sheet of [disinfecting wipes] revealed under Section 7. Handling and Storage: storage conditions: Keep the container closed when not in use ... On 2/18/25 at 1:47 PM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6), and U.S. FOIA (b) (6) for an exit conference, the U.S. FOIA (b) (6) did not provide additional information. 3. On 2/7/25 at 10:24 AM, the surveyor interviewed the NJ Exec Order 26.4b1 U.S. FOIA (b) (6) regarding if the unit had any residents that were on NJ Exec Order 26.4b1). The NJ Exec Order 26.4b1 U.S. FOIA (b) (6) stated that Resident #292 was on NJ ex order 26.4b1 On 2/7/25 at 10:54 AM, the surveyor observed Resident #292's room door closed. The surveyor	F 880		

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	315021	A. BUILDING _____ B. WING _____	C 02/18/2025

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 880	Continued From page 104	F 880		

observed that there was no signage outside the room to indicate the resident was on NJ Exec O and that in order to enter the room NJ Exec O including a NJ Exec Order 26.4b1) was required to be donned. The surveyor observed a large cart near the resident's room that contained NJ Exec O which also included NJ Exec O NJ Exec Order 2 and had instructions for donning and doffing PPE. The surveyor asked the NJ Exec Order 26.4b1 U.S. FOIA to observe Resident #292's room. The NJ Exec Order 26.4b U.S. FOI confirmed that there was no signage outside the room to indicate that the resident was on NJ Exec O and what was required to don prior to entrance into the room. The NJ Exec Order 26.4b1 U.S. FOIA stated that he thought that the sign was on the inside of the door. The first floor U.S. FOIA confirmed that Resident #292 was transferred to the facility from the hospital and was NJ Exec Order 26.4b1 and was on NJ Exec Ord

A review of Resident #292's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ ex order 26.4b1 and NJ ex order 26.4b1 .

A review of Resident #292's care plan, included the following with an initiated date of NJ ex order 26 : NJ ex order

On 2/12/25 at 1:03 PM, the surveyor interviewed the U.S. FOI regarding NJ ex orde and Resident #292. The U.S. FOIA stated that there should be signage on the door to indicate NJ ex orde . She added that if the

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	315021	A. BUILDING _____ B. WING _____	C 02/18/2025

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 105	F 880		

resident was on a unit that was not the designated [redacted] that the resident's door should remain closed. The surveyor notified the [redacted] of the observation of Resident #292's room. The [redacted] confirmed that the resident was not on the facility's designated [redacted] and that there should have been signage on the outside of the door. She added that a staff probably put the sign on the inside of the door (when it was in the open position) before the resident came to the facility. The [redacted] stated that the sign should not be on the inside of the door and that for [redacted], the door should be closed.

On 2/12/25 at 1:40 PM, the surveyor notified the [redacted], and [redacted] of the concern that Resident #292 did not have [redacted] signage posted outside the room and that the [redacted] stated that it was probably inside the door. The [redacted] stated that she had placed the [redacted] sign herself. The surveyor asked the [redacted] if a resident had [redacted] should the [redacted] signage be on the inside of the door when the door should be closed. The [redacted] stated that the [redacted] signage should not be on the inside of the door.

A review of the Resident #292's [redacted] Medication Administration Record (MAR) included the following order:
[redacted]: All activities and services performed in room. every shift for [redacted] and night shift on [redacted] was not signed as administered (done).

A review of Resident #292's Progress Notes (PN) for [redacted] did not indicate the resident was on [redacted].

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 02/18/2025

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 106 On 2/13/25 at 2:14 PM, in the presence of the U.S. FOIA (b) (and U.S. FOIA (b), the U.S. FOIA (b)(6) stated that the NJ ex orde was posted on the inside of the door. On 2/14/25 at 1:22 PM, in the presence of the U.S. FOIA (b) (6) the U.S. FOIA (b stated that she investigated the NJ Exec O sign for Resident #292 and that the door was opened when the NJ ex order 26.4b1 was posted and that she inserviced the staff. On 2/14/25 at 1:54 PM, the surveyor notified the U.S. FOIA (b) (and U.S. FOIA (b the concern that Resident #292's MAR was not signed for NJ Exec O for two shifts and that the PN did not indicate that the resident was on NJ Ex Orde for NJ Exec Order 26. On 2/18/25 at 11:42 AM, in the presence of the U.S. FOIA (b) (and US FOIA (b)(6) the U.S. FOIA (b stated that she reached out to the staff members and they stated that it was an omission but that they knew the resident NJ ex order 26.4b1 The U.S. FOIA (b) (did not provide any additional information. A review of the facility provided policy titled "Transmission-Based (Isolation) Precautions" with a reviewed/revised date of 2/5/25 included the following: 1. Facility staff will apply TBP, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission ... 9. e. Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room ...Additionally, either the CDC category of	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 02/18/2025

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 107 transmission-based precautions (e.g., contact, droplet, or airborne) or instructions to see the nurse before entering will be included in the signage ... N.J.A.C. 8:39-19.4(a)(1,2),(l),(n)	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 02/18/2025

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 was 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #NJ168894 Complaint #NJ178822 REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for	S 560	S560 Mandatory Access to Care 1. No residents were found to be affected by this 2. All active residents have the potential to be affected by this deficient practice. 3. The Administrator/designee provided in-service education to the staffing coordinator on N.J. S.A. 30:13-18 (the Act) which establish minimum staffing requirements in nursing home in New Jersey. The facility has implemented a significant above market rate for nurses and certified	3/9/25

