

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>315438</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>10/23/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Atrium Post Acute Care at Park Ridge</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>120 NOYES DRIVE , PARK RIDGE, New Jersey, 07656</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS  Complaint #: NJ2578488, NJ2611374, and NJ2621276  Census: 177  Sample Size: 3  The facility is not in substantial compliance with the requirements of 42 CFR PART 483, Subpart B, for Long-Term Care Facilities based on this complaint visit. Deficiencies were cited for this survey.	F0000		11/13/2025
F0658 SS = E	Services Provided Meet Professional Standards  CFR(s): 483.21(b)(3)(i)  §483.21(b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (i) Meet professional standards of quality.  This REQUIREMENT is NOT MET as evidenced by:  Complaint #2611374  Based on interview, record review, and review of other pertinent facility provided documentation, the facility failed to follow appropriate <b>NJ Ex Order 26.4(b)(1)</b> and documentation for 3 of 3 residents, Residents #1, #2, and #3 according to the standard of clinical practice and facility's policies.  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	F0658	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR EACH RESIDENT AFFECTED BY THE CONCERN(S):  Resident #2 was discharged from our facility on <b>NJ Ex Order 26.4</b> and has not returned.  Resident #3 was discharged from our facility on <b>NJ Ex Order 26.4(b)</b> and has not returned.  Resident #1 who received a second dose of <b>NJ Ex Order 26.4(b)(1)</b> did not have any <b>NJ Ex Order 26.4(b)(1)</b> . This concern was investigated and self-identified as medication error and addressed in our Quality Assurance Performance Improvement (QAPI) plan on 9/8/2025. Education provided to <b>U.S. FOIA (b)</b> and RN#2, as well as other nurses on 9/5 regarding validating medication administration on the electronic medication administration record (eMAR).  HOW WE IDENTIFIED OTHER RESIDENTS/AREAS THAT COULD POTENTIALLY BE AFFECTED:  All new and readmitted residents have potential to be affected by this deficient practice.  MEASURES PUT IN PLACE TO ENSURE CONCERN(S) IS/ARE CORRECTED & WOULD NOT RECUR:	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0658 SS = E	<p>Continued from page 2</p> <p>A review of <sup>NJ Ex Order 26.4(b)(1)</sup> progress notes (PN) revealed there was no documentation to indicate if the <sup>NJ Ex Or</sup> was administered or not administered to Resident #2 on <sup>NJ Ex Order 26.</sup></p> <p>On 10/23/25 at 1:39 PM, S #1 interviewed the <sup>U.S. FOIA (b) (6)</sup>, regarding <sup>NJ Ex Or</sup> solution administration. The <sup>U.S. FOIA</sup> stated there was a <sup>NJ Ex</sup> for <sup>NJ Ex Or</sup> administration upon a resident's admission, according to a PO. The <sup>U.S. FOIA</sup> further explained the <sup>NJ Ex Or</sup> administration would be documented in the eMAR, and the order entry would be signed to indicate that the <sup>NJ Ex Or</sup> was administered or not administered. The <sup>U.S. FOIA</sup> stated it was expected that eMAR order entries were signed and not left blank.</p> <p>On 10/23/25 at 4:09 PM, S #1 notified the <sup>U.S. FOIA (b) (6)</sup>, the <sup>U.S. FOIA</sup> the <sup>U.S. FOIA (b) (6)</sup>, and the <sup>U.S. FOIA (b) (6)</sup> of the above concern that Resident #2's order entry for the <sup>NJ Ex Or</sup> testing which was scheduled to be administered <sup>NJ Ex Order 26</sup> was unsigned and left blank. There was no verbal response from the facility management at this time.</p> <p>On 10/23/25 at 4:59 PM, the <sup>U.S. FOIA (b) (6)</sup>, <sup>U.S. FOIA</sup>, <sup>U.S. FOIA (b) (6)</sup> and the <sup>U.S. FOIA (b) (6)</sup> met with the survey team. There was no additional information provided by the <sup>U.S. FOIA (b) (6)</sup>.</p> <p>A review of the facility's "Tuberculosis, Screening Residents for Policy," last reviewed date of January 2025, under the Policy statement revealed, this facility shall screen all residents for <sup>NJ Exec Order 26.4(b)</sup>.</p> <p>Further review of the above policy did not address documentation for <sup>NJ Ex Or</sup> administration.</p> <p>2. On 10/23/25 at 10:00 AM, Surveyor #2 (S #2) reviewed the paper and eMR of Resident #1.</p> <p>A review of the AR revealed Resident #1 with diagnoses that included but not limited of <sup>NJ Ex Order 26.4(b)(1)</sup>, <sup>NJ Ex Order 26.4(b)(1)</sup>, <sup>NJ Ex Order 26.4(b)(1)</sup>, <sup>NJ Ex Order 26.4(b)(1)</sup>, and <sup>NJ Ex Order 26.4(b)(1)</sup>.</p>	F0658		

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F0658 SS = E	<p>Continued from page 3</p> <p>A review of the cMDS, with an ARD of [redacted] revealed a BIMS score of [redacted] out of 15 indicating [redacted]</p> <p>A review of the PO dated [redacted], [redacted], [redacted] <b>NJ Ex Order 26.4(b)(1)</b> one time only for [redacted] until [redacted], [redacted] administration. Repeat in 14 days if results of 1st [redacted] <b>NJ Ex Order 26.4(b)(1)</b></p> <p>A review of the [redacted] <b>NJ Ex Order 26.4(b)(1)</b> eMAR of the above [redacted] order entry dated [redacted] revealed the entry was signed and administered by Registered Nurse #1 (RN #1) (3-11 shift). An additional entry on the [redacted] eMAR of the above [redacted] order entry dated <b>NJ Ex Order 26.4(b)(1)</b> [redacted] Other/See PN Ineffective. A review of the nursing PN at 11:00 AM, revealed [redacted] "Double Entry."</p> <p>At 2:20 PM, S #2 interviewed the [redacted] <b>U.S. FOIA (b) (6)</b> who stated, that when the [redacted] <b>U.S. FOIA (b) (6)</b> was completing an audit for [redacted] <b>NJ Ex Order 26.4(b)(1)</b> the next day after admission, she saw the [redacted] <b>NJ Ex Order 26.4(b)(1)</b> tab in the Resident #1's eMR was blank, so she asked the nurse to give the [redacted] <b>NJ Ex Order 26.4(b)(1)</b> not knowing that it was already given the previous day. The [redacted] <b>U.S. FOIA (b) (6)</b> stated that this was a self-identified medication (med) error, investigation, report, statements, and education were completed.</p> <p>At 3:22PM, S #2 interviewed RN #2, who stated that he admitted the Resident#1, he forgot to put an order for [redacted] <b>NJ Ex Order 26.4(b)(1)</b> and to administer it. He further stated that the [redacted] <b>U.S. FOIA (b) (6)</b> asked him the next day if a [redacted] <b>NJ Ex Order 26.4(b)(1)</b> was given because according to the admission checklist, the [redacted] <b>NJ Ex Order 26.4(b)(1)</b> was not checked off that it was given. He was then asked to administer the [redacted] <b>NJ Ex Order 26.4(b)(1)</b> and he confirmed he administered the [redacted] <b>NJ Ex Order 26.4(b)(1)</b> the next day.</p> <p>At that same time, RN #2 stated that the [redacted] <b>U.S. FOIA (b) (6)</b> was in the room when he administered the [redacted] <b>NJ Ex Order 26.4(b)(1)</b> The PA called the Resident's Representative (RR), and the RR called the facility to say that Resident#1 received the [redacted] <b>NJ Ex Order 26.4(b)(1)</b> the previous day. RN #2 stated he was not aware that the [redacted] <b>U.S. FOIA (b) (6)</b> from the day before (3-11 shift) put an order in for the [redacted] <b>NJ Ex Order 26.4(b)(1)</b> and administered it. RN #2 further stated that there was <b>NJ Ex Order 26.4(b)(1)</b> to the resident, the Physician was made aware, and he received education.</p>	F0658		



