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	315438	A. BUILDING _____ B. WING _____	C 06/30/2021

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ATRIUM POST ACUTE CARE OF PARK RIDGE	**120 NOYES DRIVE PARK RIDGE, NJ 07656**

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F 000	INITIAL COMMENTS C#NJ00145520 Standard Survey: 6/30/21 CENSUS: 77 SAMPLE SIZE: 18 (plus 2 closed records) A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=G	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: C#NJ00145520 Based on interview and record review, it was determined that the facility failed to a.) promptly notify the physician of a change in condition and provide timely service; b.) monitor and document the change of condition; c.) document the assessment of a Registered Nurse; and d.) ensure that staff were aware of the physician's written transfer order. This deficient practice was identified for 1 of 2 residents (Resident #223) reviewed for hospitalization, according to the standards of clinical practice. Resident #223 was [redacted] Executive Order 26, 4.b.	F 658	1. HOW CORRECTIVE ACTIVE WILL BE ACCOMPLISHED FOR THOSE RESIDESNTS FOUND TO HAVE BEEN AFFECTED BY THE DEFFICENT PRACTICE? Reeducation was provided regarding the following: - Policy and procedure for change in condition (this includes monitoring and documentation) - Standards of practice	8/1/21

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

Electronically Signed | 07/21/2021

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F 658	Continued From page 1 Executive Order 26, 4.b. [redacted] 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." According to the Centers for Disease Control and Prevention (CDC), Stroke guidelines Page last reviewed: August 28, 2020, included "Stroke	F 658	To address survey concerns the following actions were taken: Reeducation was provided to LPN #1 7/17/2021 and 7/19/2021 RN # 1 in the following areas: - Change in condition - Scope of practice - Shift to shift communication - SBAR/eInteract - Documentation In addition reeducation was provided to RN/UM #1 on Following written physician orders. 7/17/2021 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? All residents who reside in the facility have the potential to be affected by these deficient practices. 3. WHAT MEASURES WILL BE PUT INTO PLACE, OR SYSTEMIC CHANGES MADE, TO ENSURE THAT THE DEFFICIENT PRACTICE WILL NOT REOCCUR? All nurses will be re-educated on change of condition, standards of practice, shift to shift communication, eInteract/SBAR. 4. HOW THE FACILITY WILL MONITOR	

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F 658	Continued From page 2 Signs and Symptoms: During a stroke, every minute counts! Fast treatment can lessen the brain damage that stroke can cause. By knowing the signs and symptoms of stroke, you can take quick action and perhaps save a life-maybe even your own. Signs of Stroke in Men and Women sudden numbness or weakness in the face, arm, or leg, especially on one side of the body. Sudden confusion, trouble speaking, or difficulty understanding speech. Also, sudden trouble seeing in one or both eyes, sudden trouble walking, dizziness, loss of balance, or lack of coordination, sudden severe headache with no known cause. Call 9-1-1 right away if you or someone else has any of these symptoms. Acting F.A.S.T. Is Key for Stroke. Acting F.A.S.T. can help stroke patients get the treatments they desperately need. The stroke treatments that work best are available only if the stroke is recognized and diagnosed within 3 hours of the first symptoms." A review of the CDC Stroke Treatment Page last reviewed: May 25, 2021, included, "If someone you know shows signs of stroke, call 9-1-1 right away. The key to stroke treatment and recovery is getting to the hospital quickly. Yet 1 in 3 stroke patients never calls 9-1-1. The emergency workers may take you to a specialized stroke center to ensure that you receive the quickest possible diagnosis and treatment. At the hospital, health professionals will ask about your medical history and about the time your symptoms started. Brain scans will show what type of stroke you had. If you get to the hospital within 3 hours of the first symptoms of an ischemic stroke, you may get a type of medicine called a thrombolytic (a "clot-busting" drug) to break up blood clots. Tissue plasminogen activator (TPA) is	F 658	ITS CORRECTIVE ACTIONS TO ENSURE THAT DEFFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCCUR? The Director of Nursing/IP and/or Designee will conduct weekly audits for four (4) weeks, then monthly for four (4) months of four (4) residents that had a change in condition to ensure the facility staff are following facility policy for change in condition status and proper documentation. The Director of Nursing/IP and/or Designee will conduct weekly audits for four (4) weeks, then monthly for four (4) months of four (4) residents regarding documentation of change in status, including shift to shift communication Results of the audits will be presented to the QAPI committee monthly for 5 months for tracking, trending, and implementation of action plans as necessary. The Administrator will take corrective action as needed to ensure compliance.	