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

Electronically Signed | 03/09/25

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 02/18/2025

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S 560	Continued From page 1 nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift. (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care	S 560	nursing assistants. The facility has implemented an incentive program including sign-on bonuses for new hires and referral bonuses for employees referring staff where appropriate. The facility continues to conduct on-going job fairs internally and externally with immediate interviews and contingency offers. The facility implemented an expedited onboarding process to new hires. The facility will use agency staff as needed to meet staff needs. The Director of Nursing or designee will review facility census, admissions, resident acuity, staff call outs if any, and staffing needs to ensure the facility meets compliance with the minimum staffing requirements in New Jersey. The daily review will be an on-going basis. The Director of Nursing or designee will report the findings of the daily staffing audits to the Administrator/designee and to the Quality Assurance Performance Improvement ("QAPI") committee weekly x 4 weeks, then monthly x 3 months, then quarterly x 3 quarters. The QAPI committee will review and determine the need for recommendation or further audits.	

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 02/18/2025

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 560	Continued From page 2 staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 5 weeks of AAS-11 and 2 weeks of AAS-12 staffing for the 2/13/2025 Standard survey with Complaints revealed the following: The 5 weeks of AAS-11 staffing was run in 3 segments by dates and revealed the following: 1. For the 2 weeks of Complaint staffing from 10/29/2023 to 11/11/2023, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows:	S 560		

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 02/18/2025

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

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S 560	Continued From page 3 -10/29/23 had 20 CNAs for 187 residents on the day shift, required at least 23 CNAs. -10/30/23 had 20 CNAs for 187 residents on the day shift, required at least 23 CNAs. -10/31/23 had 20 CNAs for 187 residents on the day shift, required at least 23 CNAs. -11/01/23 had 20 CNAs for 187 residents on the day shift, required at least 23 CNAs. -11/02/23 had 20 CNAs for 185 residents on the day shift, required at least 23 CNAs. -11/03/23 had 20 CNAs for 185 residents on the day shift, required at least 23 CNAs. -11/04/23 had 19 CNAs for 185 residents on the day shift, required at least 23 CNAs. -11/05/23 had 20 CNAs for 185 residents on the day shift, required at least 23 CNAs. -11/06/23 had 19 CNAs for 190 residents on the day shift, required at least 24 CNAs. -11/07/23 had 19 CNAs for 190 residents on the day shift, required at least 24 CNAs. -11/08/23 had 19 CNAs for 190 residents on the day shift, required at least 24 CNAs. -11/09/23 had 20 CNAs for 190 residents on the day shift, required at least 24 CNAs. -11/11/23 had 20 CNAs for 190 residents on the day shift, required at least 24 CNAs. 2. For the week of Complaint staffing from 10/13/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/13/24 had 20 CNAs for 207 residents on the day shift, required at least 26 CNAs. -10/14/24 had 20 CNAs for 207 residents on the day shift, required at least 26 CNAs. -10/15/24 had 20 CNAs for 206 residents on the day shift, required at least 26 CNAs. -10/16/24 had 24 CNAs for 206 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ATLAS HEALTHCARE AT DAUGHTERS OF MIR	155 HAZEL STREET CLIFTON, NJ 07011

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S 560	Continued From page 4 day shift, required at least 26 CNAs. -10/17/24 had 22 CNAs for 205 residents on the day shift, required at least 26 CNAs. -10/18/24 had 22 CNAs for 203 residents on the day shift, required at least 25 CNAs. -10/19/24 had 21 CNAs for 202 residents on the day shift, required at least 25 CNAs. 3. For the 2 weeks of staffing prior to survey from 1/19/2025 to 2/1/2025, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -01/20/25 had 22 CNAs for 207 residents on the day shift, required at least 26 CNAs. -01/28/25 had 20 CNAs for 201 residents on the day shift, required at least 25 CNAs. -01/30/25 had 24 CNAs for 198 residents on the day shift, required at least 25 CNAs. On 2/13/25 at 11:52 AM, the surveyor interviewed the Staffing Coordinator (SC), who stated, "I have full time, part time and per diem CNAs and nurses. The empty holes, I will fill up with my per diems and the part times. I go according to the census, I divide the census by 8 in the morning, 1 CNA to eight residents, 1/10 on 3-11 shift and 1/14 on 11-7 shift. I am meeting those ratios since I started because we have been hiring people. We use agency and offer people too when it's bad weather." On 2/13/25 at 12:36 PM, the Director of Nursing (DON) stated, "The Staffing Policy and Procedure is the same as the Staffing Posting Policy and Procedure. We don't have another one." A review of the Staffing Posting Policy and Procedure revealed that it did not reflect the ratios of CNAs per shift.	S 560		

