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 01/10/2025

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 000	INITIAL COMMENTS Complaint#s: NJ#169279, NJ#172122, and NJ#172916 Survey Date: 1/10/2025 Census: 180 Sample: 35 sample + 3 closed records =38 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		2/10/25

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

Electronically Signed | 01/31/2025

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility-provided documents, it was determined that the facility failed to ensure that a.) meals were consistently provided in a dignified and homelike manner. The deficient practice was observed in the recreation dining area for 2 of 6 residents (Residents #103 & #147). The deficient practice was evidenced by the following: The surveyor reviewed the electronic medical records (EMR) for Resident #103 and Resident #147. Resident #103: The Admission Record (AR; an admission summary), revealed that the resident was admitted with diagnoses which included but are	F 550	How the corrective action will be accomplished for any resident affected by deficient practice: Residents #103 & #147 meal trays are now delivered on the same food truck and staff will serve meals for these residents on the same table at the same time. A list of residents attending the dining room is provided daily to Dietary Department to ensure the residents meal trays are served consistently together. Residents #103 & #147 NJ Exec Order 26.4b [redacted] with this deficient practice.	

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F 550	Continued From page 2 not limited to, *NJ Ex Order 26. 4B1* [redacted].	F 550	All residents who attend the dining room were observed and monitored after it was identified that they were not offered hand hygiene and there are no adverse effects noted.	
	A comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted], indicated the facility assessed the resident's [redacted] using a Brief Interview for Mental Status (BIMS) test, Resident #103 scored a [redacted] out of 15, which indicated the resident had no [redacted].		How we identified other residents/areas that could potentially be affected: Residents receiving meals have the potential to be affected by this deficient practice.	
	Resident #147: The AR revealed that the resident was admitted with diagnoses which included but are not limited to, *NJ Ex Order 26. 4B1* [redacted].			
	The MDS with an ARD of [redacted] of Resident #147 had a BIMS score of [redacted] out of 15, which indicated the resident had no [redacted].		Measures to ensure were/will be put into place to assist this area of concern: Infection Preventionist/Designee educated staff on 1/17/2025 & 1/20/2025 about serving one table at a time in the dining area at the same time ensuring all residents on the same table have their meal trays. Infection Preventionist educated staff on 1/17/2025 about hand hygiene when serving residents their meals.	
	On 1/7/25 at 12:33 PM, the surveyor observed the Dietary Staff (DS) deliver a food truck marked 3W #1 to the floor. On that same date at 12:43 PM, a second food truck marked 3W #2 brought to the floor. At 12:51 PM, the surveyor observed 1 of 2 residents, Resident #103, at a table in the recreation dining area of [redacted] receive a meal tray and begin to eat. The other resident at the table, Resident #147, did not receive a meal tray.			

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F 550	Continued From page 3 The surveyor observed staff members removed trays from the food trucks and delivered 1 tray at a time to various residents located on the unit in their rooms or in the hallway. At 12:55 PM, the surveyor observed a 3rd food truck brought onto the floor by DS and left. At 12:59 PM the surveyor observed a [redacted] with an ID (identification) that reflected that they were a *U.S. FOIA (b) (6)* [redacted] brought a tray to another resident at a different table and began to assist the resident to eat. Another staff member brought another tray to a second resident at the same table. The [redacted] then helped that resident begin eating and was actively helping the resident to eat. The surveyor did not observe any hand hygiene for either residents or for the [redacted]. The surveyor asked the [redacted] if those 2 residents required help eating. The [redacted] stated, yes, they are both feeders. The surveyor asked the [redacted] if hand hygiene was performed for the residents. The [redacted] did not have a clear answer for the surveyor. At 1:17 PM, the surveyor observed Resident #147, who was seated at the 1st table with Resident #103, got a meal tray. The surveyor observed the finished meal trays of several residents. The meal trays contained individually wrapped hand wipes/moist towelettes. The surveyor observed that at least three (3) of the packs of wipes were unopened and not used. On 1/8/25 at 12:59 PM, the survey team met with the *U.S. FOIA (b) (6)*	F 550	Unit Managers/Designee will monitor dining areas to ensure meals are being properly distributed to residents consistently, and residents are offered/assisted with hand hygiene. Notify Dietary Department immediately for any changes in the resident list of who eats in the dining room to ensure meal trays are delivered and served at the same time. Meal trays are delivered on the same food truck based on the resident list that is reviewed daily by the unit manager. Residents will be offered or assisted with hand hygiene by utilizing the individual packet of wipes on residents trays. Alcohol hand wipes are maintained in the dining rooms to be used as needed. Ongoing observations from Recreation Director/designee of the dining areas will be implemented to ensure consistently with meal trays and hand hygiene with staff. How the concern will be monitored and title of person responsible for monitoring: Unit managers/designee will do weekly audits of each dining area for 3 months	

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F 550	Continued From page 4 U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) to discuss concerns with residents in the dining area not being served at the same time and hand hygiene. On 1/9/25 at 10:37 PM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA (b) for responses to the dining concerns. The U.S. FOIA (b) (6) stated that during the lunch meal pass, some residents that sit together may have trays in different trucks. The surveyor asked the U.S. FOIA (b) (6) if serving residents at same table 26 minutes apart would be considered dignified and home-like. The U.S. FOIA (b) (6) stated, no, but they will try to have all residents a table served at the same time. The U.S. FOIA (b) (6) stated that staff will be educated on hand hygiene for residents at mealtimes. A review of the facility's Food and Dining Service Policy, with a reviewed date of 10/2024 revealed: Policy Explanation and Procedures: Nursing staff will remind all residents of the meal. Nursing is responsible for those needing help. Individuals are assisted to prepare for the meal (..hands washed, etc.). Individuals are offered (or assisted to use) a hand wipe or cloth to wipe their hands prior to leaving the dining room. Eating Environment: Nursing Services personnel will help to seat and position residents and identify factors that might adversely affect food intake. All residents seated at a table will be served together, when feasible. On 1/10/25 at 11:26 AM, they survey team met with the U.S. FOIA (b) (6). The facility did not provide any further pertinent information.	F 550	for meal tray distribution and hand hygiene. Results of this audit and observations will be discussed in the morning clinical meeting for immediate resolution. Director of Recreation /Designee will present 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.	

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F 550	Continued From page 5 NJAC 8:39-4.1(a),12,28;27.1(a);27.3(a)	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		2/10/25

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F 584	Continued From page 6 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: COMPLAINT #NJ172916 Based on observation, interview, and record review, it was determined that the facility failed to maintain residents' environment in a safe, clean, comfortable, and homelike surrounding for 3 of 35 residents reviewed, Resident #2, #121 and #109. The deficient practice was evidenced by the following: 1. On 1/8/25 at 9:59 AM, the surveyor and the [U.S. FOI] observed in Room [NJ Ex Order 26.] Resident #2 sitting on the [NJ Ex Order 26. 4B1], privacy curtain was missing, and a black, portable fan on top of the bedside table was on with a large amount of dust accumulation on the front grill. The surveyor and [U.S. FOI] observed [NJ Ex Order 26.] Resident #121 sitting on the [NJ Ex Or]. The surveyor and the [U.S. FOI] observed in the Room [NJ Ex Or] the broken shade by the window; the bottom part of the two overbed tables with splattered white substances; the bathroom soap dispenser broken off the wall and laying on the garbage can; the floors in the residents' room and bathroom with dark black stains. The [U.S. FOI] completed a finger swipe test on the surface of the overbed lighting for dust on Room [NJ Ex Order 26.] and found an accumulation of dust. The [U.S. FOI] confirmed all the findings.	F 584	How the corrective action will be accomplished for any resident affected by deficient practice: Resident #2 room was evaluated. Privacy curtain was put back up immediately from the laundry. Black portable fan was immediately cleaned and free from dust. The overbed table was also thoroughly cleaned. The bathroom wall was fixed immediately. The broken soap dispenser was replaced and placed back on the bathroom wall immediately. Resident #121 room was evaluated. Broken blinds were fixed. The overbed table was thoroughly cleaned. Resident #109 room was evaluated. Brown substance on wall was removed. Broken blinds were fixed. Room [NJ Ex Or] was deep cleaned on 1/29/25 by buffing floors. Both overbed lights were cleaned and free from dust. How we identified other residents/areas	