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F0658 SS = E	<p>Continued from page 5 signed as administered by LPN #3 at 11:06 AM.</p> <p>A PO with a SD of [redacted], read [redacted] one time only for HP for 1 day read 72 hours after [redacted] and document in mm. The order was coded with a check mark in the eMAR, the [redacted] was [redacted] on [redacted] by LPN #3 at 11:06 AM. The [redacted] check mark meant the [redacted] was read and the measurement (result) was [redacted] which did not have a corresponding information in the custom prompt legend and chart codes.</p> <p>Further review of the medical record revealed that there was no documented evidence that the [redacted] was read and result was [redacted].</p> <p>On 10/23/25 at 12:25 PM, S #3 interviewed LPN #2, who informed S #3 that [redacted] should be administered on the day of admission, read within 48-72 hours, and [redacted] should be administered on the 14 day if [redacted] was [redacted]. LPN #2 stated that the orders for [redacted] and the reading should be in the eMAR, other documentation should be in the PN and the electronic record [redacted] tab.</p> <p>On that same date and time, S #3 asked LPN #2 what the expectation for the nurse would be to do when the resident was hospitalized and returned the same day and the [redacted] was due to read. LPN #2 stated that he did not know the answer. LPN #2 was unable to remember Resident #3.</p> <p>On 10/23/25 at 12:55 PM, S #3 attempted to call LPN #3 twice for an interview.</p> <p>On 10/23/25 at 4:10 PM, the survey team met with the [redacted] and the [redacted] and S #3 notified them of the above findings and concerns with Resident #3's [redacted].</p> <p>On 10/23/25 at 4:44 PM, the survey team met with the [redacted] and the [redacted] and the [redacted] acknowledged that [redacted] should be administered after [redacted] was [redacted] and [redacted] should be read within 48-72 hours of [redacted].</p> <p>On 10/23/25 at 5:00 PM, the survey team met with the</p>	F0658		

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F0658 SS = E	Continued from page 6 [REDACTED] and [REDACTED] for an exit conference, and there was no additional information provided by the [REDACTED].  NJAC 8:39-11.2(b)	F0658		
F0684 SS = D	Quality of Care  CFR(s): 483.25  § 483.25 Quality of care  Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.  This REQUIREMENT is NOT MET as evidenced by:  NJ#2578488  Based on interview, review of medical record, and other pertinent documentation, it was determined that the facility failed to; a.) ensure [REDACTED] and [REDACTED] were addressed appropriately, b.) obtain and follow physician order for [REDACTED], c.) document reason as to why the order was not followed, and c.) ensure Certified Nursing Aide (CNA) documented provided care to the resident, for 1 of 3 residents, Resident #3 reviewed for quality of care.  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	F0684	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THIS RESIDENT AFFECTED BY THE CONCERN(S):  Resident #3 was [REDACTED] by this deficient practice. The [REDACTED] was not a [REDACTED]. Resident #3 was discharged from our facility on [REDACTED] and has not returned.  HOW WE IDENTIFIED OTHER RESIDENTS/AREAS THAT COULD POTENTIALLY BE AFFECTED:  All residents with skin impairment have the potential to be affected by this deficient practice.  MEASURES PUT IN PLACE TO ENSURE CONCERN(S) IS/ARE CORRECTED & WOULD NOT RECUR:  LPN#1 was an agency nurse who only worked once in our facility and documented the incorrect location of the blister. This nurse will not be working in our facility again.  LPN#2 was in-serviced on 10/24/2025 about skin assessments and to document correct anatomic body part. Any new skin findings will be addressed immediately with the physician for new orders specific to the resident's treatment.  LPN#2 was in-serviced on 10/24/25 about transcribing physician telephone orders into physician order sheet to ensure that the correct order is entered in the system.  Certified Nursing Assistants (CNAs) were in-serviced from 10/28/25 to 11/3/2025 regarding documentation of care in the accountability log.  HOW THE CONCERN(S) WILL BE MONITORED AND TITLE OF	10/23/2025

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F0684 SS = D	<p>Continued from page 7 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."</p> <p>On 10/23/25 at 9:46 AM, the surveyor reviewed the closed medical records (MR) of Resident #3, and revealed:</p> <p>A review of Admission Record or face sheet (an admission summary) reflected that Resident #3 was admitted to the facility with <b>NJ Ex Order 26.4(b)(1)</b> [REDACTED] [REDACTED] [REDACTED] [REDACTED], <b>NJ Ex Order 26.4(b)(1)</b>), and <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>A review of the most recent comprehensive Minimum Data Set (cMDS), an assessment tool, with an assessment reference date (ARD) of <b>NJ Ex Order 26.4(b)(1)</b>, with a brief interview for mental status (BIMS) score of <b>NJ Ex Order 26.4(b)(1)</b> out of 15, reflected that the resident's <b>NJ Ex Order 26.4(b)(1)</b> was <b>NJ Ex Order 26.4(b)(1)</b> Section <b>NJ Ex Order 26.4(b)(1)</b> was coded <b>NJ Ex Order 26.4(b)(1)</b> [REDACTED]</p> <p>A review of the <b>NJ Ex Order 26.4(b)(1)</b> Assessment/Observation revealed that Resident #3 had <b>NJ Ex Order 26.4(b)(1)</b> [REDACTED] and <b>NJ Ex Order 26.4(b)(1)</b> [REDACTED] [REDACTED]. There were no other documented <b>NJ Ex Order 26.4(b)(1)</b> except for the <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>A review of the progress notes (PN) dated <b>NJ Ex Order 26.4(b)(1)</b> at 2:26 PM, that was electronically signed by Licensed Practical Nurse #1 (LPN#1), documented an alert note that Resident #3 was noted with <b>NJ Ex Order 26.4(b)(1)</b> [REDACTED], the <b>NJ Ex Order 26.4(b)(1)</b> was cleaned with soap and warm water.</p> <p>Further review of the MR revealed that there was no documented evidence that the physician was notified of the <b>NJ Ex Order 26.4(b)(1)</b> to obtain an order and further assessment to determine the <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b> of the <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>A review of the PN dated <b>NJ Ex Order 26.4(b)(1)</b> at 3:06 PM, that was electronically signed by LPN#2, documented a skilled note that Resident #3's findings: <b>NJ Ex Order 26.4(b)(1)</b></p>	F0684	<p>Continued from page 7 PERSON RESPONSIBLE FOR MONITORING:</p> <p>Wound Nurse/Designee will review and audit 5 residents weekly for 3 months to make sure that any new finding is appropriately addressed and treated.</p> <p>Wound Nurse/Designee will present audit findings at the monthly Quality Assurance Performance Improvement (QAPI) meeting for 3 months and will be a part of quarterly QAPI where recommendations will be made for continued monitoring.</p> <p>Unit Managers/Supervisors will audit 10 residents weekly for documentation of care in the accountability log.</p> <p>DON/Designee will present audit findings at the monthly Quality Assurance Performance Improvement (QAPI) meeting for 3 months and will be a part of quarterly QAPI where recommendations will be made for continued monitoring.</p>	