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 5 On 2/18/25 at 1:47 PM, during the exit conference, the surveyor notified the DON, Licensed Nursing Home Administrator, and the Regional of Clinical Services of the shifts when the minimum direct care staff to resident ratio was not met.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315021 (Y1)	A. Building B. Wing (Y2)	3/31/2025 (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 F0580 Reg. # 483.10(g)(14)(i)-(iv)(15) LSC	Correction Completed 03/09/2025	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(h)(1)-(5) LSC	Correction Completed 03/09/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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 2/18/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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 B. Wing Y2	3/31/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0580	Correction	ID Prefix F0607	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed
LSC	03/09/2025	LSC	03/09/2025	LSC	03/09/2025
ID Prefix F0625	Correction	ID Prefix F0637	Correction	ID Prefix F0640	Correction
Reg. # 483.15(d)(1)(2)	Completed	Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(f)(1)-(4)	Completed
LSC	03/09/2025	LSC	03/09/2025	LSC	03/09/2025
ID Prefix F0641	Correction	ID Prefix F0656	Correction	ID Prefix F0658	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	03/25/2025	LSC	03/09/2025	LSC	03/09/2025
ID Prefix F0689	Correction	ID Prefix F0693	Correction	ID Prefix F0695	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(4)(5)	Completed	Reg. # 483.25(i)	Completed
LSC	03/09/2025	LSC	03/09/2025	LSC	03/09/2025
ID Prefix F0698	Correction	ID Prefix F0711	Correction	ID Prefix F0732	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.30(b)(1)-(3)	Completed	Reg. # 483.35(g)(1)-(4)	Completed
LSC	03/09/2025	LSC	03/18/2025	LSC	03/09/2025

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

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 B. Wing Y2	3/31/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0806	Correction	ID Prefix F0842	Correction	ID Prefix F0880	Correction
Reg. # 483.60(d)(4)(5)	Completed	Reg. # 483.20(f)(5), 483.70(h)(1)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	03/09/2025	LSC	03/09/2025	LSC	03/09/2025

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?
2/18/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
031601 Y1	A. Building B. Wing Y2	3/31/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/09/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 2/18/2025	☐ 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
	315021	A. BUILDING **01** B. WING _____	C **02/18/2025**

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
E 000	Initial Comments Atlas Health Care at Daughters of Miriam is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/12/2025 and 02/13/2025. Atlas Health Care at Daughters of Miriam 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 Occupancies. Atlas 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 two exterior generators power approximately 100 % of the building per the Maintenance Director. The current occupied beds are 201 of 210.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		3/4/25

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

Electronically Signed | 03/06/2025

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 211	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/12/25 in the presence of the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6), it was determined the facility failed to a.) ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of a fire or other emergency and b.) ensure aisles, passageways, corridors, exit discharges, exit locations, and accesses were in accordance with NFPA 101: 2012 Edition, Sections 7.1.10.1 and 7.2.2.4.1.1. These deficient practices had the potential to affect all 201 residents and were evidenced by the following: An observation at 2:01 PM in the presence of the U.S. FOI and U.S. FOIA (b) (6) revealed the emergency exit door leading to the exit discharge from the laundry room was stuck to its frame. The U.S. FOI and U.S. FOIA (b) (6) tried to open it by applying force, but they could not open the emergency exit door. Observations in the kitchen at 3:10 PM revealed that 2 of 2 exit sets of doors from the kitchen to the exit corridor were equipped with thumb turn lock on the egress side. The thumb turn lock and fastening device on the doors could restrict emergency use of the exit. An observation at 4:30 PM revealed the physical therapy emergency exit door was stuck. The U.S. FOI was initially unable to open but was successful after forcing it open. In an interview at the times, the U.S. FOI and the U.S. FOIA (b) (6) confirmed the observations.	K 211	K211 - Means of Egress 1. The laundry room and physical therapy emergency exit doors were repaired to ensure smooth operation. The thumb turn locks on kitchen doors were removed and replaced with compliant panic push bars hardware. 2. All residents could have been affected by this deficient practice. 3. A facility-wide assessment of all emergency exits was conducted by Director of Maintenance/designee to identify any other non-compliant doors. A monthly inspection protocol, to be conducted by Director of Maintenance and/or designee, was implemented for all exit doors, ensuring that all doors open freely and comply with egress standards. Monthly audits of all egress doors will be performed by Director of Maintenance and/or designee for 3 months. 4. Audit results will be reviewed by Administrator during QA meeting monthly for 3 months to ensure compliance.	

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K 211	Continued From page 2 The facility's Administrator and the Regional Administrator were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference.	K 211		
K 225 SS=F	NJAC 8:39-31.1(c), 31.2 (e) Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/12/25 and 02/13/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6) it was determined that the facility failed to ensure that exit stair landings and exit stair handrails were marked in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3,7.2.2.5.5.2, and 7.2.2.5.5.3. This deficient practice had the potential to affect all 201 residents and was evidenced by the following: Observations during the tour between 8:10 AM and 5:08 PM in the presence of the U.S. FOI and U.S. FOIA (b) (6), revealed 8 of 8 exit stairways had no marking stripes on the steps and the upper surface of the handrails were not marked as required by the Code.	K 225	K225 - Stairways and Smokeproof Enclosures 1. Marking stripes were applied to all 8 stair steps and handrails according to NFPA 101 standards. 2. All residents could have been affected by this deficient practice. 3. All stairways in the facility were inspected by the Director of Maintenance to ensure compliance. Director of Maintenance trained all maintenance staff on stairwell and handrail striping requirements and implemented monthly inspections to ensure striping remains intact . Director of Maintenance and/or designee to audit all	3/14/25