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thrombolytic. TPA improves the chances of recovering from a stroke. Studies show that patients with ischemic strokes who receive TPA are more likely to recover fully or have less disability than patients who do not receive the drug. Patients treated with TPA are also less likely to need long-term care in a nursing home. Unfortunately, many stroke victims don't get to the hospital in time for TPA treatment. This is why it's so important to recognize the signs and symptoms of stroke right away and call 9-1-1."

A review of the resident's [redacted] Sheet (an Executive Order 26, 4.b.) reflected that the resident was admitted to the facility with diagnoses that Executive Order 26, 4.b. [redacted]

A review of the electronic late entry Nursing Note (NN) dated [redacted] and timed at 19:24 documented by a Licensed Practical Nurse #1 (LPN#1) indicated, "1 PM-During rounds, was informed that resident is with [family member/RP] downstairs. 2 PM-Resident transferred to unit after [family member] visited. The [family member] left and [LPN #1] was informed by PT Executive Order 26, 4.b. that [family member] placed concern [about] the resident: VS taken: Executive Order 26, 4.b. [redacted] Executive Order 26, 4.b. Executive Order 26, 4.b. [redacted] Assessment done. RN [Registered Nurse] supervisor was called ... [family member] was made aware that if any

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changes he would be informed ...Will continue to monitor."

A review of the medical records for Resident # 223 revealed that there was no assessment documented by the Registered Nurse/Supervisor #1 (RN/S #1) on [redacted]. There was no documented evidence that the physician or the nurse practitioner was notified of the RP's concern with the resident's change in condition.

A review of the 24-Hour Daily Report (24 HDR) provided by the Director of Nursing (DON) did not reveal a report or documentation on [redacted] regarding the RP's concern of a change in condition or that Resident # 223 would be monitored.

A review of the Nursing schedule (Ns) provided by the Licensed Nursing Home Administrator (LNHA) dated [redacted] revealed that both LPN #1 and RN/S #1 worked the 7-3 and 3-11 shifts. The [redacted], Ns indicated that LPN #1 was scheduled to start the shift at 1:00 PM for the 7-3 shift.

A review of the [redacted], Ns revealed that the Registered Nurse/Unit Manager (RN/UM) and LPN #2 worked the 7-3 shift, and LPN #1 and RN/S#2 worked the 3-11 shift.

A review of the NN dated [redacted] timed at 17:38 and documented by the RN/UM indicated, "11-12 PM ...NP [nurse practitioner] also examined resident as requested by resident's [family member]. 3:30 PM complete head-to-toe body assessment done by [name redacted] nurse NP, this writer, and shift supervisor..."

A review of the NN dated [redacted], timed at 19:29

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and documented by LPN #1 indicated "Received report regarding resident's [family member's] request. [name redacted] NP ...ordered to send resident to [name redacted] ER [emergency room] for further evaluation. Altered mental status. [name redacted] NP discussed with [name redacted] NP ...Resident left facility at 5:19 PM via [name redacted] transportation."

A review of the [redacted] Minimum Data Set [redacted]), an assessment tool used to facilitate care management, indicated that Resident # 223 had an [redacted]. The [redacted] also indicated that the [redacted] skills for [redacted].

A review of the NP #1's handwritten Physician's Orders: Interim/Telephone dated [redacted] timed at 3:45 PM, included "Send pt [patient] to [name redacted] ER [emergency room] for eval-[redacted] discussed with Np #2."

A review of the [redacted] timed at 19:37 [redacted] Note [redacted] by [name redacted]-LSW (Licensed Social Worker) indicated that the resident was seen for a face-to-face encounter.

A review of the NP's #1 [redacted] which reflected that the "[family member] called NP and reported that while visiting [Resident # 223] on [redacted] Resident # 223] [redacted],' he/she was [redacted] and could not [redacted] what was going on with him/her.' Pt [patient] was elevated at [redacted] ...Pt noted to be slower in responses and noted to have [redacted] [Family member]

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denied any previous hx [history] of stroke. Executive Order 26, 4.b. with pt and [family member]-pt [patient] Executive Order 26, 4.b. with [family member] ...Pt [patient] to be Executive Order 26, 4.b.] per family request."

On 6/28/21 at 8:27 AM, the surveyor interviewed NP #1, who stated that the RP called her on Executive Order 26, and notified her about a change in the condition of Resident #223 during a visit with the resident on Executive Order. NP #1 further stated that according to the RP, the resident Executive Order 26, 4.b. P #1 said that she did not receive a call from the facility on Executive Order regarding the RP's concerns.

On that same date and time, NP #1 informed the surveyor that the resident was Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Furthermore, NP #1 stated that "further test on Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b.