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F 584	Continued From page 7 At that time, the U.S. FOIA (b) (6) entered the room and confirmed all the issues found. Resident #121 stated, "NJ Ex Order 26. 4B1 " and Resident #2, stated, "NJ Ex Order 26. 4B1 " The surveyor reviewed the medical records and revealed: Resident's #2's Annual Minimum Data Set (MDS), an assessment tool used to facilitate the plan of care, with an assessment reference date (ARD) of NJ Ex Order 26. 4B1, revealed a Brief Interview of Mental Status (BIMS) score of NJ Ex out of 15 indicated NJ Ex Order 26. 4B1. Resident #121's Quarterly MDS (QMDS), with an ARD of NJ Ex Order 26. 4B1 revealed a BIMS score of NJ Ex out of 15, indicated NJ Ex Order 26. 4B1. 2. On 1/8/25 at 10:06 AM, the surveyor in the presence of the U.S. FOIA (b) observed the wall near the doorway in the Room NJ Ex Ord with large amount of brown substances splattered and also observed the broken window shades in the room. The U.S. FOIA (b) confirmed the findings and stated, "NJ Ex Order 26. 4B1 " The surveyor observed Resident #109 was inside the room. A review of the Resident #109's QMDS dated NJ Ex Order 26. 4B1 revealed a BIMS score of NJ Ex out of 15, indicated NJ Ex Order 26. 4B1. A review of the maintenance log for NJ Exec Order 26.4b1 from 5/2024 -12/25/24 revealed no work orders for the concerns above mentioned in rooms NJ Ex Ord	F 584	that could potentially be affected: All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Inservice done on 01/20/25 to all housekeepers was implemented to ensure proper cleaning of every resident room. A weekly deep cleaning schedule implemented and to be signed off by designee when completed. Ongoing training for all housekeepers will be done by maintenance director, assistant administrator/or designee. Window shades vendor was contacted the week of January 20, 2025 for a quote to replace older vertical blinds. This window shade replacement project is anticipated to be done in sections over the next 6 months. Until then, maintenance will continue to check on resident room blinds and repair as needed.	

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F 584	Continued From page 8 and [redacted]. On 1/8/25 at 1:07 PM, the surveyor discussed the concerns above with the *U.S. FOIA (b) (6)* [redacted]. On 1/9/25 at 10:39 AM, the [redacted] and the [redacted] responded to the survey team, "*NJ Ex Order 26. 4B1* [redacted]." On 1/9/25 at 11:31 AM, the surveyor requested for the facility Maintenance/Work Order policy and the [redacted] stated, "*NJ Ex Order 26. 4B1* [redacted]." A review of the facility's Cleaning and Disinfection of Environmental Surfaces Policy and Procedure, revised 10/2024 revealed that the housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily three times per week) and when surfaces are visibly soiled. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. Horizontal surfaces will be wet dusted regularly (e.g., daily, three times per week) using clean cloths moistened with an registered hospital disinfectant (or detergent).	F 584	How the concern will be monitored and title of person responsible for monitoring: Maintenance Director/Designee will audit 5 rooms weekly for 3 months to ensure all residents are in a safe, comfortable, homelike environment. Findings will be addressed immediately. Maintenance Director/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.	

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F 584	Continued From page 9 A review of the facility Policy and Procedure Maintenance Reporting, reviewed 12/2024 revealed that the facility maintains systems to report and resolve all maintenance related concerns, to sustain a safe and comfortable environment.....If the item is deemed irreparable, Maintenance will tag the equipment, take it out of service, and will arrange to order new parts/equipment.	F 584		
F 640 SS=D	NJAC 8:39-31.4(a)(c)(f), 31.8(c)5,7 Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		2/10/25

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F 640	Continued From page 10 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined that the facility failed to transmit the completed Minimum Data Set (MDS), an assessment tool used to facilitate the management of care within fourteen days as required for 2 of 3 residents, Residents #110 and #155 reviewed for system selected for MDS over 120 days, and 1 of 38 residents, Resident #589, in accordance with federal guidelines. This deficient practice was evidenced by the following:	F 640	How the corrective action will be accomplished for any resident affected by deficient practice: Residents #110, #155, #589 MDS was modified to accurately submit the MDS to the Quality Improvement and Evaluation System (QIES). No residents were affected by this deficient practice.	

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F 640	Continued From page 11 1. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #110 and revealed: The Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, U.S. FOIA (b) (6) [redacted]. The most recent Discharge Return Not Anticipated (DRNA) MDS revealed that the assessment was completed but not transmitted. 2. The surveyor reviewed the hybrid medical records of Resident #155 and revealed: The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, NJ Ex Order 26. 4B1 [redacted]. The most recent DRNA MDS revealed that the assessment was completed but not transmitted. On 1/8/25 at 8:33 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted]. The U.S. FOIA (b) (6) informed the surveyor that the facility followed the RAI (Resident Assessment Instrument) Manual as their policy for doing MDS. The surveyor asked the U.S. FOIA (b) (6) when the MDS should be completed and transmitted, and the U.S. FOIA (b) (6) responded that she would get back to	F 640	How we identified other residents/areas that could potentially be affected: All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Minimum Data Set coordinators (MDS) were in-serviced on transmission of MDS assessments on NJ Ex Order 26. 4B1 [redacted]. Minimum Date Set Director/Designee will review and audit MDS completed to ensure proper submission and transmission of MDS Assessments. How the concern will be monitored and title of person responsible for monitoring: Regional Minimum Data Set Director/Designee will audit 5 MDS	

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F 640	Continued From page 12 the surveyor because she did not want to give a wrong answer. The surveyor asked the U.S. FOIA (b) (6) to review Residents #110 and #155's MDS and to let the surveyor know the concerns with both residents' MDS. The surveyor also notified the U.S. FOIA (b) (6) that the surveyor had concerns with residents' MDS transmission. On 1/8/25 at 11:30 AM, the U.S. FOIA (b) (6) stated that Resident #110's and Resident #155'2 DRNA MDS were completed but were not submitted (transmitted). On 1/8/25 at 12:59 PM, the survey team met with the U.S. FOIA (b) (6) The surveyor notified of the above concerns for Residents#155 and #110's MDS that both MDS's were completed but were not submitted in accordance with federal regulations. On 1/10/25 at 11:45 AM, the survey team met with the U.S. FOIA (b) (6) for an exit conference, the facility did not provide additional information. 3. The surveyor reviewed the hybrid medical records of Resident #589 and revealed the following: The AR reflected that Resident #589 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26. 4B1 .	F 640	Assessments weekly for 3 months for timely submission and transmission of MDS Assessments to QIES. Minimum Data Set Director/Designee will present 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.	