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 225	Continued From page 3 In an interview at the times, the U.S. FOI and U.S. FOIA (b) (6) confirmed the observations. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. NJAC 8:39-31.2 (e)	K 225	stairwells monthly for 3 months to ensure compliance. 4. Audit results will be reviewed by Administrator during QA meeting monthly for 3 months to ensure compliance.	
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. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/12/25 and 02/13/25 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6) it was determined that the facility failed to provide illumination of the means of egress that was either continuously in operation or capable of automatic operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all 201 residents and was evidence by the following: Observations on 02/12/25 revealed the following: At 1:36 PM, all the lights in the auditorium were off when the wall switch was turned Off.	K 281	K281 - Illumination of Means of Egress 1. Continuous emergency egress lighting have been connected to the emergency panel to ensure compliant continuous lighting in all affected areas: Auditorium, first floor west wing dining room, second floor west wing dining room, third floor day/dining room, fourth floor day/dining room, corridor (approximately 195 feet) by the kitchen, and the second corridor (approximately 150 feet) from the kitchen to the exit door. 2. All residents could have been affected by this deficient practice.	3/21/25

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K 281	Continued From page 4 At 4:31 PM, the first floor west wing dining room had no lighting when the light switch was turned Off. In an interview at the times, the U.S. FOI and the U.S. FOIA (b) (6) confirmed the observations. Observations on 02/13/25 revealed the following: At 12:44 PM, the second floor west wing dining room had no lighting when the light switch was turned Off. At 1:23 PM, the third floor day/dining room had no lighting when the light switch was turned Off. At 2:45 PM, the fourth floor day/dining room had no lighting when the light switch was turned Off. At 3:01 PM, the corridor (approximately 195 feet) by the kitchen had no lighting when the light switch was turned Off. At 3:15 PM, the second corridor (approximately 150 feet) from the kitchen to the exit door had no lighting when light switch was turned Off. In an interview at the times, the U.S. FOIA and the U.S. FOIA (b) (6) confirmed the observations. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) [redacted] were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e)	K 281	3. A review of egress pathways, corridors, and dining areas was conducted by Director of Maintenance and or/designee to ensure proper illumination facility wide. 4. Administrator educated the U.S. FOIA (b) (6) [redacted] on the requirements of continuous emergency egress illumination and that emergency lighting to be tested monthly by Director of Maintenance and/or designee. Audit to be conducted by the Director of Maintenance/designee monthly for 3 months to ensure compliance. 5. Audit results will be reviewed by Administrator during QA meeting monthly for 3 months to ensure compliance.	
K 291 SS=F	Emergency Lighting	K 291		3/14/25

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K 291	Continued From page 5 CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 02/12/25 and 02/13/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6), it was determined that the facility (A) failed to ensure that a battery-operated emergency backup light was provided at 1 of 2 fire pump transfer switches in accordance with NFPA 99:2012 Edition and (B) failed to conduct functional testing of the emergency lighting system in accordance with NFPA 101: 2012 Edition, Section 19.2.9.1 and 7.9.3. These deficient practices had the potential to affect all 201 residents and was evidenced by the following: An observation on 02/12/2025 at 12:44 PM revealed the Fire pump #2 transfer switch was not provided with a battery-operated emergency backup lighting. In an interview at the time, the US FOIA (b)(6) confirmed the observation. A documentation review at approximately 3:17 PM on 02/13/25, revealed no documents were provided for functional testing of the battery backed-up emergency lighting system, monthly for not less than thirty seconds and annually for one and half hours.	K 291	K291 - Emergency Lighting 1. Installed battery-operated emergency backup lighting at the fire pump #2 transfer switch. 2. All residents could have been affected by this deficient practice. 3. Audit was conducted facility wide by Director of Maintenance and/or designee to ensure all emergency lighting systems are present and functional. Director of Maintenance educated all maintenance personnel on monthly testing of 30 seconds minimum and annual testing of 1 and a half hours minimum and established a formal monthly and annual emergency lighting testing schedule, with proper documentation maintained. Audit will be conducted by the Director of Maintenance monthly for 6 months to ensure functionality and testing maintained. 4. Audit results will be reviewed by Administrator during QA meeting monthly for 6 months to ensure compliance.	

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K 291	Continued From page 6 In an interview at that time, the U.S. FOIA stated functional testing of emergency lighting system was conducted but could not provide documentation. The facility's US FOIA (b)(6) were informed of the deficient practices on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e) NFPA 99	K 291		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/12/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6), it was determined that the facility failed to ensure exit and directional exit signs were provided and marked by approved, readily visible signs in all cases where the exit or way to reach the exit was not readily apparent to the occupants in accordance with NFPA 101: 2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect approximately 89 of 201 residents and was evidenced by the	K 293	K293 - Exit Signage 1. Installed compliant exit and directional signage in the affected areas: Exit access from Door G-6 marketing area to the exit corridor, as well as to exit access from the maintenance shop area to the nearest exit discharge to outside. 2. Approximately 89 residents could have been affected by this deficient practice.	3/21/25