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F0684 SS = D	<p>Continued from page 8</p> <p>noted <b>NJ Ex Order 26.4(b)(1)</b> without <b>NJ Ex Order 26.4(b)(1)</b>. The MD (medical doctor) was notified and a new order received to <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p><b>NJ Ex Order 26.4(b)(1)</b> care was done as ordered, provided nursing care as tolerated and accepted by the resident.</p> <p>A review of the <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b> electronic Treatment Administration Record (eTAR) revealed the following physician orders (PO):</p> <p>A PO with a start date (SD) of <b>NJ Ex Order 26.4(b)(1)</b> assessment every day shift every Fri (Friday) for <b>NJ Ex Order 26.4(b)(1)</b> Assessment <b>NJ Ex Order 26.4(b)(1)</b> document findings in <b>NJ Ex Order 26.4(b)(1)</b> tool in assessment tab. The order was discontinued (dc'd) on <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>Further review of the MR revealed that the above PO for <b>NJ Ex Order 26.4(b)(1)</b> assessment was transcribed to the <b>NJ Ex Order 26.4(b)(1)</b> eTAR and was signed on <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b> by LPN#2. LPN#2 coded the <b>NJ Ex Order 26.4(b)(1)</b>."</p> <p>A PO with a SD of <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b> every day shift for 14 days. The order was dc'd on <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>Further review of the MR revealed that there was no documented evidence as to why the PN or <b>NJ Ex Order 26.4(b)(1)</b> for an MD order of <b>NJ Ex Order 26.4(b)(1)</b> was not followed. There was no documented evidence that the MD was notified of the change in the PO for <b>NJ Ex Order 26.4(b)(1)</b>. In addition, there was no documented evidence on what happened to the <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>On 10/23/25 at 12:33 PM, the surveyor interviewed LPN#2, who informed the surveyor that as per facility's practice, when a nurse noted a resident's <b>NJ Ex Order 26.4(b)(1)</b> the nurse would notify the <b>U.S. FOIA (b) (6)</b>, <b>U.S. FOIA (b) (6)</b> and the MD, notify them of the <b>NJ Ex Order 26.4(b)(1)</b>, and to obtain a PO that would be transcribed to the eTAR. LPN#2 stated that an investigation would be initiated by the nurse and the nurse would also document in the PN. She further stated that <b>NJ Ex Order 26.4(b)(1)</b> meant that the <b>NJ Ex Order 26.4(b)(1)</b> was <b>NJ Ex Order 26.4(b)(1)</b>."</p> <p>At that same time, the surveyor notified LPN#2 of the above findings and concerns. LPN#2 responded that she was unable to remember the resident and what had happened.</p>	F0684		



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F0684 SS = D	<p>Continued from page 10 for the [U.S. FOIA] to document the care provided to the resident in the accountability log in the resident's electronic medical record. She further stated that she was an agency aide.</p> <p>On that same date and time, the surveyor notified the [U.S. FOIA] of the above findings and concerns that there were missing documentation from the [U.S. FOIA] and if she remembered the resident's [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] stated that she did not remember the resident and denied working on those days identified.</p> <p>On 10/23/25 at 4:10 PM, the survey team met with the [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)], and surveyor notified them of the above findings and concerns with Resident #3's [NJ Ex Order 26.4(b)(1)] and [U.S. FOIA] accountability log. The surveyor also asked the facility management if the [NJ Ex Order 26.4(b)(1)] [U.S. FOIA] were considered [NJ Ex Order 26.4(b)(1)] if they were not present on admission, and there was no response from the [U.S. FOIA] and [U.S. FOIA (b) (6)].</p> <p>On 10/23/25 at 4:44 PM, the survey team met with the [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)]. The [U.S. FOIA] informed the surveyor that the blister identified on [NJ Ex Order 26.4(b)(1)] was from an agency nurse and the facility was trying to reach out to the nurse. The [U.S. FOIA] stated that the [NJ Ex Order 26.4(b)(1)] did not require a treatment [NJ Ex Order 26.4(b)(1)] that the [U.S. FOIA] documentation of [NJ Ex Order 26.4(b)(1)] was the [NJ Ex Order 26.4(b)(1)] identified from admission and "probably" a wrong documentation, and there was no delay in treatment.</p> <p>A review of the facility's "Pressure Ulcers/Skin Breakdown-Clinical Protocol Policy" that was provided by the [U.S. FOIA (b) (6)] with a revised date of October 2025, revealed:</p> <p>Assessment and Recognition:...</p> <p>2. In addition, the nurse shall assess and document/report the following:</p> <p>a. Vital signs</p> <p>b. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue...</p> <p>Treatment/Management:...</p> <p>2. The physician will help identify medical interventions related to (r/t) wound management; for example, treating a soft tissue infection surrounding</p>	F0684		

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F0684 SS = D	<p>Continued from page 11 an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc...</p> <p>Monitoring:</p> <p>1. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or non-healing wounds...</p> <p>A review of the facility's "Urinary Incontinence-Clinical Protocol Policy" that was provided by the LNHA, with a revised date of 10/2025, revealed:</p> <p>Assessment and Recognition:</p> <p>1. As part of the initial assessment, the physician will help identify individuals with impaired urinary continence...</p> <p>4. For incontinent individuals, the nursing staff will identify and document circumstances r/t the incontinence..</p> <p>On 10/23/25 at 5:00 PM, the survey team met with the LNHA, DON, ADON, and RDON for an exit conference, and there was no additional information provided by the LNHA.</p> <p>NJAC 8:39-11.2(b); 27.1(a)</p>	F0684		
F0689 SS = D	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Complaint #: NJ2611374 and NJ2621276</p> <p>Based on interview, record review, and review of other</p>	F0689	<p>HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THIS RESIDENT AFFECTED BY THE CONCERN(S):</p> <p>Resident #2 was discharged from our facility on <b>NJ Ex Order 26.4</b> and has not returned.</p> <p>Resident #1 did not <b>NJ Ex Order 26.4(b)(1)</b> from this incident. CNA #4 was educated on 9/8/2025 asking only trained staff to <b>NJ Ex Order 26</b> residents using <b>NJ Ex Order 26.4</b></p> <p>HOW WE IDENTIFIED OTHER RESIDENTS/AREAS THAT COULD POTENTIALLY BE AFFECTED:</p> <p>All residents requiring 2-staff assistance during transfer and care have potential to be affected by this deficient practice.</p>	10/23/2025