At that same time, NP #1 confirmed that she handwrote the Executive Order 26 order timed at 3:45 PM to Executive Order 26, 4.b. for Executive Order 26, 4.b it with NP #2. NP #1 stated, "it will not make any difference now" because the hospital will ask when the Executive Order 26, 4.b., and according to the RP, it began on Executive Order. The surveyor asked NP #1 why the Executive Order 26, 4.b. Executive Order 26, 4.b. on Executive Order 26, 4.b. The NP #1 stated, "because the

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[redacted]

On 6/28/21 at 10:12 AM, the RN/UM informed the surveyors that as a standard of practice, if a staff member or responsible party reported a change in condition of the resident, then the LPN should have called the RN/S or the RN/UM to assess the resident because the assessment should be done by an RN. The RN/UM stated that the RN/S #1 should have assessed the resident on [redacted], called the physician, and documented [redacted] assessment and findings in the electronic medical records.

On 6/28/21 at 10:48 AM, the surveyor, in the presence of the survey team, conducted a telephone interview with LPN #1 who stated she was the nurse assigned to Resident # 223 on [redacted], from 1:00 PM and the 3-11 shift, and on [redacted] during the 3-11 shift. LPN #1 stated that as a standard of practice, an LPN should call the RN/S or RN/UM if there is a report of change in condition because the RN was responsible for assessing the resident. She further stated that the RN would initiate a Situation-Background-Assessment-Recommendation (SBAR), notify the physician, and document; [The SBAR allows for an easy and focused way to set expectations for what will be communicated and how between a member of the team, which is essential for developing teamwork and fostering a culture of patient safety in the electronic medical record as part of the RN's assessment]. LPN #1 further indicated that the nurse should have documented in the 24 HDR for another shift to continue monitoring the resident. She further acknowledged that she should have documented in the 24 HDR to communicate with the oncoming shift.

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On that same date and time, LPN #1 informed the surveyors that she remembered that the RP visited on Executive Order 2 at 1:00 PM and had a concern regarding a change in the resident's condition. The RP asked the Restorative Certified Nursing Aide (RCNA) to have the nurse call the RP. LPN #1 stated that she informed RN/S#1 of the RP concerns. LPN #1 could not speak to why there was no report in the HDR on Executive Order 2. When asked why there was no documented evidence of the change in condition reported by the RP until Executive Order 26, timed at 7:24 PM. LPN #1 stated, "I have no answer." LPN #1 further said, "looking back now, I should have called the doctor on Executive Orde to notify the physician that the RP had a concern with the resident's condition." LPN #1 informed the surveyors that the resident was Executive Order 26, 4.b. Executive Order 26, 4.b. She further stated that there should have been an SBAR in the electronic medical records on Executive Order 2.

On 6/28/21 at 11:08 AM, the [name redacted]-LSW (SCT/LSW) informed the surveyors that she's been "coming" to the facility as a Executive Order 26, 4.b. and writes her consultation reports electronically. The SCT/LSW stated that before she saw the resident on Executive Order 26 at 1:30 PM, the facility Director of Social Services (DSS) asked her to check on the resident to see if there were any changes in condition because the RP called him and expressed concerns that the resident had a change in condition regarding the resident's Executive Order 26, 4.b.

On that same date and time, the SCT/LSW stated, "since I've been seeing the resident for a while now, and I know the resident well. I can't remember what side of the Executive Order 26, 4.b. The

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SCT/LSW stated, as per her observations, that the resident's Executive Order 26, 4.b. [redacted], which was different for the resident. She further said that she informed NP #1 and RN/UM at that time, and that "staff was aware of the RP's concerns since Executive Order [redacted]. The staff just wanted me to confirm the resident's changes since I knew the resident well." She stated, "unless you take time to talk to the resident, you wouldn't be able to see the changes." The surveyor asked the SCT/LSW if she documented the resident's change of condition in her consult notes on Executive Order 26, 4 [redacted] She stated, "it should have been documented."

On 6/28/21 at 11:20 AM, the RCNA informed the surveyors that on Executive Order [redacted], he transported the resident to the visiting area and back to the unit. The RCNA stated that the resident was "ok" when he transported the resident to see the RP, and later, the RP called him because the RP observed changes in the resident. He further stated that he observed the resident was Executive Order 26 [redacted] Executive Order 26, [redacted] and Executive Order 26, 4.b. [redacted] but he couldn't remember which side of the body. The RCNA stated that he brought the resident back to the unit, informed LPN #1 of the RP's concerns and that the RP wanted a call back regarding the resident's condition.

On 6/28/21 at 11:32 AM, the surveyor, in the presence of the surveyor team, interviewed the DSS, who stated that he was unable to remember what the concerns of the RP were on Executive Order [redacted] and could not speak of an incident or the RP's concerns. He further stated that there was no documented report regarding the Executive Order [redacted] incident.