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F 640	Continued From page 13 The most recent Discharge Return Anticipated (DRA) MDS dated [NJ Ex Order 26. 4B] revealed that the assessment was completed but not transmitted until [NJ Ex Order 26. 4B]. A review of the "Final Validation Report" given by the [U.S. FOIA (b) (6)] on 1/8/25 at 11:52 AM revealed that "Record Submitted Late: The submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment." On 1/8/25 at 10:49 AM, the surveyor interviewed the [U.S. FOIA (b) (6)], who said they reviewed the DRA MDS assessment and confirmed it was transmitted late. NJAC 8:39-11.1	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 4 of 38 residents, (Residents #38, #118, #176, and #188), reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following:	F 641	How the corrective action will be accomplished for any resident affected by deficient practice: Residents #38, #118, #176, and #188 MDS was modified to accurately reflect the status of the patient.	2/10/25

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F 641	Continued From page 14 A review of the latest version of the MDS 3.0 Manual (updated October 2024), Chapter 1, page 1-5, revealed " ...An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record ...It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT (Interdisciplinary Team) completing the assessment..." Chapter 3, page A-42-43, revealed "Item Rationale o This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning." Coding Instructions o Code 04, Short-Term General Hospital (acute hospital/IPPS): if the resident was discharged to a hospital ..." 1. On 01/06/25 at 12:19 PM, the surveyor observed Resident #38, seated in a [redacted] in their room. The surveyor interviewed the resident regarding a facility acquired [redacted]. Resident #38 stated that they had a [redacted] that was being treated and that they had gotten them in different places and the facility treated them and they healed. A review of Resident #38's Admission Record (AR; or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but	F 641	How we identified other residents/areas that could potentially be affected: All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern: Minimum Data Set coordinators (MDS) were in-serviced on accuracy of MDS coding on 01/13/25. Minimum Date Set Director or designee will review and audit MDS completed to ensure accuracy of coded before it is transmitted. How the concern will be monitored and title of person responsible for monitoring: Regional Minimum Data Set Director/Designee will audit 5 MDS Assessments weekly for accuracy of	

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F 641	Continued From page 15 were not limited to [redacted] A review of Resident #38's most recent significant change MDS (scMDS), indicated a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which reflected that the resident's [redacted] was [redacted]. A review of Resident #38's most recent Discharge Return Anticipated MDS, indicated that Resident #38 did not have any [redacted] when the resident left the facility. A review of Resident #38's most recent readmission MDS indicated that the resident had [redacted] which was present upon admission/readmission and [redacted] which was present upon admission/readmission. A review of Resident #38's most recent scMDS indicated that the resident had [redacted] which was not present upon admission/readmission and [redacted] which was not present upon admission/readmission. A review of Resident #38's [redacted] progress notes (PN) indicated that the resident	F 641	assessment. Minimum Data Set Director/Designee will present 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.	

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returned from the hospital with the [NJ Ex Order 26. 4B1] and that the [NJ Ex Order 26. 4B1] were not facility acquired. Further review reflected that the resident's [NJ Ex Order 26] were [NJ Exec Order 26.4b1]

Further review of the medical records revealed that there was discrepancy on what was documented in the MDS and what was documented in the PN.

On 01/08/25 at 11:35 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] regarding the process for coding the MDS related to [NJ Ex Order 26]. The [U.S. FOIA (b) (6)] stated that she would review the all the assessments and would code the MDS based on that information in the lookback period. The surveyor asked for information on Resident #38's MDS.

On 01/08/25 at 12:52 PM, the [U.S. FOIA (b) (6)] stated that Resident #38's most recent readmission MDS was correct and the resident had [NJ Ex Order 26. 4B1] that were present on readmission. The [U.S. FOIA (b) (6)] stated that Resident #38's most recent scMDS the resident had the [NJ Ex Order 26. 4B1] present on admission and that the [NJ Ex Order 26. 4B1] changed from a [NJ Ex Order 26. 4B1]. The [U.S. FOIA (b) (6)] confirmed that the MDS was coded incorrectly. She then stated she would modify the MDS.

On 01/08/25 at 01:41 PM, the surveyor notified the [U.S. FOIA (b) (6)] the concern that Resident #38's MDS was coded incorrectly.

On 01/09/25 at 11:23 AM, the [U.S. FOIA (b) (6)] stated that

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F 641	Continued From page 17 the resident's MDS had been revised. The facility did not provide any additional information. 2. On 1/6/25 at 12:03 PM, the surveyor observed Resident #118 in bed, with eyes closed. The surveyor further observed the resident using an [redacted] mattress ([redacted]). The surveyor reviewed Resident #118's medical records and revealed: The AR reflected that Resident #118 was admitted to the facility with medical diagnoses which included but not limited to, [redacted]. A review of the quarterly MDS (qMDS), with an assessment reference date (ARD) of [redacted], had a BIMS score of [redacted] out of 15 indicating that the resident had [redacted]. The qMDS under [redacted] revealed that resident used a walker for mobility. The Resident Interdisciplinary Screen dated [redacted] for Resident #118 revealed under Mobility, "[redacted]." On 1/8/25 at 11:37 AM, the surveyor interviewed the [redacted] taking care of the resident who confirmed that Resident #118 does not [redacted] On 1/8/25 at 12:54 PM, the surveyor interviewed	F 641		

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the U.S. FOIA (b) (6) who stated the qMDS was coded in error. The U.S. FOIA (b) (6) also confirmed Resident #118 does not NJ Exec Order 26.4b1 and does not use a NJ Exec Order 26

On 1/8/25 at 1:20 PM, the survey team met with the U.S. FOIA (b) (6) to discuss the above concern. No further information was provided.

3. The surveyor reviewed the medical records of Resident #176 and revealed:

The AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to, NJ Ex Order 26. 4B1 [redacted].

The most recent (modified) comprehensive MDS (cMDS), with an ARD of NJ Ex Order 26. 4B1 revealed in Section C Cognitive Patterns, BIMS score of NJ Ex of 15 which reflected that the resident was NJ Exec Order 26.4b1 was NJ Ex Order 26. 4B1. Section Q Participation in Assessment and Goal Setting included that the resident responded in the interview with regard to the discharge plan. Section V Care Assessment (CAA) Summary #2 for NJ Exec Order 26.4b1 revealed that the resident had a diagnosis of NJ Ex Order 26. 4B1. Section V CAA Summary #4 for NJ Exec Order 26.4b1 revealed that

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the resident's NJ Exec Order 26.4b1 was NJ Ex Order 26. 4B1, the resident's ability to make NJ Exec Order 26.4b1 when spoken to was *NJ Ex Order 26. 4B1* [redacted], and all the resident's needs were anticipated by staff.

Further review of the above cMDS revealed that there was a discrepancy in how the resident was able to answer Section Q and Section V CAA summaries.

On 1/8/25 at 8:33 AM, the surveyor interviewed the U.S. FOIA (b) (6). The U.S. FOIA (b) (6) informed the surveyor that the facility followed the RAI (Resident Assessment Instrument) Manual as their policy for doing MDS. The surveyor notified the U.S. FOIA (b) (6) of the above concerns and findings regarding Resident #176's cMDS, and the U.S. FOIA (b) (6) responded that she would get back to the surveyor.

On 1/8/25 at 11:01 AM, the surveyor notified the US FOIA (b) of the concerns regarding the resident's MDS.

On 1/8/25 at 11:30 AM, the U.S. FOIA (b) (6) stated that Resident #176's MDS with an ARD of NJ Ex Order 26. 4B1 Section Q was miscoded. She further stated that there were many PN that showed that the resident's responsible party (RP) was interviewed for the discharge plan, and that Section Q should have been coded for RP and not the resident. The U.S. FOIA (b) (6) also stated that Section B for communication was also miscoded.