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F0689 SS = D	<p>Continued from page 13</p> <p>A CP with a focus area on risk for [redacted] with a last revised dated on [redacted], included interventions to be sure the resident's call light was within reach and encourage resident to use it for assistance as needed; and ensure that the resident was wearing appropriate [redacted] when [redacted] as needed.</p> <p>A review of the progress note (PN) dated [redacted], by Registered Nurse #1 (RN#1), documented Resident #2 was [redacted] and [redacted] with [redacted]. The resident was on [redacted] management, safety maintained, and plan of care to continue.</p> <p>A review of the Situation Background Assessment Recommendations (SBAR) PN dated [redacted] at 8:00 AM (8 AM), by RN#1, documented Resident #2 was awake lying on bed [redacted] and [redacted] at 4:00 AM (4 AM). Resident #2 had [redacted] to [redacted]. [redacted] and [redacted]. Resident #2 complained of [redacted] on [redacted]. The U.S. FOIA (b) (6) [redacted] and Physician were notified, the resident was medicated for [redacted] and the resident was sent to emergency room (ER) at an acute care hospital for further evaluation. Resident's Representative #1 (RR #1) was notified.</p> <p>A review of the PN dated [redacted] at 11:01 PM, by Licensed Practical Nurse #1 (LPN#1), documented, as per an ER nurse the resident was transferred due to [redacted] incident and was admitted to the hospital for [redacted].</p> <p>Further review of the eMR revealed, there was no documented evidence by the night shift nurse regarding the resident's [redacted] incident and assessment on [redacted] at the time of the incident.</p> <p>An interdisciplinary team PN dated 9/9/25 at 12:21 PM, by the [redacted] documented the interdisciplinary CP team met to discuss the resident's [redacted] a CNA (Certified Nursing Aide) was providing care to Resident #2, stepped away from the resident who was laying on the bed on their [redacted] to get a dry towel. Upon returning with the dry towel, the [redacted] observed the resident [redacted] in [redacted].</p>	F0689		

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F0689 SS = D	<p>Continued from page 14</p> <p>their room. The [U.S. FOIA (b) (6)] called the [U.S. FOIA (b) (6)] and [NJ Ex Order] on duty immediately and the resident was assessed. Resident #2 was observed with [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] was observed from the resident's [NJ Ex Order 26.4(b)(1)]. Resident #2 was asked what happened and stated they were [NJ Ex Order 26.4(b)(1)] and [NJ Ex] BIMS=[NJ Ex Order 26.4(b)(1)]). RR #1 and Physician were notified, and the Physician gave orders to send resident out for further evaluation.</p> <p>On 10/23/25 at 11:40 AM, S #1 requested investigations for Resident #2 and their closed (paper) medical record.</p> <p>On 10/23/25 at 12:01 PM, S #1 interviewed RN #1 about [NJ Ex Order] protocols and facility policy. RN #1 stated if a resident had [NJ Ex Order], the nurse assessed the resident, performed a [NJ Ex Order 26.4(b)(1)] assessment to check for visible [NJ Ex Order] checked their vital signs [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)], assessed their [NJ Ex Order] level, [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)], and asked the resident what happened. RN #1 further explained if a resident [NJ Ex Order 26.4(b)(1)] or it could not be excluded, then [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] would be initiated.</p> <p>On that same date and time, S #1 asked RN #1 about documentation at the time that [NJ Ex Order] occurred. RN #1 stated an incident report for risk management would be completed, and witness statements by staff at time of the incident would be obtained. RN#1 continued that the nurse would document a PN regarding their assessment and who was notified, and the [NJ Ex Order] event would be included in the 24-hour (shift to shift) report to endorse monitoring of the resident.</p> <p>At that same time, S #1 asked RN #1 about Resident #2's fall incident. RN #1 stated at the start of the shift, the 11-7 nurse notified her that Resident #2 had [NJ Ex Order] incident around 4-5 (4 AM – 5:00 AM). RN #1 stated she conducted her rounds, and the resident was observed with [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)(1)] RN #1 continued that Resident #2 was assessed, she notified the 11-7 [U.S. FOIA (b) (6)] [NJ Ex Order], the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)]. The Physician was called and notified of the resident's assessment and sent out for further evaluation at the ER. RN #1 stated she administered the resident's PRN (as needed) [NJ Ex Order] medication prior to their transfer to the</p>	F0689		

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F0689 SS = D	<p>Continued from page 15 hospital. RN#1 stated the resident was usually [redacted], had a history of [redacted] NJ Ex Order 26.4(b)(1), was [redacted] with [redacted] and received [redacted] management for [redacted].</p> <p>On 10/23/25 at 12:30 PM, S #1 interviewed Certified Nurse Aide #1 (CNA #1) about protocol for staff caring for a resident while in bed. CNA #1 stated that staff should not leave a resident unattended in the middle of care. CNA #1 further explained if a staff had to step away from the resident's bedside, they should make sure the bed was [redacted] NJ Ex Order 26.4(b)(1), the resident was covered to ensure privacy, and that the resident was comfortable and safe. CNA #1 stated if a CNA could not assist a resident alone, they should ask for assistance before providing care and follow the CP for safety.</p> <p>On 10/23/25 at 12:48 PM, the investigation for Resident #2 and their closed record was provided to S #1 and revealed an investigation dated [redacted] NJ Ex Order 26.4(b)(1) 5:15 AM, prepared by LPN #2. The [redacted] NJ Ex Order 26.4(b)(1) investigation included that CNA #2 entered the resident's room to provide care at about 5:20 AM by herself, when CNA #2 [redacted] NJ Ex Order 26.4(b)(1) Resident #2 to their [redacted] NJ Ex Order 26.4(b)(1) and needed help to [redacted] NJ Ex Order 26.4(b)(1). The nurse was with another resident and the CNA continued [redacted] NJ Ex Order 26.4(b)(1) resident and needed [redacted] NJ Ex Order 26.4(b)(1). CNA #2 wrote she had the resident [redacted] NJ Ex Order 26.4(b)(1) and went to [redacted] NJ Ex Order 26.4(b)(1). When CNA #2 arrived in room, Resident #2 was observed [redacted] NJ Ex Order 26.4(b)(1). CNA #2 immediately went to call the [redacted] U.S. FOIA (b) (6) and [redacted] U.S. FOIA (b) (6).</p> <p>Under Incident Description: LPN #2 was called by the Supervisor for assistance. Upon walking into the room, Resident #2 was noted [redacted] NJ Ex Order 26.4(b)(1) with [redacted] NJ Ex Order 26.4(b)(1) and [redacted] NJ Ex Order 26.4(b)(1). The [redacted] U.S. FOIA (b) (6) assessed the resident who had [redacted] NJ Ex Order 26.4(b)(1), [redacted] NJ Ex Order 26.4(b)(1), and [redacted] NJ Ex Order 26.4(b)(1). [redacted] NJ Ex Order 26.4(b)(1), [redacted] NJ Ex Order 26.4(b)(1), and [redacted] NJ Ex Order 26.4(b)(1). The resident's vital signs were assessed. LPN #2 documented the resident [redacted] NJ Ex Order 26.4(b)(1) and stated, [redacted] NJ Ex Order 26.4(b)(1).</p> <p>Under Immediate Action Taken: Resident #2 was [redacted] NJ Ex Order 26.4(b)(1) by LPN #2 and two CNAs via [redacted] NJ Ex Order 26.4(b)(1).</p>	F0689		