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F 658	Continued From page 10 On 6/28/21 at 1:08 PM, the surveyor conducted a telephone interview with the Registered Nurse (RN) in the presence of two other surveyors. The RN confirmed that he worked the 11-7 shift on Executive Orde. The RN stated that he remembered Resident # 223, and there were no reports or a shift to shift report to monitor the resident's condition. He said he was unaware that the resident's RP had concerns regarding the resident's condition on Executive Orde. On 6/28/21 at 2:18 PM, the survey team met with the LNHA, DON, Assistant Director of Nursing (ADON), Quality Assurance Performance Improvement Certified Specialist (QAPI/CS), Regional Nurse and discussed the above concerns. On 6/28/21 at 9:00 AM, 9:15 AM, and 10:00 AM, the surveyor, in the presence of the survey team, attempted to conduct a telephone interview with RN/S #1 but was unable to. On that same date, at 9:30 AM and 9:36 AM, the surveyor, in the presence of the survey team, attempted to conduct a telephone interview with NP#2 and the resident's primary care physician but was unable to. On 6/29/21 at 9:29 AM, the surveyor, in the presence of the survey team, interviewed LPN #2, who stated that Resident #223 was Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Orde. LPN #2 confirmed that she worked the 7-3 shift on Executive Order 26 and that "there was an incident over the weekend that happened. I don't know what happened." She further stated, "I know that	F 658		

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was the priority at that time because the RN/UM and NP #1 were the ones taking care of the resident." The surveyor asked LPN #1 what the priority was at that time? LPN #1 stated, "I don't know."

On 6/29/21 at 9:37 AM, the surveyor, in the presence of another surveyor, interviewed the RN/UM, who confirmed that she worked the 7-3 shift on Executive Order 2[redacted]. She stated there were no reports about the resident from the medical record and no reports from the Staff about monitoring the resident's Executive Order 26, 4.b. The RN/UM noted that she was unaware that the RP had concerns on Executive Order[redacted], not until NP #1 came into the facility on Executive Order 2[redacted]. The NP #1 informed her that the RP called the NP #1 with concerns of the resident, that the resident had a change in the condition of Executive Order 26, 4.b.. The RN/UM further stated that NP #1 and the RN/UM were able to assess the resident when the resident came back from an Executive Order 26, 4.b. appointment in the afternoon. She further stated that the assessment was done with the RP via Executive Order 26,4.[redacted]. The RN/UM noted that the resident was Executive Or[redacted] at that time, except the resident was Executive Order 26[redacted] Executive Order 26, 4.b., and NP #1 ordered to transfer the resident to the hospital for further evaluation.

On that same date and time, the RN/UM stated that she was not aware of NP #1's handwritten order dated Executive Order 26, 4.b. to Executive Order 2[redacted] the resident to the hospital for Executive Order 26, 4.b. She further stated that the resident should have been Executive Order 26, 4.b. if the reason for the transfer was Executive Order 26, 4.b. Executive Order 26, 4.b. which was Executive Order 26, 4.b., and stated, "yes, I should have called 911."

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F 658	Continued From page 12 On 6/29/21 at 10:58 AM, the DON, in the presence of the ADON, informed the surveyors that the eInteract is the same as an SBAR. On that same date and time, the surveyor, in the presence of the DON, reviewed the electronic medical records for Resident # 223. There was no documented eInteract dated Executive Order 26, 4.b. A review of the staff statements provided by the DON on 6/29/21 at 1:38 PM reflected that the DSS had a typewritten statement which reflected that he received a call from the RP on Executive Order 26, 4.b. indicating that the RP visited on Executive Order 26, 4.b. and felt there were Executive Order 26, 4.b. . On 6/30/21 at 12:58 PM, the survey team met with the LNHA, Corporate Vice President of Nursing, DON, ADON, QAPI/CS. The DON informed the surveyors that she provided the staff statements to the surveyor. On 7/2/21 at 9:22 AM, during a post-survey telephone interview with RN/S#2, who confirmed that she worked the 3-11 shift on Executive Order 26, 4.b. but arrived at work "around 3:30-4:00 PM." The RN/UM asked her to go with RN/UM and NP #1 to assess the resident. RN/S#2 stated that she could not remember the RN/UM and NP's names and why the resident was being assessed. RN/S#2 was unable to remember the Executive Order 26, 4.b. Executive Order 26, 4.b. of Resident # 223 on Executive Order 26, 4.b. . She further stated that "there was a concern on Sunday. I didn't work that day." She noted that the resident's family member was concerned that the resident Executive Order 26, 4.b. , and "there were different stories about that day." She further stated that as a standard of practice, the RN/S should	F 658		