On 1/8/25 at 12:59 PM, the survey team met with the *U.S. FOIA (b) (6)* [redacted]. The surveyor notified the *U.S. FOIA (b) (6)* [redacted] of the above

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F 641	Continued From page 20 findings and concerns for Resident #176. On 1/9/25 at 10:37 AM, the survey team met with the U.S. FOIA (b) (6). The U.S. FOIA (b) (6) stated that the MDS staff had been educated with regard to MDS accuracy. On 1/10/25 at 11:45 AM, the survey team met with the U.S. FOIA (b) (6) for an exit conference and there was no additional information provided. 4. The surveyor reviewed the medical records of Resident #188 and revealed the following: The AR revealed that Resident #188 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26. 4B1 A review of the most recent discharge MDS, with an ARD (the last day of the observation period) of NJ Ex Order 26. 4B1 indicated in Section A Type of Discharge 2. NJ Exec Order 26.4b1 Discharged Status 01. Home/Community (e.g., private home/apartment...) A review of the PN dated NJ Exec Order 26.4b1 revealed that the U.S. FOI brought the resident to the hospital because NJ Exec Order 26.4b1. On 1/8/25 at 10:49 AM, the surveyor interviewed the U.S. FOIA (b) (6). The U.S. FOIA (b) (6) informed the surveyor that	F 641		

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F 641	Continued From page 21 Resident #188 was brought to the hospital by a family member and added that the discharge MDS was miscoded. On 1/8/25 at 01:22 PM, the survey team met with the U.S. FOIA (b) (6) regarding the above concern and the facility did not provide further information.	F 641		
F 657 SS=D	NJAC 8:3-11.1, 11.2(e)(1), 33.2 (d) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		2/10/25

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F 657	Continued From page 22 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise the comprehensive care plans (CP) for 1 of 35 residents reviewed (Resident #118). This deficient practice was identified by the following: On 1/6/25 at 12:03 PM, the surveyor observed Resident #118 in bed, with eyes closed. The surveyor further observed the resident using an NJ Ex Order 26. 4B1 mattress (NJ Ex Order 26. 4B1). The surveyor reviewed Resident #118's hybrid (computer and paper chart) medical records. The Admission Record reflected that Resident #118 was admitted to the facility with medical diagnoses which included but not limited to, NJ Ex Order 26. 4B1 . A review of the Quarterly Assessment Minimum Data Set, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26. 4B1 reflected that the resident had a Brief Interview for Mental Status score of NJ out of 15 indicating that the resident had NJ Ex Order 26. 4B1 . A review of the NJ Ex Order 26. 4B1 Order Summary Report revealed a physician's order dated NJ Ex Order 26. 4B1 for DNR NJ Ex Order 26. 4B1 . The surveyor reviewed Resident #118's list of comprehensive CP's which included a CP titled,	F 657	How the corrective action will be accomplished for any resident affected by deficient practice: Resident #118 care plan was reviewed by Interdisciplinary Team and revised to reflect current care which includes code status, physical functioning status, and resolved the care plan related to risk for elopement. Current Practitioner Orders for Life Sustaining Treatment obtained from the chart and uploaded into electronic medical record. Code status of NJ Ex Order 26. 4B with no NJ Exec Order 26.4b1 updated on 1/11/2025 in orders and care plan. Resident #118 was NJ Exec Order 26.4b1 affected with this deficient practice. How we identified other residents/areas that could potentially be affected: All residents identified with elopement risk have the potential to be affected by this deficient practice.	

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F 657	Continued From page 23 "[Name Redacted] is an NJ Ex Order 26. 4B1 " with a date initiated on NJ Ex Order 26. 4B1 and was revised on NJ Exec Order 26.4 The CP interventions included but were not limited to, NJ Ex Order 26. 4B1 . Another CP titled, "[Name redacted] is NJ Exec Order 26.4b" (NJ Ex Order 26. 4B1). A review of the form titled, "Resident Interdisciplinary Screen" dated NJ Ex Order 26. 4B1 for Resident #118 revealed under NJ Exec Order 26.4b '[NJ Exec Order 26.4b1] On 1/8/25 at 11:37 AM, the surveyor interviewed the U.S. FOIA (b) (6) taking care of the resident who confirmed that Resident #118 does not NJ Ex Order 26. 4B1 and does not have a NJ Ex Order 26. 4B1 . On 1/8/25 at 1:20 PM, the survey team met with the facility's U.S. FOIA (b) (6) to discuss the above concern. On 1/9/25 at 10:40 AM, the U.S. FOIA (b) met with the survey team and stated that the U.S. FOI for Resident #118 was not updated to reflect the current plan of care they are providing the resident. The U.S. FOIA (b) further stated the resident does not have a NJ Ex Order 26. 4B1 and was not at a NJ Exec Order 26.4b for NJ Ex Order 26. 4B1 . The U.S. FOIA (b) also confirmed that Resident #118 was a NJ Exec Orde No further information was provided.	F 657	With regards to code status, all residents identified have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Risk for Elopement assessment will be done on Admission, readmission, quarterly, annually, and with significant change. The outcome of the assessment will be reviewed by Interdisciplinary Team and care plan will be updated immediately and be reviewed for completion in the care planning meeting. Code status changes will be communicated to the specific departments to act accordingly and update the care plans. Director of Nursing provided education on 1/13/2025 to the social workers and unit managers about updating code status changes on the care plans. Director of Nursing provided education 1/13/2025 to the unit managers about updating elopement care plans as changes occur.	

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F 657	Continued From page 24 A review of the facility's policy titled, "Care Plans-Comprehensive" under #9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans:..." NJAC 8:39-11.2(i)	F 657	How the concern will be monitored and title of person responsible for monitoring: Assistant Director of Nursing (ADON)/Designee will review and audit 5 residents with elopement risk monthly for 3 months to ensure that elopement assessment is reflected on the care plan. Social worker/Designee will audit 10 advance directive care plans weekly to ensure code status matches the orders obtained from the chart. Results of this audit and observation will be discussed in the morning clinical meeting for immediate resolution. ADON/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.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at	F 661		2/10/25

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F 661	Continued From page 25 the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of pertinent documents it was determined that the facility failed to ensure residents who were discharged to the community had a discharge order, discharge summary, and care plan. This deficient practice was identified for 2 of 5 residents, Residents #110 and #176, reviewed. This deficient practice was evidenced by the following: 1. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #110 and revealed: The Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, [redacted]	F 661	How the corrective action will be accomplished for any resident affected by deficient practice: Resident #110 was safely discharged back to the community on [redacted]. Resident #176 was safely discharged back to the community on [redacted]. Both residents had Discharge Instructions that include a summary of discharge instructions or precautions of ongoing care, home services, physician contact information, rehab services, nutrition, recreation, nursing care and any additional special instructions, medication list, follow up appointments, and resident/representative education was	

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F 661	Continued From page 26 NJ Ex Order 26. 4B1 [redacted]. A review of the most recent Discharge Return Not Anticipated (DRNA) Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, of Resident #110 revealed in Section A Identification Information that the discharge (d/c) status was coded # [redacted] to the community. Further review of the hybrid medical records revealed that there was no physician order (PO) for d/c, no d/c summary from the physician, and no d/c care plan (CP) was initiated for Resident #110. 2. The surveyor reviewed the hybrid medical records of Resident #176 and revealed: The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, NJ Ex Order 26. 4B1 [redacted]. A review of the most recent DRNA MDS of Resident #176 revealed in Section A that the d/c	F 661	completed by Interdisciplinary team and provided to the resident/designee on day of discharge. Attending physician agreed with this safe discharge and provided discharge medication prescriptions. Discharge instructions for resident # 176 were completed on NJ Ex Order 26. 4B1. Discharge instructions for resident # 110 were completed on NJ Ex Order 26. 4B1. Residents #110 & #176 were not NJ Exec Order 26.4b1 with this deficient practice. How we identified other residents/areas that could potentially be affected: All residents with planned discharge have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Transfer and Discharge Policy was reviewed by the team and Medical Director on 01/17/2025. Discharge Instructions include required elements of a discharge summary.	