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K 293	Continued From page 7 following: An observation at 1:26 PM revealed the exit access from Door G-6 marketing area to the exit corridor was not provided with a directional or an exit sign. An observation at 2:30 PM revealed the exit access from the maintenance shop area to the nearest exit discharge to outside was not provided with a directional or an exit sign. In an interview at the times, the U.S. FOI and the U.S. FOIA (b) (6) confirmed the observations. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference.	K 293	3. Facility-wide audit was conducted by the Director of Maintenance to identify other areas missing signage. Administrator educated the U.S. FOIA (b) (6) on exit signage requirements. Inspections of exit signage to be conducted quarterly by the Director of Maintenance/designee. Audits will be conducted by the Director of Maintenance/designee quarterly x 2 quarters to ensure compliance. 4. Audit results will be reviewed by Administrator during QA meeting quarterly for 6 months to ensure compliance.	
K 321 SS=F	NJAC 8:39-31.1 (c), 31.2(e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of	K 321		3/4/25

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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
K 321	Continued From page 8 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/12/25 in the presence of the[redacted] from a sister facility ([redacted] it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7, 8.4 This deficient practice had the potential to affect all 201 residents and was evidenced by the following: An observation at 1:30 PM revealed that the Dark room was being used for storage of combustible items and was not provided with a self-closing or automatic-closing door. An observation on the ground floor at 2:13 PM revealed the room next to the elevator was being used for storage of combustible items and was not provided with a self-closing or automatic-closing door. An observation at 2:22 PM revealed the main	K 321	K321 - Hazardous Areas - Enclosure 1. Self-closers were installed on the dark room door and the door to the room next to the elevator. Identified gaps were sealed on the main boiler set of doors and the second floor housekeeping storage set of doors. 2. All residents had the potential be affected by this deficient practice. 3. Facility-wide inspection was conducted by the Director of Maintenance and/or designee of hazardous area enclosures to ensure no gaps and self-closers were present on storage areas of combustibles. Director of Maintenance educated maintenance personnel on hazardous area enclosure requirements. Monthly audits conducted by Director of Maintenance/designee to	

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K 321	Continued From page 9 boiler room set of doors had a gap between the meeting edges. An observation on the second floor at 3:47 PM revealed the housekeeping storage set of doors had a gap between the meeting edges. In an interview at the times, the [redacted] and the [redacted] confirmed the observations. The facility's [redacted] were informed of the deficient practices on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference.	K 321	ensure self-closures and intact and doors remain gap free x 6 months to ensure compliance. 4. Audit results will be reviewed by Administrator during QA meeting monthly for 6 months to ensure compliance.	
K 324 SS=F	N.J.A.C 8:39-31.2 (e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the	K 324		3/25/25

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K 324	Continued From page 10 corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 02/12/25 and 02/13/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6) it was determined that the facility failed (A) to ensure that Commercial Kitchen exhaust/hood equipment was clean to prevent accumulation of grease, (B) to conduct monthly visual inspection on the suppression system and (C) to ensure kitchen suppression system was tied into fire alarm control panel/ monitoring company in accordance with NFPA 101:2012 edition, Section 19.3.2.5.3*(10) and NFPA 96. This deficient practice had the potential to affect all 201 residents and was evidenced by the following: An observation on 02/12/25 at 3:00 PM revealed the kitchen suppression system monthly inspection tag was not logged. A documentation review on 02/13/25 in presence of the U.S. FOI revealed the following: At 9:52 AM, the uniform code quarterly inspection (dated 05/11/24) indicated Commercial Cooking System/ Kitchen hood system needs to be tied into fire alarm, sprinkler monitoring company and Abate by 08/10/24.	K 324	K324 - Cooking Facilities 1. Exhaust/hood equipment was cleaned to prevent accumulation of grease. Kitchen suppression system was tied into fire alarm control panel/ monitoring company in accordance with code. 2. All residents had the potential to be affected by this deficient practice. 3. Audit conducted by Director of Maintenance on all facility kitchen suppression systems to ensure they were cleaned on schedule from grease, they are tied into fire alarm control panel, and monthly inspections are being logged. Administrator educated U.S. FOIA (b) (6) on hood cleaning scheduling, monthly logging, and being tied into fire alarm panel requirements. Director of Maintenance to audit compliance on kitchen suppression requirements monthly x6 months. 4. Audit results will be reviewed by Administrator during QA meeting quarterly for 6 months to ensure compliance.	

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K 324	Continued From page 11 At 10:00 AM, the kitchen suppression report (dated 02/04/25) vendor indicates the system is not connected to the Fire Alarm Control Panel (FACP). At 10:05 AM, no documentation was provided for a repair or a correction. At 10:15 AM, no documentation was provided for the kitchen suppression semi-annual hood cleaning. At 10:20 AM, no further documentation was provided to the surveyor. In an interview at 10:45 AM, the U.S. FOI acknowledged and confirmed the findings. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practices on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference.	K 324		
K 351 SS=F	NJAC 8:39-31.1(c), 31.2(e) Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.	K 351		3/21/25

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K 351	Continued From page 12 In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/12/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6), it was determined that the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all 201 residents and was evidenced by the following: An observation at 1:16 PM revealed the electrical closet on the first floor was not provided with fire sprinkler coverage. An observation at 1:44 PM revealed the storage closet next to the dark room was not provided with fire sprinkler coverage. In an interview at the time, the U.S. FOI and the U.S. FOIA (b) (6) confirmed the findings. The facility's US FOIA (b)(6) U.S. FOIA (b) (6) were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	K351 - Sprinkler System - Installation Correction Plan: 1. A fire safety contractor was commissioned to install fire sprinkler solutions in the electrical closet on the first (ground) floor as well as in the storage closet next to the dark room. 2. All residents have the potential to be affected by this deficient practice. 3. Facility wide audit was conducted by Director of Maintenance to ensure appropriate sprinkler coverage. US FOIA (b)(6) was in-serviced by Administrator on the requirement for proper fire sprinkler coverage. The Director of Maintenance / Maintenance Tech will check for adequate sprinkler coverage in the identified areas monthly x 3. 4. Results of the audits will be reviewed by the Administrator during monthly QA committee for 3 months to ensure compliance.	