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F0689 SS = D	<p>Continued from page 16</p> <p><b>NJ Ex Order 26.4(b)(1)</b>, Resident #2 was assessed by the <b>U.S. FOIA (b) (6)</b> the supervisor notified RR #1 and the physician, <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b> applied, vital signs obtained, and <b>NJ Ex Order 26.4(b)(1)</b> started.</p> <p>Under Statements included statements from LPN #2, <b>U.S. FOIA (b) (6)</b> and CNA #2. The <b>U.S. FOIA (b) (6)</b> documented she was called by CNA#2, the resident's assigned CNA for help. The <b>U.S. FOIA (b) (6)</b> went to the resident's room and noted the resident <b>NJ Ex Order 26.4(b)(1)</b> with <b>NJ Ex Order 26.4(b)(1)</b>. When asked what happened the resident was <b>NJ Ex Order 26.4(b)(1)</b> what happened. The CNA reported to the <b>U.S. FOIA (b) (6)</b> that the resident <b>NJ Ex Order 26.4(b)(1)</b> while <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>Under Notes dated 9/10/25, by the <b>U.S. FOIA (b) (6)</b> revealed CNA #2 was re-interviewed and stated she did not step out of the room, she turned her back to the resident to <b>NJ Ex Order 26.4(b)(1)</b> on the overbed table where she had her supplies, and by the time she grabbed it Resident #2 was <b>NJ Ex Order 26.4(b)(1)</b>. The <b>U.S. FOIA (b) (6)</b> noted the CNA's statement indicated a time of 5:20 AM but <b>NJ Ex Order 26.4(b)(1)</b> were initiated at 4:20 AM by the nurse. The CNA was in-serviced by the <b>U.S. FOIA (b) (6)</b> on not leaving residents unattended during care. <b>NJ Ex Order 26.4(b)(1)</b> the resident had the <b>NJ Ex Order 26.4(b)(1)</b> treated and the <b>NJ Ex Order 26.4(b)(1)</b>, was cleaned and <b>NJ Ex Order 26.4(b)(1)</b> was noted. The <b>U.S. FOIA (b) (6)</b> documented <b>NJ Ex Order 26.4(b)(1)</b> the resident was stable until 8:30 AM when <b>NJ Ex Order 26.4(b)(1)</b> presented <b>NJ Ex Order 26.4(b)(1)</b> with <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b> out of 10 on <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>On 10/23/25 at 1:39 PM, S #1 interviewed the <b>U.S. FOIA (b) (6)</b> who stated she was notified by RN #1 that Resident #2 fell on the previous shift, the resident was <b>NJ Ex Order 26.4(b)(1)</b> and she wanted to send the resident to the hospital. The <b>U.S. FOIA (b) (6)</b> stated after investigating, they determined CNA #2 left the resident <b>NJ Ex Order 26.4(b)(1)</b> to get <b>NJ Ex Order 26.4(b)(1)</b> turned to get <b>NJ Ex Order 26.4(b)(1)</b> and the resident <b>NJ Ex Order 26.4(b)(1)</b>. The <b>U.S. FOIA (b) (6)</b> added the resident had a <b>NJ Ex Order 26.4(b)(1)</b> in use which could have contributed to the resident <b>NJ Ex Order 26.4(b)(1)</b> of the <b>NJ Ex Order 26.4(b)(1)</b> and the <b>NJ Ex Order 26.4(b)(1)</b> had <b>NJ Ex Order 26.4(b)(1)</b>. The <b>U.S. FOIA (b) (6)</b> stated contracted CNA #2 was provided education on the same day interviewed regarding not <b>NJ Ex Order 26.4(b)(1)</b> a resident <b>NJ Ex Order 26.4(b)(1)</b>; and if needing to <b>NJ Ex Order 26.4(b)(1)</b> from the bedside to ensure <b>NJ Ex Order 26.4(b)(1)</b> was <b>NJ Ex Order 26.4(b)(1)</b>, the resident was <b>NJ Ex Order 26.4(b)(1)</b>, and to bring all supplies into room prior to starting care.</p>	F0689		

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F0689 SS = D	<p>Continued from page 17</p> <p>At that same time, S #1 notified the concern that the CP was not followed for two person assist with bed mobility, and the [U.S. FOIA] had no response.</p> <p>On 10/23/25 at 2:01 PM, S #1 interviewed the [U.S. FOIA], who recalled she was passing near the resident's room when CNA #2 called for assistance. The [U.S. FOIA] stated that according to the CNA, she was [NJ Ex Order 26.4(b)(1)] the resident, went to get something and the resident [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] stated that she assessed the resident, [NJ Ex Order 26.4(b)(1)] was [NJ Ex Order 26.4(b)(1)], the resident had [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] did not recall [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)] at the time and the [U.S. FOIA] told LPN #2 to start [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] stated she called RR #1 and the Physician to notify them of the [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] could not recall when she spoke with the Physician but stated it would be documented in the in the incident report/risk management report. The [U.S. FOIA] stated after the resident's [NJ Ex Order 26.4(b)(1)] the resident was being monitored for the rest of the shift.</p> <p>On 10/23/25 at 2:19 PM, S #1 interviewed CNA #2 via a phone conference, who stated that approximately 4 AM she was rounding on residents and Resident #2 needed [NJ Ex Order 26.4(b)(1)] care. CNA #2 stated that she went to ask the nurse to assist her as she would need another person's [NJ Ex Order 26.4(b)(1)] ([NJ Ex Order 26.4(b)(1)]). CNA #2 stated that the nurse was [NJ Ex Order 26.4(b)(1)] another resident, could not [NJ Ex Order 26.4(b)(1)] her, and there was no one else who could help. CNA #2 further stated that Resident #2 had a [NJ Ex Order 26.4(b)(1)] and needed to [NJ Ex Order 26.4(b)(1)]. She added that she gathered the supplies needed [NJ Ex Order 26.4(b)(1)] and went [NJ Ex Order 26.4(b)(1)] Resident #2.</p> <p>At that same time, CNA #2 stated [NJ Ex Order 26.4(b)(1)] on the side she was standing, and Resident #2 was [NJ Ex Order 26.4(b)(1)] with the [NJ Ex Order 26.4(b)(1)]. CNA #2 stated it was not [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)] and that the [NJ Ex Order 26.4(b)(1)] was only at the [NJ Ex Order 26.4(b)(1)] of the resident. She also stated she reached for a towel, that she had not fully turned away from the resident and Resident #2 [NJ Ex Order 26.4(b)(1)]. CNA #2 acknowledged she did not see the resident's [NJ Ex Order 26.4(b)(1)]. CNA #2 stated she immediately called for assistance and the [U.S. FOIA (b) (6)], Nurse, and another staff member arrived to help the resident. CNA #2 acknowledged that she needed [NJ Ex Order 26.4(b)(1)] to provide care for the resident. CNA #2 stated that she was not permitted and did not return to work at the facility.</p>	F0689		