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F 661	Continued From page 27 status was coded #[redacted] to the community. Further review of the hybrid medical records revealed that there was no PO for d/c, no d/c summary from the [redacted], and no d/c CP was initiated for Resident #176. On 1/07/25 at 11:47 AM, the surveyor asked the [redacted] to review the provided closed record documents by the [redacted]. The surveyor asked the [redacted] if a resident should have a d/c order, a d/c summary from the [redacted], and a d/c care plan. The [redacted] stated that there should be a d/c order and summary from the [redacted] and all residents should have a d/c care plan. At that same time, after reviewing Resident #176's medical records, the [redacted] stated that there was no d/c order, and the d/c summary of the [redacted] was incomplete. The [redacted] acknowledged that the d/c summary was only dated and signed by the [redacted] but did not include any information about the resident's stay in the facility and status. On 1/8/25 at 12:59 PM, the survey team met with the [redacted]. The surveyor notified the [redacted] of the above findings and concerns regarding Residents #110 and #176's no d/c summaries and d/c orders from the physicians, and no d/c CP. On 1/9/25 at 10:37 AM, the survey team met with the [redacted]. The [redacted] stated that the facility will be doing QA (Quality Assurance) about d/c summaries of the physicians and that the [redacted] will be working with the [redacted]	F 661	Nurse Manager/Designee will ensure that there is a physician□s discharge order during morning clinical meeting. Social Worker will initiate discharge care plan upon admission and update to reflect post discharge plan with participation of resident or representative with resident□s consent. How the concern will be monitored and title of person responsible for monitoring: Social Worker/Designee will review and audit all planned discharges for 3 months to ensure that a physician□s discharge order, discharge care plan, and written physician□s acknowledgement of planned discharge are in place. Results of this audit and observation will be discussed in the morning clinical meeting for immediate resolution. [redacted] 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.	

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F 661	Continued From page 28 [redacted] to enforce it. A review of the facility's Transfer and D/c Policy with a reviewed date of [redacted] that was provided by the [redacted] revealed: Policy Explanation and Procedures: 2. Resident-initiated transfer or d/c ... a. The comprehensive, person-centered CP shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the d/c ... 9. Anticipated Transfer or D/C-initiated by the resident a. Obtain PO for transfer or d/c and instructions or precautions for ongoing care. b. A member of the interdisciplinary team completes relevant sections of the D/C Summary. The nurse caring for the resident at the time of d/c is responsible for ensuring the D/C Summary is complete ... On 1/10/24 at 11:45 AM, the survey team met with the [redacted] for an exit conference and there was no additional information provided.	F 661		
F 684 SS=D	NJAC 8:39-36.1(b)(c) 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	F 684		2/10/25

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F 684	Continued From page 29 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: REPEAT DEFICIENCY Based on observation, interview, review of medical record, and other pertinent documentation, it was determined that the facility failed to ensure NJ Exec Order 26.4b1 were addressed by professional standards by failing to: a.) document a NJ Ex Order 26. 4B1 on the admission assessment, obtain a physician order to assess, document and monitor the NJ Ex Order 26. 4B1, develop a care plan which addressed the NJ Ex Order 26. 4B1 and ensure NJ Exec Order 26.4 follow up for the NJ Ex Order 26. 4B1 for 1 of 5 residents, Resident #119, reviewed for NJ Exec Order 26.4b1 and b.) failed to set the NJ Ex NJ Exec Order 26.4b1 NJ Ex Order 26. 4B1 to reflect the NJ Exec Order 2 of Resident #118 to ensure proper support and comfort. This deficient practice was evidenced by the following: 1. On 1/7/25 at 10:00 AM, the surveyor observed Resident #119 lying in a NJ Exec Order 26.4 against the wall in their NJ Exec Order 26.4b1. According to the Admission Record (AR; or face sheet, an admission summary), Resident #119 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26. 4B1	F 684	How the corrective action will be accomplished for any resident affected by deficient practice: Resident # 119 NJ Exec O was reassessed promptly, U.S. FDA gave order to remove staples, no order to monitor site was necessary. Resident NJ Exec Order 26. on NJ Ex Order 26. 4B1, care plan closed on NJ Exec Order 26.4b1 Resident # 119 was NJ Exec Order 26.4b1 affected with this deficient practice. Resident # 118 NJ Ex NJ Exec Order 26.4b1 was checked and promptly changed to the proper setting according to resident□s NJ Exec Order 26 Care plan was updated accordingly. Resident #118 was NJ Exec Order 26.4b1 affected with this deficient practice. How we identified other residents/areas that could potentially be affected: All residents identified with skin impairment have the potential to be	

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F 684	Continued From page 30 According to the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted], the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated that the resident's [redacted] was [redacted]. The MDS included that the resident had [redacted]. According to the facility's Nursing Admission-Readmission Screening, [redacted] evaluation, dated [redacted], revealed the resident had a current [redacted] or [redacted]. The site that was identified was on the [redacted]. There was no documentation that the resident had [redacted]. According to the facility's [redacted] Assessment/Observation, dated [redacted], under known [redacted], the resident had a [redacted] to the [redacted] with [redacted] to be given every shift and as needed. The area had no [redacted] and [redacted] were to be assessed every shift. The [redacted] had a [redacted] drain to the [redacted] and was monitored for signs and symptoms of [redacted] every shift. There was a [redacted], which no treatment was needed at the time. [redacted] was identified, and a treatment was to apply a [redacted] every shift and as needed for [redacted] protection. Further review revealed that under the question '[redacted]	F 684	affected by this deficient practice. All residents identified with air mattress have the potential to be affected by this deficient practice. All residents with surgical incisions were reviewed on 2/5/25, care plans in place. Measures to ensure were/will be put into place to assist this area of concern: Preadmission clinical review will be available for each resident before admission/readmission. Nurses were in-serviced on 1/17/2025 about skin assessments on admission/readmission, and a second skin assessment will be done within 3 days of admission/readmission. Any new skin findings will be addressed immediately with the physician for orders specific to the resident□s needs. All air mattresses will be checked daily by the primary nurse for proper setting, placement and functioning. Order template was updated on 1/28/2025 to include setting check. All residents admitted/re-admitted with any surgical wound/s will be assessed and care planned accordingly.	

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F 684	Continued From page 31 NJ Ex Order 26. 4B1 [redacted] The Progress Notes (PN) dated NJ Exec Order 26.4b1, included that the resident had a NJ Ex Order 26. 4B1 in the NJ Ex Order 26. 4B1 and a [redacted]. A review of the PN labeled history and physical completed by the resident's U.S. FOIA (b) (6) dated NJ Exec Order 26.4B1 at 11:53 PM included that the resident was admitted to the facility with NJ Ex Order 26. 4B1 [redacted] and that the resident was status post NJ Ex Order 26. 4B1 [redacted] and NJ Ex Order 26. 4B1 [redacted]. A review of a PN dated NJ Exec Order 26.4b1 7:23 PM, late entry with a created date of NJ Exec Order 26.4B1 by the U.S. FOIA [redacted] indicating that there were [redacted] to the NJ Ex Order 26. 4B1 and that there was a follow-up with the U.S. FOIA (b) (6) on NJ Exec Order 26.4b1. A review of a PN dated NJ Exec Order 26.4b1 at 3:57 PM, indicated that the U.S. FOIA (b) (6) followed up with the resident's U.S. FOIA (b) (6) regarding having NJ Ex Order 26 [redacted]. The U.S. FOIA (b) (6) verbalized that he spoke to the U.S. FOIA (b) (6) and stated that the U.S. FOIA (b) (6) said that this was to be expected. There was no documentation that the U.S. FOIA (b) (6) talked to the U.S. FOIA (b) (6) about the NJ Exec Order 26 on the NJ Ex Order 26. 4B1. Further review of the medical records revealed that there were no orders that addressed the [redacted] NJ Exec Order 26 on the resident's NJ Ex Order 26. 4B1 that would include assessment, follow-up, and the removal	F 684	How the concern will be monitored and title of person responsible for monitoring: Unit Managers/Designee will review and audit at least 5 new admission/readmission skin assessments per week for 3 months to ensure that any new finding during the skin assessment is is care planned, monitored, and followed up. Wound Nurse/Designee will review and audit at least 5 air mattresses weekly for 3 months to ensure that the proper setting is appropriate. Results of this audit and observation will be discussed in the morning clinical meeting for immediate resolution. 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.	