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F 658	Continued From page 13 immediately assess the resident, call the doctor about the assessment and concern of the RP about Executive Order 26, 4.b. as reported, follow the physician's order, and document. She further stated that Executive Order 26, 4.b., "even though you're not sure but there's a concern reported already, the nurse should call 911." A review of the facility's Change in a Resident's Condition or Status Policy that the DON provided with the last update of March 2021 included "Our facility shall promptly notify the resident, his or her attending Physician, and representative of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation: 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an): a. accident or incident involving the resident..."	F 658		
F 880 SS=E	NJ 8:39-11.2 (b) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/1/21

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F 880	Continued From page 14 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 15 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, and record review, it was determined that the facility failed to ensure a.) appropriate infection control practices were followed in accordance with the Center for Disease Control guidance (CDC) and facility guidelines for 1 of 4 housekeeping staff observed on 1 of 3 nursing units; b.) store an indwelling Executive Order 26, 4.b. to prevent the transmission of infection for 1 of 1 resident (Resident #40) reviewed for Executive Order 26, 4.b.; and c.) follow appropriate infection control practices for the administration of medications for 1 of 3 nurses during the medication observation pass. The evidence was as follows: According to the U.S. CDC guidelines for Hand Hygiene in Healthcare Settings, Hand Hygiene Guidance, updated 1/30/20, included Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: "Immediately before touching a patient Before performing an Executive Order 26, 4.b. (e.g., Executive Order 2 Executive Order 26, 4.b.) or Executive Order 26, 4.b.	F 880	1. HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDESNTS FOUND TO HAVE BEEN AFFECTED BY THE DEFFICENT PRACTICE? To address survey concerns, an individual training and counseling was conducted. After conducting an RCA it is believed the housekeeper acted in the identified manner due to being nervous under observation, lack of identification of an infection apart from COVID and a language barrier. Re-education was provided as follows: - Hand Hygiene - Transmission based precautions - Contact precautions - Biohazard vs. regular trash (not co-mingling) proper disposal of - Proper utilization and disposal of gloves - When to change gloves (hand hygiene included) - Infection control	

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F 880	Continued From page 16 Executive Order 26 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 Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands." According to the U.S. CDC guidelines for Management of Multidrug-Resistant Organisms in Healthcare Settings (2006) last updated February 2017, included Table 3. Tier 1. General Recommendations for Routine Prevention and Control of MDROs in Healthcare Settings indicated to "Follow Standard Precautions in all healthcare settings ... Use of Contact Precautions in LTCFs: Consider the individual patient's clinical situation and prevalence or incidence of MDRO in the facility when deciding whether to implement or modify Contact Precautions in addition to Standard Precautions for a patient infected or colonized with a target MDRO. For relatively healthy residents (e.g., mainly independent), follow Standard Precautions, making sure that gloves and gowns are used for contact with uncontrolled secretions, pressure ulcers, draining wounds, stool incontinence, and ostomy tubes/bags ... For MDRO colonized or infected patients without draining wounds, diarrhea, or uncontrolled secretions, establish ranges of permitted ambulation, socialization, and use of	F 880	- Cleaning of equipment after potential infection exposure. - In-service dates 6/28/2021 and 7/16/2021 RN UM #1 was re-educated on transmission based precautions 7/19/2021 The following actions were taken to address survey concerns about Resident #40□s Executive Order 26, 4.b. placement: - Resident and responsible party was re-educated on infection control including risk vs benefits of placing the Executive Order 26, 4.b. on the floor 7/21/21 which is the preference of the resident. - A Executive Order 26, was offered to the patient but refused 7/16/2021 and 7/21/21 - The resident was re-educated on the importance of using facility provided privacy bag 7/21/2021. - The resident Care Plan was updated 7/16/2021 - Re-education was provided to the ADON/IFCP on documentation 7/16/2021 To address survey concerns about staff handling medication during med pass the identified LPN was questioned by Center Administration why she touched the medication with bare hands; An RCA reveals she was nervous under	