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K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 02/12/25 and 02/13/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6), it was determined that the facility failed to (A) maintain the fire sprinkler system by ensuring that the ceiling was smoke resistant and sprinkler heads were free from buildup of foreign material and (B) ensure the electric fire pump was tested monthly, annually and documented in accordance with NFPA 101:2012 Edition, Section 9.7.5 and NFPA 25: 2011 Edition, Section 5.2.1.1. This deficient practice had the potential to affect all 201 residents and was evidenced by the following:	K 353	K353 - Sprinkler System - Maintenance and Testing Correction Plan: 1. Identified ceiling holes in the basement classroom and in the Auditorium were repaired; missing escutcheon plate in the kitchen (1 od 18) was replaced; fire pump testing records have been completed for the current missing month; a fire safety contractor was hired to perform the missing annual fire pump flow test, as well as to resolve all identified deficiencies: Main Building: " Standard response sprinkler 50 or more years old replaced or successfully	3/20/25

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K 353	Continued From page 14 Observations on 02/12/25 revealed the following: At 11:15 AM, the basement classroom had two holes in the ceiling. At 11:25 AM, the Auditorium had a 4-foot by 2-foot hole in the ceiling. At 3:00 PM, one of 18 kitchen sprinkler heads was missing the escutcheon plate. In an interview at the times, the [redacted] and [redacted] confirmed the observations. A documentation review on 02/13/25 revealed the following: At 2:10 PM, no records were provided that 2 of 2 electric fire pumps were tested monthly and documented. At 2:35 PM, documentation provided by the [redacted] indicated the vendor conducted four quarterly fire pump flow tests. No documentation was provided on an annual fire pump data test. A inspection vendor report dated 10/17/2024 (main Bldg.#3) indicated the following deficiencies: 1. Standard response sprinkler 50 or more years old replaced or successfully sample tested within last 10 years? NO. 2. Hydrostatic test for fire department connection piping been conducted within the last 5 years? NO 3. Maintenance program been performed within	K 353	sample tested within last 10 years. " Hydrostatic test for fire department connection piping within the last 5 years. " Maintenance program within the last 5 years. [redacted] Building " Visible sprinklers to be free of corrosion and physical damage on unit manager west . " Fast response sprinklers 20 or more years old replaced or successfully sample tested within last 10 years. " Dry-type sprinklers replaced or successfully sample tested within last 10 years. " Maintenance program performed within the last 5 years. 2. All residents have the potential to be affected by this deficient practice. 3. Facility wide audit was conducted to ensure all ceiling tiles were free from holes, all escusion plates are in place, all sprinkler test and fire pump records are conducted and in place. [redacted] was in-serviced by Administrator on the requirement for Sprinkler System Maintenance, Testing, and proper Documentation. The Director of Maintenance will audit to ensure compliance for Sprinkler System Maintenance, Testing, and proper Documentation, monthly x 6 months. 4. Results of the audits will be reviewed by the Administrator during monthly QA committee for 6 months to ensure compliance.	

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K 353	Continued From page 15 the last 5 years? NO. The inspection vendor report dated 10/18/2024 U.S. FOIA (b) (6) indicate the following deficiencies: 1. Are visible sprinklers free of corrosion and physical damage? NO U.S. FOIA (b) (6) 2. Fast response sprinklers 20 or more years old replaced or successfully sample tested within last 10 years? NO. 3. Dry-type sprinklers replaced or successfully sample tested within last 10 years? NO. 4. Maintenance program been performed within the last 5 years? NO. No documentation for repairs or corrections was provided. In an interview at the times, the U.S. FOI and the U.S. FOIA (b) (confirmed the observations. The facility's US FOIA (b)(6) were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. NJAC 8:39-31.1(c), 31.2(e) NFPA 20, 25	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke	K 363		3/5/25

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K 363	Continued From page 16 and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 02/12/25 and 02/13/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was	K 363	K363 - Corridor Doors Maintenance Director has adjusted and repaired affected corridor doors between	

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K 363	Continued From page 17 determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance of NFPA 101: 2012 Edition, Section 19.3.6,19.3.6.3,19.6.3.1 and 19.6.5. This deficient practice had the potential to affect 89 of 201 residents and was evidenced by the following: An observation on 02/12/25 at 3:05 PM revealed the set of corridor doors between the kitchen and the mechanical room did not close when tested by the [redacted]. An observation on 02/13/25 at 1:34 PM revealed the door to resident room [redacted] did not close to latch when tested by the [redacted] In an interview at the times, the [redacted] and the [redacted] confirmed the observations. The facility's U.S. FOIA (b) (6) and the [redacted] were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. NJAC 8:39-31.1(c), 31.2(e)	K 363	the kitchen and mechanical room, as well as the door to resident room 407, to ensure proper closure and latching All residents have the potential to be affected by this deficient practice. Facility wide audit was conducted the Director of Maintenance to ensure proper closure for all corridor and resident doors. US FOIA (b)(6) was in-serviced by Administrator on the requirements of proper corridor door closure. The Director of Maintenance / Maintenance Tech will conduct door function tests, monthly x 3. Results of the audits will be reviewed by the Administrator during monthly QA committee for 3 months to ensure compliance.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		2/28/25