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of the [redacted]. The staff did not consistently address or assess the [redacted] and that there were no indications as to when to remove them or how to care for the [redacted].

A review of the resident's personalized Care Plan (CP) included a focus area indicating an actual [redacted] to the [redacted] of the [redacted]. There was no CP that addressed the resident's [redacted] and the [redacted]

On 1/8/25 at 9:38 AM, the surveyor interviewed the [redacted], who stated that she was aware of the [redacted] on the resident's [redacted] and that the [redacted] was to transport the resident to the surgeon's office for a follow-up appointment. The [redacted] further stated that the [redacted] was unable to take them to the appointment. The [redacted] was unable to explain why there was no further follow-up or documentation of the event.

On 1/8/25 at 9:40 AM, the surveyor interviewed the resident's primary Licensed Practical Nurse #1 (LPN#1), who stated that she was the admission nurse, and that the resident when admitted at the facility, the [redacted] was covered at that time. LPN#1 further stated that the physician was aware of the [redacted] on the [redacted]. LPN#1 was unable to explain why there was no documentation in the admission notes or assessment about the [redacted] with [redacted]

On 1/8/25 at 9:42 AM, the surveyor interviewed the [redacted], who stated that the resident was to be transported by the [redacted] on [redacted] for a surgical follow-up, however, the [redacted] stated that

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it was too far to transport the resident. The [redacted] did not provide further information as to why the resident was not seen for a follow-up appointment.

On 1/8/25 at 9:45 AM, the surveyor interviewed the [redacted], who stated that there should have been documentation for the [redacted] and follow-up and that the staples do not usually stay in for that long.

On 1/8/25 at 10:05 AM, the surveyor interviewed the [redacted], who stated that the staff should have called the physician to inform him of the [redacted] and the follow-up that was needed. She further stated that the nurses should have called the specialist's office for further instructions and requested the hospital records and the staff should have had documentation.

On 1/8/25 at 1:11 PM, the survey team met with the [redacted] and the [redacted]. The surveyor notified the [redacted] and the [redacted] of the above findings and concerns.

On 1/8/25 at 2:10 PM, the surveyor interviewed the resident's physician, who stated that the resident had had [redacted] and that he spoke to the staff at the hospital and said that he was unable to find out the exact date of the surgery and was unable to determine how long the [redacted] were intact. He further stated that the resident took a while to heal and that he was aware of the [redacted] which were left intact because the resident had had [redacted]. The physician further acknowledged that there was no documentation of the [redacted]

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F 684	Continued From page 34 on the history and physical or physician's PN. A review of a nurses PN dated [NJ Exec Order] at 5:10 PM, revealed that the Physician removed the [NJ Ex.] staples from the resident's [NJ Ex Order 26. 4B1]. Further review of the medical records revealed that there was no documented evidence that the resident's [NJ Ex.] [NJ Exec Order 26] were identified, assessed, care planned, and obtained an order for care until the surveyor's inquiry. On 1/9/25 at 10:38 AM, the surveyor met with the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b)], and the [U.S. FOIA (b) (6)] stated that she acknowledged that the [NJ Exec Order 26] were not addressed or monitored consistently and that the staples should have been addressed and monitored because doing so would ensure that the staff would not lose sight of the [NJ Exec Order 26.4]. A review of a facility's Nursing Skin Assessment Policy, effective 10/18 with a review date of 10/24, included that a resident received a full body assessment upon admission, daily for three days, and weekly thereafter. The nurse should document the skin assessment and other information as indicated or appropriate. A review of the facility's Care Plans - Comprehensive Policy, dated 2001, with a revised date of October 2010, revealed that the facility should develop a comprehensive CP that identifies the highest level of functioning the resident may be expected to attain. CP is based on a thorough assessment that includes but is not limited to the MDS. The CP are designed to identify problem areas, incorporate risk factors identified with the problem, reflect treatment goals, timetable, and objectives in measurable	F 684		

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	315438	A. BUILDING _____ B. WING _____	C 01/10/2025

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F 684	Continued From page 35	F 684		

outcomes, and reflect currently recognized standards of practice for problem areas and conditions.

2. On 1/6/25 at 12:03 PM, the surveyor observed Resident #118 in bed, with eyes closed. The surveyor further observed the resident using an [redacted] which showed the AM setting at [redacted] (NJ Exec Order 26.4b1

The surveyor reviewed Resident #118's medical records (MR) and revealed:

The AR reflected that Resident #118 was admitted to the facility with medical diagnoses which included but not limited to, [redacted]

Further review of the resident's MR indicated that the resident's most recent weight was [redacted].

A review of the Quarterly MDS, with an ARD of [redacted] reflected that the resident had a BIMS score of [redacted] out of 15 indicating that the resident had [redacted].

On 1/6/25 at 12:05 PM, the surveyor interviewed LPN#2 who was assigned to Resident #118 inside the resident's room. The surveyor showed the AM setting to LPN#2 who stated that the nurses do not check the AM settings. LPN#2 also stated that the [redacted] would call the nurses' attention if the [redacted] would beep or alarm. LPN#2 in the presence of the surveyor acknowledged that Resident #118 did not weight [redacted]. and changed the setting of the AM to [redacted].

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F 684	Continued From page 36 On 1/8/25 at 1:20 PM, the surveyor met with the U.S. FOIA (b) (6) to discuss the above concern. On 1/9/25 at 10:39 AM, the U.S. FOIA (b) stated to the surveyor that the facility does not have a specific policy on how and when to check the AM. The U.S. FOIA (b) also stated that the AM was delivered on 9/12/24. The U.S. FOIA (b) further acknowledged that the AM must be set according to the resident's NJ Exec Order 2 as indicated. The facility could not provide any accountability of when to check the NJ Exec Order 26.4b1. NJAC 8:39-11.2(i); 27.1	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to ensure that a new intervention was implemented and documented in the resident's care plan after a resident's NJ Exec in order to prevent any additional falls for 1 of 3 residents reviewed for NJ Exec C (Resident #26).	F 689	How the corrective action will be accomplished for any resident affected by deficient practice: Resident #26 fall incident on NJ Ex Order 26. 4B1 was reviewed by Interdisciplinary Team with continued recommendation to check on this resident periodically each shift and	2/10/25

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F 689	Continued From page 37 This deficient practice was evidenced by the following: On 1/6/25 at 11:57 AM, the surveyor observed Resident #26 seated in a [redacted] in the resident's room. The surveyor observed that Resident #26's bed had one side against the wall and was in the [redacted]. The surveyor did not observe a floor mat in the room. A review of Resident #26's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. A review of Resident #26's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which reflected that the resident's [redacted] was [redacted]. Further review of the MDS indicated that under Section [redacted], the resident had a [redacted] with no [redacted] since admission/entry or reentry or the prior assessment. A review of the Resident #26's Progress Notes	F 689	respect resident's desire to remain as independent as possible. IDCP Team reviewed this incident again on 1/28/2025 and agreed that the root cause of this fall was that resident continues to have [redacted] to use the bathroom. A door alarm was ordered and installed on 1/30/25 on the bathroom door to alert staff when resident attempts to use the bathroom, and care plan was updated. Resident #26 was [redacted] affected by this deficient practice. How we identified other residents/areas that could potentially be affected: All residents with fall incident have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Interdisciplinary Team will review each fall	