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F 880	Continued From page 17 common areas based on their risk to other patients and on the ability of the colonized or infected patients to observe proper hand hygiene and other recommended precautions to contain secretions and excretions." Review of "Table 3. Tier 2. Recommendations for Intensified MDRO Control Efforts are implemented when the incidence or prevalence of MDROs are not decreasing despite the use of routine control measures, or the first case or outbreak of an epidemiologically important MDRO (e.g., VRE, MRSA, VISA, MDR-GNB) is identified within a healthcare facility or unit." 1. On 6/22/21, during the initial pool, the surveyor observed Room Executive with the door closed and a red stop sign on the door. There was a personal protective equipment (PPE) bin right outside the door with adequate PPE. There was an alcohol-based hand rub (ABHR) mounted to the wall right outside of Room Executive. The surveyor interviewed the Registered Nurse Unit Manager (RN/UM #1) on the Executive Order 26, 4.b., who stated that the resident inside Room Executive was on isolation for contact precautions due to Executive Order Executive Order 26, 4.b. On 6/24/21 at 11:15 AM, the surveyor observed a housekeeper in the hallway right in front of Room Executive wearing an N-95 mask, goggles, and clear vinyl disposable gloves. There was a red stop sign on the door which indicated to "Stop see the nurse before entering." There was a PPE bin with adequate PPE right outside Room Executive. The surveyor observed the housekeeper open the door to Room Executive and remove the red biohazard plastic bag from the dedicated black PPE bin	F 880	observation and was "afraid she was going to drop the pill". LPN #1 was re-educated on the following areas: on 7/19/2021. - Infection control - Infection control during med pass 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? All residents who reside in the facility have the potential to be affected by these deficient practices. 3. WHAT MEASURES WILL BE PUT INTO PLACE, OR SYSTEMIC CHANGES MADE, TO ENSURE THAT THE DEFFICIENT PRACTICE WILL NOT REOCCUR? On 06/24/2021 all staff were re-educated on hand hygiene, infection control, transmission based precautions, not wearing gloves in the hallway, bio-hazard vs regular trash (co-mingling). When to change gloves. On 06/24/2021 members of the Interdisciplinary Care Plan Team (IDCP) and licensed nurses were re-educated on proper Documentation and person centered plan of care.	

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F 880	Continued From page 18 used to dispose of PPE located inside the room near the door. He placed the red biohazard plastic bag into a large clear plastic bag. He then went into the resident's bathroom and emptied the bathroom trash bin into the large clear plastic bag. He then emptied the trash bin located near the resident's bed into the large clear plastic bag. The housekeeper tied the large clear plastic bag in the middle of the resident's room, walked out into the hallway wearing gloves, and placed the large bag on the floor near the housekeeping cart. While wearing the same gloves, he removed the broom and dustpan from the housekeeping cart and proceeded to sweep Room [redacted]. The surveyor then observed the housekeeper come out of that room and place the broom and dustpan back onto the housekeeping cart while wearing the same gloves. He then removed his gloves and disposed of the gloves inside the housekeeping cart trash bin. He removed the mop from the housekeeping cart without performing hand hygiene and without putting on new gloves. He went back into Room [redacted] and began mopping the room with bare hands. The surveyor observed the housekeeper touch the black dedicated PPE bin used to dispose of PPE with his bare hands to mop behind the bin. He was observed touching several objects inside the room with his bare hands, such as the resident's walker, wheelchair, over-bed table, and the trash bin next to the resident's bed. After mopping the room, the housekeeper came out of Room [redacted] placed the mop back onto the housekeeping cart, picked up a yellow sign, and placed the sign in front of that same room. He then picked up the large clear plastic bag off the floor and pushed the housekeeping cart to the soiled utility room located near the nurse's station. He opened the soiled utility room via a code and placed the large	F 880	On 06/24/2021 all licensed nurses were re-educated on infection control and transmission based precautions. Directed In-service Training is completed for the following: - The Nursing Home Infection Preventionist - Training Course □ Module 1, Module 7 and Module 6B is being viewed by the Management staff/Topline staff and the Infection Preventionist Certificates are printed upon completion. - The Nursing Home Infection Preventionist Training Course □ Module 6B and Module 7 is being viewed by all staff. - CDC COVID -19 Prevention Messages for Front-Line Long□Term Care Staff: Keep COVID-19 Out! Is being viewed by the front line staff. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT DEFFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT REOCCUR? The Environmental Service Director or Designee will conduct weekly audits for four (4) weeks, then monthly for four (4) months of random employees to ensure compliance with	

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F 880	Continued From page 19 clear plastic bag into a large bin, and closed the door. He did not perform hand hygiene. Simultaneously, the surveyor attempted to interview the housekeeper, but there was a language barrier, and the surveyor asked the RN/UM #1 to call a translator. At 11:35 AM, the surveyor interviewed the RN/UM #1, who could not speak to the facility policy for transmission-based precaution for a contact precaution room. She stated that gowns and gloves are worn for a transmission-based room. She stated, "if you are not sure about the stop sign, you should ask the nurse what to do. That is why the stop sign is on the door." At 11:45 AM, the surveyor interviewed the housekeeper via the 1 West RN/UM #2, who translated. During the interview, the housekeeper stated that the stop signs and PPE bin were for people who were sick. He acknowledged that if he did not know what to do, he should have asked the nurse. He further acknowledged that he should not have worn gloves in the hallway and that he should have performed hand hygiene after removing gloves and should have put on gloves before mopping the room. When asked if he had any training or in-services on infection control regarding PPE and hand hygiene, he stated, "yes." On 6/28/21 at 9:51 AM, the surveyor interviewed the director of Environmental Services (EVS), who stated that the housekeeper should not have worn gloves in the hallway and should have washed his hands. He said, "there was a sign, and he should have asked the nurse since there	F 880	The Director of Nursing/IP and/or Designee will conduct weekly audits for four (4) weeks, then monthly for four (4) months of four (4) employees to ensure the facility staff are following facility policy for transmission based precautions and infection control. The Director of Nursing/IP and/or Designee will conduct weekly audits for four (4) weeks, then monthly for four (4) months of four (4) residents with identified need for education and associated documentation. The Director of Nursing/IP and/or Designee will conduct a weekly audit for four (4) weeks, then monthly for four (4) months of four (4) nurses for medication pass observation. Results of the audits will be forward to the QAPI committee monthly for 5 months for tracking, trending, and implementation of action plans as necessary. Staff will be held accountable to be in compliance with infection control practice. The Administrator will take corrective action as needed.	