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K 521	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/12/25 and 02/13/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6) it was determined that the facility failed to ensure resident bathroom ventilation system units were maintained in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice had the potential to affect 64 of 201 residents was evidenced by the following: Observations on 02/12/25 from 12:51 PM to 5:18 PM, revealed first floor residents' room bathroom ventilation systems were not functioning. The surveyor requested that the U.S. FOI confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue was not held in place by any suction. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. In an interview at the time, the U.S. FOI confirmed that the exhaust vents in the first-floor resident's room bathrooms were not functioning when tested. An observation on 02/13/25 at 1:06 PM in room NJ Exec O revealed bathroom ventilation was not functioning when tested by the U.S. FOIA In an interview at the times, the U.S. FOI and the U.S. FOIA (b) (confirmed the observations. The facility's Administrator and the U.S. FOIA (b) (6) informed of the deficient	K 521	K521 - HVAC (Resident Bathroom Ventilation) Correction Plan: Ventilation systems of resident bathrooms on the first floor, and in Room 222 have been repaired. All residents have the potential to be affected by this deficient practice. Facility wide audit on all bathroom ventilation has been conducted by the Director of Maintenance/designee to ensure compliance. US FOIA (b)(6) was in-serviced by Administrator on the code and requirements of air quality and ventilation performance. The Director of Maintenance / Maintenance Tech will check operation of the ventilation systems of resident bathrooms monthly x 3. Results of the audits will be reviewed by the Administrator during monthly QA committee for 3 months to ensure compliance	

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K 521	Continued From page 19 practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 90 A	K 521		
K 912 SS=E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/13/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6) it was determined that the facility failed to ensure that 2 of 2 electrical outlets located next to a water source were equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice had the potential to affect 84 of 201 residents and was evidenced by the following: An observation at 12:45 PM revealed that the second-floor fish tank was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations.	K 912	K912 - Electrical Systems - Receptacles Correction Plan: Electrical outlets serving the second and third floors fish tanks were replaced with compliant outlets with GFCI-protected receptacles. All residents have the potential to be affected by this deficient practice. Facility wide audit on outlets requiring GFCI protection was conducted by the Director of Maintenance. U.S. FOIA (b) (6) was in-serviced by Administrator on the code for electrical outlets in areas near water sources. The Director of Maintenance / Maintenance Tech will check the electrical outlets in areas near water sources,	3/5/25

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 _____	C **02/18/2025**

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 912	Continued From page 20 In an interview at the time, the [redacted] confirmed the finding. an observation at 2:45 PM with the [redacted] and the [redacted] revealed that the third-floor fish tank was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. The [redacted] and the [redacted] confirmed the finding at the time of observation. The facility's [redacted] and the [redacted] were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. NJAC 8:39 -31.2 (e) NFPA 99	K 912	monthly x 3. Results of the audits will be reviewed by the Administrator during monthly QA committee for 3 months to ensure compliance	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		3/17/25

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K 918	Continued From page 21 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 02/13/25 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6), it was determined that the facility failed to ensure that the 2 of 2 emergency and standby power generators were tested for diesel fuel quality and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8. This deficient practice had the potential to affect all 201 residents and was evidenced by the following: A review of the facility's 2 generators annual service reports dated 04/05/ 2024, provided by the U.S. FOI, revealed no record that a diesel fuel sample analysis test had been conducted. No further documentation was provided regarding	K 918	K918 - Electrical Systems - Essential Electric System Correction Plan: A contractor was hired to conduct diesel fuel sample analysis for both emergency generators. All residents have the potential to be affected by this deficient practice. Facility audit was conducted by Director of Maintenance to ensure the records are in place for both generators. US FOIA (b)(6) was in-serviced by Administrator on the requirements of diesel fuel sample testing. The Director of Maintenance will ensure that diesel fuel sample analysis for both emergency generators are current. Monthly audit will be conducted by the Director of Maintenance for 3 months to confirm	

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

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K 918	Continued From page 22 diesel fuel sample analysis testing had been conducted. In an interview at 3:20 PM, the U.S. FOI confirmed the findings. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	documented records are in place. Results of the audits will be reviewed by the Administrator during monthly QA committee for 3 months to ensure compliance	
K 919 SS=F	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/13/25 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6), it was determined that the facility failed to ensure that 2 of 2 emergency generators were equipped with a remote manual stop station in accordance with NFPA 110 Standard for Emergency and Standby Power Systems: 2010 Edition, Section 5.6.5.6. This deficient practice had the potential to affect all 201 residents and was evidenced by the following:	K 919	K919 - Electrical Equipment - Other 1. Remote manual emergency stop stations were installed for both generators. 2. All residents had the potential to be affected by this deficient practice. 3. Administrator educated U.S. FOIA (b) (6) on remote manual emergency stop station requirements. Quarterly audit to be conducted by Director of Maintenance on both generators x2 quarters to ensure	3/17/25