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F0689 SS = D	<p>Continued from page 18</p> <p>On 10/23/25 at 2:36 PM, S #1 interviewed LPN #2 via a phone conference, who was assigned to care of Resident #2 at the time of the incident. LPN #2 stated that at some time after 4:00 AM she was notified by the [U.S. FOIA] that her assistance was needed with Resident #2 as the resident [NJ Ex] LPN #2 stated at the time of the resident's [NJ Ex] she was [NJ Ex Order 26.4] another resident with care. LPN #2 stated the [U.S. FOIA] assessed the resident, the resident appeared to have [NJ Ex Order 26.4(b)(1)] and was [NJ Ex Order 26.4(b)(1)]. LPN #2 stated with the assistance of the two CNAs via [NJ Ex Order 26.4] the resident was [NJ Ex Order 26.4(b)(1)] to bed. LPN #2 stated the incident report in risk management was done and was not sure if the [U.S. FOIA] wrote a PN in the eMR. LPN #2 stated she was still at facility when resident was [NJ Ex Order 26.4(b)(1)] by oncoming shift. LPN #2 stated she was interviewed by the [U.S. FOIA] and [U.S. FOIA] that day. LPN #2 stated she was not permitted and did not return to work at the facility.</p> <p>On 10/23/25 at 2:45 PM, S #1 interviewed the [U.S. FOIA (b)] who stated when she came to work that morning RN #1 notified her that the resident had [NJ Ex] on the previous shift during [NJ Ex Order] care. The [U.S. FOIA (b)] interviewed LPN #2 who stated she was assisting other resident at time of the resident's [NJ Ex] initiated the [NJ Ex Order 26.4(b)(1)], and started an incident report in risk management. The [U.S. FOIA] reported at the time of the [NJ Ex] to assessing the resident, the staff assisted the resident back to bed, RR #1 and Physician were notified of the incident.</p> <p>On that same date and time, S #1 asked the [U.S. FOIA (b)] about protocol when caring for resident at the bedside. The [U.S. FOIA (b)] stated that patient safety came first and if a staff member had to [NJ Ex Order 26.4(b)(1)] the bed, they should ensure the resident was covered, make sure the bed was [NJ Ex Order 26.4(b)(1)], informed the resident they were [NJ Ex Order 26.4(b)(1)] and ensure call light was within reach. The [U.S. FOIA (b)] further stated the resident should not be left on their side and should be [NJ Ex Order 26.4(b)(1)] of the bed and to follow the resident's CP.</p> <p>At that same time, S #1 asked about documentation at the time of the [NJ Ex] event. The [U.S. FOIA (b)] stated documentation would be done in the incident report under risk management. S #1 asked the [U.S. FOIA (b)] if the incident report was part of the resident's medical record. The [U.S. FOIA (b)] replied that it was separate from the medical record but could be linked into a PN in the eMR. The [U.S. FOIA (b)] added some nurses do create a separate</p>	F0689		

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NAME OF PROVIDER OR SUPPLIER <b>Atrium Post Acute Care at Park Ridge</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>120 NOYES DRIVE , PARK RIDGE, New Jersey, 07656</b>	
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	<p>Continued from page 19</p> <p>PN. The [U.S. FOIA (b) (6)] stated [NJ Ex Order 26.4(b)(1)] was a paper document and would be in the paper chart.</p> <p>On 10/23/25 at 3:34 PM, the [U.S. FOIA (b) (6)] provided the [NJ Ex Order 26.4(b)(1)] dated [NJ Ex Order 26.4(b)(1)] for Resident #2. The [NJ Ex Order 26.4(b)(1)] started at 4:25 AM and ended at 9:00 AM at the time of the resident's transfer to the hospital.</p> <p>On 10/23/25 at 4:09 PM, S #1 notified the [U.S. FOIA (b) (6)] the [U.S. FOIA (b) (6)] the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] of the concern that CNA #2 did not follow the facility's protocol and the resident's CP while providing care to the resident which resulted in a resident's [NJ Ex Order 26.4(b)(1)], and there was no documentation in the resident's medical record at the time of the resident's [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] stated the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] at the time of the [NJ Ex Order 26.4(b)(1)] incident documented in the incident report under risk management. The [U.S. FOIA (b) (6)] stated and confirmed that the incident report under risk management was not part of Resident #2's medical record. The [U.S. FOIA (b) (6)] added the [NJ Ex Order 26.4(b)(1)] checks initiated after the [NJ Ex Order 26.4(b)(1)] event included the resident's vital signs and [NJ Ex Order 26.4(b)(1)] assessment.</p> <p>On 10/23/25 at 4:59 PM, the [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] met with the survey team. The [U.S. FOIA (b) (6)] provided a printout of the resident's CP and stated that the bed [NJ Ex Order 26.4(b)(1)] was applied for all residents as a precaution, and that not all residents needed [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] acknowledged that the CP should reflect the resident's current status and updated accordingly.</p> <p>A review of the facility's "Falls-Clinical Protocol Policy" with a revised date of 10/1/25, revealed under Assessment and Recognition:...5. The staff will evaluate, and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc...</p> <p>A review of the facility's "Change in a Resident's Condition or Status Policy" with a revised date of October 2025, revealed under Policy Interpretation and Implementation, Documentation of Changes in Medical Record:...6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status...</p>			