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was a sign on the door." The director of EVS confirmed that the housekeeper had in-service training on handwashing, PPE uses, and infection control.

On 6/28/21 at 2:15 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing/Infection Control Preventionist (ADON/IFCP), and the Quality Assurance and Performance Improvement specialist. The DON and the ADON/IFCP stated that the housekeeper did not have to wear a gown to enter the room because the resident was on contact precautions and the housekeeper had no resident contact, but that the housekeeper should not have worn his gloves in the hall, he should have changed gloves and performed hand hygiene. The LNHA and the QAPI specialist stated the housekeeper was re-educated over the weekend in his language.

The surveyor reviewed the medical record for Resident #123.
A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident was [redacted] Executive Order 26, 4.b. [redacted].

A review of the resident's individual comprehensive Care Plan initiated on 6/20/21 and revised 6/22/21, reflected that the resident has [redacted] to the Executive Order 26, 4.b. The interventions included but were not limited to "Contact Precautions: Wear gowns and masks when changing contaminated lines. Place soiled linens in bags marked biohazard. Bag linens and

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close bag tightly before taking to laundry, educate resident/family on precaution policies at the facility. Follow facility policy for implementation of contact precautions r/t [related to] active infection. Staff to follow standard precautions and transmission precautions when appropriate, give Executive Order 26, 4.b.

A review of the Executive Order 26, 4.b. and Executive Order 26, 4.b. results dated Executive Order 26, 4.b. reflected the culture revealed Executive Order 26, 4.b. ...positive for Executive Order 26, 4.b. Contact precautions indicated .... organism identification: Executive Order 26, 4.b.

A review of the electronic order summary report reflected a physician's order (PO) dated 6/22/21 for Executive Order 26, 4.b.

A review of the Advanced Practice Nurses electronic progress note dated Executive Order 26, timed at 15:41 indicated that the Executive Order 26, 4.b., Executive Order 26, 4.b., and Executive Order 26, 4.b. Executive Order 26, 4.b..

Further review of the electronic order summary report reflected a PO dated Executive Order 26 to discontinue isolation precautions r/t [related to] Executive Order 26, 4.b. in the Executive Order 26, 4.b.

A review of the facility's Isolation-Initiating Transmission-Based Precautions provided by the DON and last updated May 2021 indicated "Transmission-Based Precautions may include Contact Precautions, Droplet Precautions, or

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F 880	Continued From page 22 Airborne Precautions ... When the Transmission-Based Precautions are implemented, the Infection Preventionist (or designee) shall: ensure that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need. Post the appropriate notice on the room entrance door and on the front of the resident's chart so that all personnel will be aware of precautions or be aware that they must first see a nurse to obtain additional information about the situation before entering the room." A review of the facility's Contact Precautions policy provided by the ADON/IFCP and last updated May 2021 indicated, "In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Examples of infections requiring Contact Precautions include, but are not limited to Infections with multi-drug resistant organisms (determined on a case by case basis) ...Gloves and Handwashing ...wear gloves (clean, non-sterile) when entering the room ... remove gloves before leaving the room and perform hand hygiene. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room ...Gown ...wear a disposable sown upon entering the Contact Precautions room or cubicle ...Signs ...the facility will implement a system to alert staff to the type of precaution resident requires.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315438	A. BUILDING _____ B. WING _____	C 06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF PARK RIDGE	**120 NOYES DRIVE PARK RIDGE, NJ 07656**