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F 689	Continued From page 38 (PN) included the following notes: NJ Exec Order 26.4b1 at 4:00 PM, Nursing Note Text: Heard a NJ Exec Order 26.4b1. Proceeded to resident room observed resident NJ Exec Order 26.4b1 Resident stated that NJ Exec Order 26.4b1 Vital signs checked and as follows: NJ Ex Order 26. 4B1 Denied NJ Exec O or NJ Exec Order 26.4b1 Assisted resident to bed. Encouraged resident to use call light for assistance. U.S. FOIA (b) (6) made aware. U.S. FOI made aware awaiting call back. NJ Exec Order 26.4b1 4:08 PM, PN included: Situation: Resident had a NJ Exec on U.S. FOIA (b) (6). NJ Exec Order 26.4b1 in NJ Ex Order 26. 4B1 obtained today NJ Ex Order 26. 4B1. Background: Resident had a NJ Exec on NJ Ex Order 26. 4B1. Complained of NJ Exec O Monday afternoon in NJ Ex Order 26. 4B1 given and order for NJ Ex Order. Assessment (U.S. FOIA (b) (6))/Appearance (U.S. FOIA (b) (6)): Resident unable to range NJ Ex Order 26. 4B1, difficulty straightening NJ Ex O. Remained in bed. Vitals obtained NJ Ex Order 26. 4B1 given with effect. Recommendations: U.S. FOIA (b) (6 contacted U.S. FOI after NJ Ex Order result showing NJ Exec Order 26.4b1 comminuted NJ Ex Order 26. 4B1. Order to send to ER (emergency room). U.S. FOI aware. NJ Exec Order 26.4b1 12:12 AM Nursing Note Text: U.S. FOIA (b) notified this writer that the resident is NJ Exec Order 26.4b1 in the resident's restroom. Resident NJ Exec Order 26.4b1 to the NJ Exec Or but NJ Exec Order 26.4b1 in their NJ Ex Orde and went NJ Exec Order 26.4b1. Resident's vital signs taken and assessed for NJ Exec O and NJ Exec Order 26.4b1. Incident endorsed to the next shift nurse to notify the U.S. FOI	F 689	incident and update the care plan the following workday in morning clinical meeting. This process was reviewed and agreed upon by the team on 1/13/2025. The administrator educated the Interdisciplinary team on 01/13/2025 about timely evaluations of fall incidents the following workday in morning clinical meeting to review plan of care and to establish new appropriate intervention. How the concern will be monitored and title of person responsible for monitoring. Assistant Director of Nursing/Designee will will review and audit at least 20 incident reports each month for 3 months to ensure that new intervention as recommended by the team is reflected on the care plan, or if no new intervention is recommended, that this is specified in the Conclusion and Summary of the incident report. Results of this audit and observation will be discussed in the morning clinical meeting for immediate resolution. Assistant Director of Nursing/Designee will present findings in monthly QAPI for 3	

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F 689	Continued From page 39 and [redacted] in the morning. On 1/7/25 at 11:00 AM, another surveyor requested from the [redacted] the files of any incidents or investigations that Resident #26 had in the last [redacted] A review of Resident #26's individualized care plan (CP) included a focus area of at risk for [redacted] r/t (related to) [redacted] due to [redacted] and use of [redacted]. also [redacted]. Hx (history) of [redacted] Intervention included but were not limited to the following: Anticipate and meet needs. Date Initiated: [redacted] Be sure the call light is within reach and encourage to use it for assistance as needed. Date Initiated: [redacted] CUSTOM [redacted]- Encourage to use the call bell and/or ask for assistance when needs to be toileted. Date Initiated: [redacted] Educate resident to used the side of her w/c pouch to place personal items. Date Initiated: [redacted] Nursing will check on resident periodically during shifts. Date Initiated: [redacted] The following intervention was initiated after Resident #26's [redacted]: Frequent [redacted] and offer assistance to the [redacted] when awake. Date Initiated: [redacted] Further review of the CP, did not have a new intervention initiated after Resident #26's [redacted] On 1/7/25 at 12:34 PM, the surveyor reviewed the	F 689	months and will be a part of quarterly Quality Assurance Performance Improvement (QAPI) where recommendations will be made for continued monitoring.	

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one facility provided incident for Resident #26 which was a [redacted] in NJ Ex Order 26. 4B1 with an [redacted] The facility did not provide an incident report and investigation for Resident #26's fall that occurred in NJ Ex Order 26. 4B1.

On 1/7/25 at 12:45 PM, the surveyor asked the [redacted] if the incident that was provided was the only incident Resident #26 had in the past [redacted]. The [redacted] stated that she [redacted]." The surveyors checked if there was another incident provided and notified the [redacted] that there was only the 1 incident provided. The [redacted] stated that she would '[redacted] NJ Ex Order 26. 4B1 [redacted]."

On 1/8/25 at 9:07 AM, the surveyor reviewed the additional facility provided incident which was an NJ Exec Order 26.4b1 [redacted] dated NJ Ex Order 26. 4B1 which indicated the resident slid off [redacted] and team agreed to check on resident periodically each shift and respect resident's desire to NJ Exec Order 26.4b1 as possible.

On 1/8/25 at 9:11 AM, the surveyor requested that the U.S. FOIA (b) (6) provide a printed copy of Resident #26's CP.

On 1/8/25 at 9:43 AM, the surveyor interviewed Resident #26's [redacted] regarding the process after a fall. The [redacted] stated that the resident would be evaluated and then a PN and incident report would be made. The [redacted] stated that the cause of fall would be investigated and a new intervention would be put in place to try to NJ Exec Order 26.4b1.

A review of the facility provided printed copy of Resident #26's CP included the intervention of '[redacted] NJ Ex Order 26. 4B1

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[redacted] " which had an initiated date of [redacted] and a revision and resolved date of [redacted]. The same intervention that was resolved was then listed again with an initiated date of [redacted] and a revision date of [redacted]. The intervention was not a new and different intervention after the [redacted] fall and was placed on the CP with a new imitated date after surveyor inquiry.

On 1/8/25 at 10:50 AM, the surveyor interviewed the [redacted] regarding the process when a resident had a [redacted] The [redacted] stated that the nurse after assessment of the resident would fill out an incident report. The [redacted] stated that the team would do an investigation of the cause of the [redacted] and implement a new intervention that would be placed on the CP. The surveyor asked the [redacted] for clarification of the revised intervention that was created after surveyor inquiry. The [redacted] stated that she did not know who revised the CP. The surveyor asked if there was a new intervention placed after Resident #26's [redacted] in [redacted]. The [redacted] stated that she would have to check.

On 1/8/25 at 1:40 PM, the surveyor notified the [redacted], the concern that Resident #26 did not have a new intervention implemented and documented on the CP prior to surveyor inquiry.

On 1/9/25 at 11:22 AM, in the presence of the survey team, [redacted] stated that the new intervention was missed being entered into the CP and that it was entered into the CP after the surveyor inquiry.

The facility did not provide any additional information.

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F 689	Continued From page 42 A review of the facility's Falls and Fall Risk, Managing Policy, with a revised date of December 2007, included the following: Policy Statement Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Prioritizing Approaches to Managing Falls and Fall Risk. 4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant ...	F 689		
F 690 SS=D	N.J.A.C. 8:39-27.1 (a) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		2/10/25

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F 690	Continued From page 43 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of pertinent facility documents, the facility failed to: a.) obtain an order and develop a care plan that included interventions for a resident that had an *NJ Ex Order 26. 4B1* and was placed on *NJ Ex Order 26. 4B1* based on current professional standards of practice for 2 of 5 residents reviewed for [redacted], Residents #40 and #115 and b.) ensure an *NJ Ex Order 26. 4B1* and tubing did not touch the floor for 1 of 5 residents, Resident #289, reviewed for *NJ Ex Order 26. 4B1*. This deficient practice was evidenced by the following: 1. On 1/6/25 at 12:03 PM, the surveyor observed Resident #40 seated in a *NJ Ex Order 26. 4B1* in the resident's room, had a *NJ Ex Order 26. 4B1* that was	F 690	How the corrective action will be accomplished for any resident affected by deficient practice: Resident #40 orders and care plan were reviewed and proper orders and care plan for [redacted] were obtained and entered. Resident #40 was NJ Exec Order 26.4b1 affected with this deficient practice. Resident #115 care plan was revised and updated to reflect *NJ Ex Order 26. 4B1*. Resident #115 was NJ Exec Order 26.4b1 affected by this deficient practice. Resident #289 *NJ Ex Order 26. 4B1* was immediately NJ Exec Order 26.4b1 to ensure that it	