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F0689 SS = D	<p>Continued from page 20</p> <p>There was no additional information provided by the [REDACTED] U.S. FOIA (b) [REDACTED]</p> <p>2. On 10/23/25 at 10:00 AM, Surveyor #2 (S #2) the paper and eMR of Resident #1.</p> <p>A review of the AR revealed Resident #1 with diagnoses that included but not limited to; [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] NJ Ex Order 26.4, [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] NJ Ex Order 26.4(b)(1), and [REDACTED] NJ Ex Order 26.4(b)(1).</p> <p>A review of the cMDS, with an ARD of [REDACTED] NJ Ex Order 26.4 revealed a BIMS score of [REDACTED] out of 15 indicating [REDACTED] NJ Ex Order 26.4(b)</p> <p>A review of the PN dated [REDACTED] NJ Ex Order [REDACTED] revealed that a CNA reported to RN #2 that during [REDACTED] NJ Ex Order 26.4(i) from the bed to wheelchair (w/c) by [REDACTED] NJ Ex Order 26.4, one of the [REDACTED] NJ Ex Order 26.4(i) of resident's [REDACTED] NJ Ex Order 26.4(b)(1). RN #2 immediately assessed Resident #1, [REDACTED] NJ Ex Order 26.4(b)(1) were initiated, notified the Physician, [REDACTED] U.S. FOIA (b) (6) and RR #2 (who was present during the transfer). RN #2 documented that there were [REDACTED] NJ Ex Order 26.4(b) and [REDACTED] NJ Ex O [REDACTED] at that time.</p> <p>A review of the CP with a created date of [REDACTED] NJ Ex Order [REDACTED] and a revised date of [REDACTED] NJ Ex Order [REDACTED] revealed a focus that Resident #1 had [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] with [REDACTED] NJ Ex Order [REDACTED]. The interventions included but not limited to, allow RR to actively participate in the care of Resident #1 as they had at home, educate RR as needed, and [REDACTED] NJ Ex Order 26.4(b)(1).</p> <p>A review of the [REDACTED] NJ Ex Order 26.4(b)(1) evaluation (eval) dated [REDACTED] NJ Ex Order 26.4(b) revealed an initial assessment that prior to [REDACTED] NJ Ex Order 26.4(b)(1), Resident #1 [REDACTED] NJ Ex Order 26.4(b) and was [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] NJ Ex Order 26.4(b) and in [REDACTED] NJ Ex Order 26.4(b) with a [REDACTED] NJ Exec Order 26.4b1. Resident #1 was in another [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] and had been [REDACTED] NJ Ex Order 26.4(b)(1) and [REDACTED] NJ Ex Order [REDACTED]</p>	F0689		

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<p>F0689 SS = D</p>	<p>Continued from page 21                  [redacted] since [redacted]. The current [redacted] assessment indicated [redacted] NJ Ex Order 26.4(b)(1) [redacted].</p> <p>A review of the [redacted] NJ Ex Order 26.4(b)(1) [redacted] eval dated [redacted] NJ Ex Order [redacted], revealed initial assessment that upon discharge from [redacted] NJ Ex Order [redacted] care, due to resident being [redacted] NJ Ex Order 26.4(b)(1) [redacted], Resident #1 was referred to [redacted] NJ Ex Order 26.4(b)(1) [redacted] facility. The prior level and current [redacted] NJ Ex Order 26.4(b)(1) [redacted] level also revealed the same as [redacted] NJ Ex [redacted] eval had documented above.</p> <p>Further review of the eMR revealed that there was no documented evidence that RR #2 was educated on [redacted] NJ Ex Order [redacted] and use of [redacted] NJ Ex Order 26.4(b)(1) [redacted].</p> <p>On 10/23/25 at 12:07 PM, S #2 observed from the hallway, Resident #1 in their room lying in [redacted] NJ Ex Order [redacted] bed. S #2 and CNA #3 entered the resident's room, and the resident was [redacted] NJ Ex Order 26.4(b)(1) [redacted] respond to S #2's questions. CNA #3 stated that Resident #1 required total care, a [redacted] NJ Ex Order 26.4(b)(1) [redacted], and always [redacted] NJ Ex Order [redacted].</p> <p>On 10/23/25 at 1:41 PM, S #2 interviewed CNA #4, who [redacted] NJ Ex Order 26.4(b)(1) [redacted] Resident #1 or [redacted] NJ Ex Order [redacted] from the bed to the w/c. CNA #4 stated that RR #2 was in Resident's #1 room and asked her to [redacted] NJ Ex Order 26.4(b)(1) [redacted] resident from bed to w/c. She further stated that she told RR #2 she needed to get [redacted] NJ Ex Order 26.4(b)(1) [redacted], and RR #2 said they would help because they [redacted] NJ Ex Order 26.4(b)(1) [redacted] would come to help. CNA #4 confirmed, "That's the mistake I did, I should not have listened to RR #2." She also stated that she was unsure if RR #2 was previously educated on how to [redacted] NJ Ex Order [redacted] Resident #1 with use of [redacted] NJ Ex Order 26.4(b)(1) [redacted].</p> <p>At that same time, CNA #4 further explained the [redacted] NJ Ex Order [redacted] from the back and the [redacted] NJ Ex Order 26.4(b)(1) [redacted] the resident's [redacted] NJ Ex Order 26.4(b)(1) [redacted]. CNA #4 stated she was educated and disciplined by management after the incident.</p> <p>On 10/23/25 at 3:00 PM, S #2 requested from the [redacted] U.S. FOIA [redacted] for any education provided to RR #2 regarding [redacted] NJ Ex Order [redacted].</p> <p>On 10/23/25 at 4:00 PM, RR #2 confirmed via phone conference that they did not receive an education with regard to use of [redacted] NJ Ex Order 26.4(b)(1) [redacted] for Resident #1.</p>	<p>F0689</p>		

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F0689 SS = D	<p>Continued from page 22</p> <p>On 10/23/25 at 4:15 PM, the surveyors met with the [U.S. FOIA (b)] [U.S. FOIA (b)] [U.S. FOIA (b)] and [U.S. FOIA (b)] regarding the above concern for [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 2], that the resident's CP was not followed for [NJ Ex Order 26.4(b)(1)] and that RR #2 [NJ Ex Order 26.4(b)(1)] with no training. The [U.S. FOIA (b)] confirmed that the RR #2 did not receive any formal training, and that RR #2 was "always at the facility."</p> <p>A review of the facility's "Lifting Machine, Using a Portable Policy" dated 10/2025, revealed, review the resident's CP to assess for any special needs of the resident.....The portable lift can be used by one nursing assistant if the resident can participate in the lifting procedures. If not, two nursing assistants will be required to perform the procedure.</p> <p>NJAC 8:39-27.1(a); 33.1 (d)</p>	F0689		