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F 880	Continued From page 23 A review of the facility's Standard Precautions policy last updated May 2021 and provided by the QAPI specialist indicated that hand hygiene refers to handwashing with soap (anti-microbial or non-antimicrobial) or using alcohol-based hand rubs (gels, foams, rinses) that do not require access to water. Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such, and before eating and after using the restroom. In the absence of visible soiling of hands, alcohol-based hand rubs are preferred for hand hygiene. Wash hands after removing gloves. Gloves ...wear gloves when handling or touching resident-care equipment that is visibly soiled or potentially contaminated with blood, body fluids, or infectious organisms ...remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. 2. On 6/22/21 at 10:40 AM, the surveyor, observed Resident #40 lying in bed. The resident's Executive Order 26, 4.b. [redacted] was observed directly on the floor on the left side of the bed. On 6/24/21 at 10:35 AM and 1:48 PM, the surveyor observed the resident's Executive Order 26, 4.b. [redacted] directly on the floor. There was no Executive Order 26, 4.b. [redacted] in use. The surveyor reviewed the medical record for	F 880		

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F 880	Continued From page 24 Resident # 40. A review of the Quarterly MDS, dated [redacted] reflected that the resident was admitted to the facility [redacted]. The MDS assessment further revealed that the resident had a [redacted]. The resident was assessed to have [redacted] that impact care and evaluated with an [redacted]. The [redacted]. A review of the resident's individual comprehensive Care Plan initiated 10/2/20 and [redacted], reflected that the resident had a [redacted]. The interventions included educating the resident regarding [redacted], the resident's [redacted]. A review of the electronic order summary report reflected a PO dated 6/27/21 to [redacted] dated [redacted]. On 6/28/21 at 12:43 PM, the surveyor interviewed	F 880		

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F 880	Continued From page 25	F 880		

the resident's assigned Certified Nursing Assistant (CNA), who stated the resident takes the Executive Order 26, 4.b. The CNA further noted that the resident walks around and moves the Executive Order 26, 4.b. all the time. "We do our best to keep the Executive Order 26, 4.b. and Executive Order ."

On that same date at 1:00 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM), who stated the resident has a Executive Order 26, 4.b. . "It's all of our jobs to make sure the Executive Order 26, 4.b. is kept Executive Order 26, 4.b. and Executive Order 26, 4.b , but the resident does walk around and moves the Executive Order 26 around. The LPN/UM further stated that the resident does not want the Executive Order 26, 4.b. attached to the bed frame because the resident gets up and walks around. She noted that the resident was educated on infection control.

On 6/30/21 at 11:45 AM, the surveyor interviewed the ADON/IFCP, who stated, "it is an Executive Order 26, 4.b. Executive Order 26, 4.b. , but the Executive Order 26, 4.b. Executive Order 26, 4.b. The resident walks around and holds the Executive Order 26, 4.b. while [Resident #40] walks around; I verbally educated [Res # 40] but did not document it."

At that time, the ADON/IFCP acknowledged that the Executive Order 26, 4.b. should be in a Executive Order 26, 4.b. and not Executive Order 26, 4.b. When questioned about the Executive Order 26, 4.b. ADON acknowledged that a Executive Order 26 should have been attempted.

A review of the facility's policy for Urinary Tract Infections (Catheter-Associated), Guidelines for

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F 880	Continued From page 26 Preventing last updated November 2020 and provided by the DON indicated to keep the drainage bag below the level of the bladder at all times and not to place the drainage bag on the floor. 3. On 6/28/21 at 8:35 AM, during the medication observation pass, the surveyor observed a Licensed Practical Nurse (LPN #1) handle a Executive Order 26, 4.b. with her bare hands. The surveyor observed LPN #1 remove the Executive Order 26, 4.b. with her bare hands from a Pharmacy packaging and then place the capsule into a medication cup prior to administering medication to the resident. On 6/28/21 at 11:00 AM, the surveyor interviewed LPN #1, who stated that she should not have handled the Executive Order 26, 4.b. with her bare hands. The LPN #1 said that she handled the medication with her bare hands because she was afraid that she was going to drop the medication. On 6/28/21 at 2:15 PM, the surveyor, in the presence of the survey team, met with the LNHA, DON, ADON/IFCP, and the Quality Assurance and Performance Improvement specialist and discussed the above observation and concern. The DON and the ADON/IFCP stated that LPN #1 should not have handled a resident's medication with her bare hands. A review of the facility's undated policy for Specific Medication Administration Procedures provided by the DON indicated to administer medications in a safe and effective manner ... use a barrier (e.g., clean disposable tray or plastic cup) to carry medication containers into the	F 880		

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F 880	Continued From page 27 resident's room. This will serve as a barrier between the supplies and the over-the-bed table or other surfaces on which the supplies are placed while the medication is administered. NJAC 8:39-19.4 (a) (1) (n) (2)	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315438	A. Building B. Wing	8/24/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF PARK RIDGE	120 NOYES DRIVE PARK RIDGE, NJ 07656

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 08/01/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 08/01/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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
6/30/2021

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**