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K 919	Continued From page 23 An observation at 2:01 PM revealed that emergency generator #1 was not equipped with a Remote Manual Emergency Stop Switch remote from the unit. There was an emergency stop located on the generator housing enclosure that was not remote from the unit to shut down in a catastrophic failure. The generator unit was located outside within a padlocked fence enclosure. An observation at 2:05 PM revealed that emergency generator #2 was not equipped with a Remote Manual Emergency Stop Switch remote from the unit. There was an emergency stop located on the generator housing enclosure that was not remote from the unit to shut down in a catastrophic failure. The generator unit was located outside within a padlocked fence enclosure. An interview at the time of observation, both U.S. FOI and the U.S. FOIA (b) (6) confirmed the generators were not equipped with a manual stop station that was remote from the unit. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e) NFPA 99, 110	K 919	placement and functionality. 4. Audit results will be reviewed by Administrator during QA meeting quarterly for 6 months to ensure compliance.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage	K 921		3/24/25

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K 921	Continued From page 24 current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 02/12/25 and 02/13/25 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b) (6), it was determined that the facility failed to conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs for all the patient care related electrical equipment (PCREE), in accordance with NFPA 99: 2012 Edition, Sections	K 921	K921 - Electrical Equipment - Testing and Maintenance A contractor was hired to perform Patient-Care Electrical Equipment testing and to apply inspection stickers to all PCREE. All residents have the potential to be affected by this deficient practice. Facility wide audit was conducted on all	

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K 921	Continued From page 25 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all 201 residents and was evidenced by the following: Observations on 02/12/25 and 02/13/25 revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility. In an interview at the time, the U.S. FOI and the U.S. FOIA (b) (6) confirmed the findings. A documentation review on 02/13/2025 revealed the policy on patient care related electrical equipment provided by the U.S. FOIA (b) (6) at 4:18 PM stated PCREE will be tested every 12 months and safety labels shall be maintained in legible condition. An interview at that time, the U.S. FOI and the U.S. FOIA (b) (6) confirmed the finding and acknowledged that no labels were provided on all equipment. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 99	K 921	PCREE to ensure required maintenance and inspection stickers. US FOIA (b)(6) was in-serviced by Administrator on the requirement that PCREE will be tested every 12 months and safety labels shall be maintained in legible condition; that the facility must conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs for all the patient care related electrical equipment (PCREE) with sticker placement. The Director of Maintenance / Maintenance Tech will conduct a monthly audit on PCREE testing, maintenance, sticker application, and records being maintained, for 6 months. Results of the audits will be reviewed by the Administrator during monthly QA committee for 6 months to ensure compliance.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and	K 923		3/4/25

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

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K 923	Continued From page 26 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 02/12/25 and 02/13/25 in the presence of the U.S. FOIA (b) (6) and the Maintenance Director from a sister facility U.S. FOIA (b) (6)), it was determined that the facility failed to 1) Store	K 923	K923 - Gas Equipment - Cylinder and Container Storage Correction Plan: Oxygen cylinders in the oxygen room near Room NJ Ex O1 were properly secured. In the	

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K 923	Continued From page 27 cylinders of compressed oxygen in a manner that would protect the cylinders against tipping and rupture, 2) provide storage of cylinders planned so that cylinders can be used in the order in which they are received from the supplier and empty cylinders segregated from full cylinders in accordance with NFPA 99 Health Care Facilities Code (2012 Edition) Section 11.6.2.3(11). This deficient practice had the potential to affect 89 of 201 residents and was evidenced by the following: Observation on 02/12/25 at 4:30 PM, revealed oxygen room next to room [redacted] had 2 full portable oxygen tanks free standing not secured from tipping and rupture. In an interview at the times, the [redacted] and the [redacted] confirmed the observations. An observation on 02/13/25 at 12:35 PM revealed the physical therapy oxygen storage area had full portable oxygen tanks in an empty rack with a sign indicating it was for empty tanks only. In an interview at the times, the [redacted] and the [redacted] confirmed the observations. The facility's [redacted] and the [redacted] were informed of the deficient practice on 02/13/2025 at 5:28 PM during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e) NFPA 99	K 923	physical therapy area, full portable oxygen tanks were removed and stored in a rack meant for empty tanks. 89 residents have the potential to be affected by this deficient practice. Facility wide audit was conducted by Director of Maintenance to ensure there are no free standing oxygen tanks to prevent tipping and that empty and full containers being stored are segregated. [redacted] was in-serviced by Administrator to adequately audit, reorganize, maintain corrective signage, and provide training to facility staff on how to secure, properly store and segregate, full and empty oxygen tanks. The Director of Maintenance / Maintenance Tech will audit all oxygen storage areas to ensure proper securing and separation weekly for 4 weeks then monthly for 5 months. Results of the audits will be reviewed by the Administrator during monthly QA committee for 6 months to ensure compliance.	

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	3/31/2025 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 K0211	03/04/2025	LSC K0225	03/14/2025	LSC K0281	03/21/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	03/14/2025	LSC K0293	03/21/2025	LSC K0321	03/04/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	03/25/2025	LSC K0351	03/21/2025	LSC K0353	03/20/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	03/05/2025	LSC K0521	02/28/2025	LSC K0912	03/05/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0918	03/17/2025	LSC K0919	03/17/2025	LSC K0921	03/24/2025

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

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	3/31/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction				
Reg. # NFPA 101	Completed				
LSC K0923	03/04/2025				

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?
2/18/2025	☐ YES ☐ NO