New Jersey State Department of Health

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S0000	Initial Comments  The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		11/13/2025
S0560	Mandatory Access to Care  CFR(s): 8:39-5.1(a)  The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.  This LICENSURE REQUIREMENT is NOT MET as evidenced by:  Complaint #2578488, #2611374, and #2621276  REPEAT DEFICIENCY  Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for 34 of 35 day shifts 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 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	S0560	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THIS RESIDENT AFFECTED BY THE CONCERN(S):  All efforts to hire facility Certified Nursing Aide(s) CNAs will continue until there is adequate staff to serve all residents. Facility will utilize staffing and hiring agencies to fill open CNA positions in the schedule.  Contracts with additional staffing agencies and recruiting company were secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. CNA trainees will be screened and hired and sent to facility sponsored CNA class. In addition, daily and weekly meetings with the staffing coordinator will be made.  No resident was affected with this deficient practice.  HOW WE IDENTIFIED OTHER RESIDENTS/AREAS THAT COULD POTENTIALLY BE AFFECTED:  All residents have the potential to be affected by this deficient practice.	11/13/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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New Jersey State Department of Health

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S0560	<p>Continued from page 1 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:</p> <p>(1) one certified nurse aide to every eight residents for the day shift;</p> <p>(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</p> <p>(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</p> <p>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.</p> <p>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.</p> <p>(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.</p> <p>(3) All computations shall be based on the midnight census for the day in which the shift begins.</p> <p>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 ...</p> <p>1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the one-week period beginning 8/3/2025 and ending 8/9/2025 revealed the facility was not in compliance with the State of New Jersey minimum</p>	S0560	<p>Continued from page 1</p> <p>MEASURES PUT IN PLACE TO ENSURE CONCERN(S) IS/ARE CORRECTED &amp; WOULD NOT RECUR:</p> <p>Contracts with additional staffing and hiring company were secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, weekly meetings with the staffing company is in place.</p> <p>CNA trainees will be screened, hired and sent to facility sponsored and State approved CNA class.</p> <p>The Director of Nursing/Designee will review staffing schedules weekly for 4 weeks and monthly for 3 months to ensure adequate staffing for all shifts.</p> <p>Corporate Staffing Director will monitor staffing needs daily to ensure facility is compliance with staffing requirements.</p> <p>The salaried employees are offered bonuses and incentives to help cover open shifts.</p> <p>The facility will work with sister facilities to help cover open positions.</p> <p>HOW THE CONCERN(S) WILL BE MONITORED AND TITLE OF PERSON RESPONSIBLE FOR MONITORING:</p> <p>Director of Nursing (DON)/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be part of quarterly QAPI where recommendations will be made for continued monitoring.</p>	

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S0560	<p>Continued from page 2 staffing requirements.</p> <p>The facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows:</p> <ul style="list-style-type: none"> <li>-08/03/25 had 19 CNAs for 187 residents on the day shift, required at least 23 CNAs.</li> <li>-08/04/25 had 16 CNAs for 184 residents on the day shift, required at least 23 CNAs.</li> <li>-08/05/25 had 19 CNAs for 182 residents on the day shift, required at least 23 CNAs.</li> <li>-08/06/25 had 22 CNAs for 181 residents on the day shift, required at least 23 CNAs.</li> <li>-08/08/25 had 20 CNAs for 180 residents on the day shift, required at least 22 CNAs.</li> <li>-08/09/25 had 21 CNAs for 180 residents on the day shift, required at least 22 CNAs.</li> </ul> <p>2. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 8/31/2025 and ending 9/13/2025 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements.</p> <p>The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:</p> <ul style="list-style-type: none"> <li>-08/31/25 had 18 CNAs for 181 residents on the day shift, required at least 23 CNAs.</li> <li>-09/01/25 had 17 CNAs for 181 residents on the day shift, required at least 23 CNAs.</li> <li>-09/02/25 had 21 CNAs for 180 residents on the day shift, required at least 22 CNAs.</li> <li>-09/03/25 had 21 CNAs for 178 residents on the day shift, required at least 22 CNAs.</li> <li>-09/04/25 had 19 CNAs for 177 residents on the day shift, required at least 22 CNAs.</li> <li>-09/05/25 had 18 CNAs for 177 residents on the day shift, required at least 22 CNAs.</li> <li>-09/06/25 had 19 CNAs for 177 residents on the day shift, required at least 22 CNAs.</li> </ul>	S0560		

New Jersey State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>62219</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>10/23/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Atrium Post Acute Care at Park Ridge</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>120 NOYES DRIVE , PARK RIDGE, New Jersey, 07656</b>	
(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
S0560	<p>Continued from page 3</p> <p>-09/06/25 had 17 CNAs for 177 residents on the day shift, required at least 22 CNAs.</p> <p>-09/07/25 had 20 CNAs for 178 residents on the day shift, required at least 22 CNAs.</p> <p>-09/08/25 had 20 CNAs for 178 residents on the day shift, required at least 22 CNAs.</p> <p>-09/09/25 had 16 CNAs for 178 residents on the day shift, required at least 22 CNAs.</p> <p>-09/10/25 had 20 CNAs for 179 residents on the day shift, required at least 22 CNAs.</p> <p>-09/11/25 had 19 CNAs for 179 residents on the day shift, required at least 22 CNAs.</p> <p>-09/12/25 had 18 CNAs for 179 residents on the day shift, required at least 22 CNAs.</p> <p>3. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 10/5/2025 and ending 10/18/2025 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements.</p> <p>The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:</p> <p>-10/05/25 had 17 CNAs for 179 residents on the day shift, required at least 22 CNAs.</p> <p>-10/06/25 had 18 CNAs for 178 residents on the day shift, required at least 22 CNAs.</p> <p>-10/07/25 had 19 CNAs for 178 residents on the day shift, required at least 22 CNAs.</p> <p>-10/08/25 had 18 CNAs for 178 residents on the day shift, required at least 22 CNAs.</p> <p>-10/09/25 had 18 CNAs for 178 residents on the day shift, required at least 22 CNAs.</p> <p>-10/10/25 had 19 CNAs for 178 residents on the day shift, required at least 22 CNAs.</p> <p>-10/11/25 had 17 CNAs for 182 residents on the day shift, required at least 23 CNAs.</p> <p>-10/12/25 had 16 CNAs for 182 residents on the day shift, required at least 23 CNAs.</p>	S0560		

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<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>62219</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>10/23/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Atrium Post Acute Care at Park Ridge</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>120 NOYES DRIVE , PARK RIDGE, New Jersey, 07656</b>	
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S0560	Continued from page 4  -10/13/25 had 17 CNAs for 182 residents on the day shift, required at least 23 CNAs.  -10/14/25 had 20 CNAs for 181 residents on the day shift, required at least 23 CNAs.  -10/15/25 had 19 CNAs for 181 residents on the day shift, required at least 23 CNAs.  -10/16/25 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs.  -10/17/25 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs.  -10/18/25 had 18 CNAs for 180 residents on the day shift, required at least 22 CNAs.	S0560		

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>315438</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/10/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Atrium Post Acute Care at Park Ridge</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>120 NOYES DRIVE , PARK RIDGE, New Jersey, 07656</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 12/10/25 in relation to the 10/23/25 complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		

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

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