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F 690	Continued From page 44 in a [redacted]. The surveyor observed that there was a sign outside Resident #40's room that indicated the resident was on [redacted] A review of Resident #40's Admission Record (AR; or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to [redacted]. A review of Resident #40's quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which reflected that the resident's [redacted]. Further review indicated under [redacted], that the resident had an [redacted] was not rated (resident had a [redacted]). A review of Resident #40's Order Summary Report (OSR) included the following orders: 18 [redacted] placed for [redacted] output every shift. [redacted] care every shift. Further review of Resident #40's OSR did not include an order for [redacted]	F 690	is not touching the floor. Resident #289 was [redacted] affected with this deficient practice. How we identified other residents/areas that could potentially be affected: All residents identified with [redacted] have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Nurses were in-serviced on 1/8/2025 and 1/17/2025 regarding residents who have [redacted] at any point during facility stay will be checked for proper [redacted] (EBP) orders and EBP care plans upon admission or readmission. Care plans for [redacted] will be monitored and updated as needed.	

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F 690	Continued From page 45 A review of Resident #40's individualized care plan (CP) did not include a focused area and interventions related to [NJ Exec Orde] On 1/9/25 at 10:15 AM, the surveyor asked the [U.S. FOIA (b) (6)] if a resident was placed on [NJ Exec Or] if the expectation was to have an order and a CP for [NJ Exec Orde] The [U.S. FOIA (b)] stated that there should be an order and a CP. On 1/9/25 at 12:49 PM, the surveyor notified the [U.S. FOIA (b) (6)] the concern that Resident #40 did not have an order and a CP for [NJ Exec Orde] On 1/10/25 at 11:23 AM, in the presence of the survey team, [U.S. FOIA (b) (6)] stated that Resident #40 had the [NJ Exec Or] signage on the wall and that an order and CP were put in place after surveyor's inquiry. A review of the facility's Care Plans-Comprehensive Policy, with a revised date of October 2010, included the following: Policy Statement An individualized comprehensive CP that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, their family or representative (sponsor), develops and maintains a comprehensive CP for each resident that identifies the highest level of functioning the resident may be expected to attain	F 690	Staff were also in-serviced on 1/8/2025 and 1/17/2025 about Infection control related to urinary care to ensure that foley bags are not touching the floor surface. Infection control education will be ongoing. All residents admitted with a foley catheter or residents with a new foley catheter will be care planned immediately. How the concern will be monitored and title of person responsible for monitoring: Infection Preventionist (IP)/Designee will review and audit at least 5 residents per week for 3 months to ensure that residents with Foley catheter have the proper Enhanced Barrier Precaution (EBP) orders and EBP care plans, as well as proper catheter care and infection control practice is being followed. Results of this audit and observation will be discussed in the morning clinical meeting for immediate resolution. Infection Preventionist (IP)/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be part of	

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	315438	A. BUILDING _____ B. WING _____	C 01/10/2025

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F 690	Continued From page 46 2. The comprehensive CP is based on a thorough assessment that includes, but is not limited to, the MDS. 3. Each resident's comprehensive CP is designed to: i. Reflect currently recognized standards of practice for problem areas and conditions. A review of the facility's Novel and Targeted Mutli-Drug Resistant Organisms (MDROs): Transmission-Based Precautions Policy, with a revised date of 12/16/24, included the following: "EBP are infection control interventions designed to reduce transmission of MDROs in nursing homes. It involves gown and glove use during high-contact resident care activities for residents with known colonization or infection with a MDRO, as well as those at increased risk of MDRO acquisition. If splashes and sprays are anticipated during the high-contact care activity, eye and/or face protection should be used in addition to the gown and gloves .... Procedure: 1. EBP are indicated for a resident with any of the following: a. Infection and colonization with an MDRO when Contact Precautions do not otherwise apply. b. Wounds and/or indwelling medical devices (indwelling urinary catheters, ...etc.) regardless of MDRO status. 2. EBP require the use of gown and glove use during high-contact resident care activities for the indicated resident. 2. On 1/7/25 at 10:06 AM, the surveyor observed Resident #115 in bed with eyes closed. The surveyor interviewed the facility's [redacted] who stated the resident was on an [redacted] due to the use of	F 690	quarterly QAPI where recommendations will be made for continued monitoring.	

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F 690	Continued From page 47 NJ Ex Order 26. 4B1 [redacted].	F 690		

On 1/7/25 at 12:06 PM, the surveyor reviewed Resident #115 's hybrid medical record and revealed:

A review of the qMDS, reflected that the resident had a BIMS score of [redacted] out of 15 indicating that the resident had NJ Ex Order 26. 4B1 [redacted]. Further review of the qMDS revealed Resident #115 had an NJ Ex Order 26. 4B1.

A review of the January 2025 OSR, revealed a physician's order (PO) dated [redacted] to document indwelling catheter output every shift.

The surveyor reviewed the CP for Resident #115 which did reflect the current plan of care for the use of NJ Ex Order 26. 4B1.

On 1/8/25 at 1:20 PM, the survey team met with the U.S. FOIA (b) (6) [redacted] to discuss the above concern.

On 1/9/25 at 10:40 AM, the [redacted] met with the survey team who stated the CP did not reflect the current plan of care for the resident who had an NJ Ex Order 26. 4B1. No further information was provided

3. On 1/6/25 at 12:00 PM, the surveyor observed Resident #289 sitting in bed with a [redacted] that was observed touching the floor.

On 1/06/25 at 12:10 PM, the surveyor interviewed a U.S. FOIA (b) (6) [redacted] who

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F 690	Continued From page 48 acknowledge that the resident's NJ Ex Order 26. 4B1 which was in a NJ Exec Order 26.4b1 was touching the floor. The US FOIA (b acknowledge that the NJ Exec should have been affixed to the resident's bed and should not have been touching the floor. A review of Resident #289's medical record revealed the following: The AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to NJ Ex Order 26. 4B1 [redacted]. A review of the Admission MDS), reflected that Resident #289 had a BIMS score of N out of 15, which indicated the resident's NJ Exec Order 26.4b1 was NJ Ex Order 26. 4B1. Further review of the MDS included the resident had an NJ Ex Order 26. 4B1. On 1/8/25 at 1:00 PM, the surveyor discussed the above concerns with the U.S. FOIA (b) (6). No further information was provided. NJAC 8:39 - 27.1(a)	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		2/10/25

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F 692	Continued From page 49 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to a.) identify, assess, and implement interventions for a resident (Resident #35) with an unplanned *NJ Ex Order 26. 4B1* (or in NJ Exec Order 26.4b1 and or *NJ Ex Order 26. 4B1* in NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 b.) identify, assess, and implement interventions for a resident (Resident #92) with a *NJ Ex Order 26. 4B1* . or *NJ Ex Order 26. 4B1* in NJ Exec Order 26.4b1; c.) identify, assess, and implement interventions for a resident (Resident #3) with a *NJ Ex Order 26. 4B1* lbs. or in NJ Exec Order 26.4b1; d.) obtain, record, and monitor in accordance with	F 692	How the corrective action will be accomplished for any resident affected by deficient practice: Interdisciplinary team, along with the physician reviewed Resident #35□s current medical and NJ Exec Order 26.4b1 in relation to current on *NJ Ex Order 26. 4B1* . reassessment was reviewed on with the physician and revealed that the is consistent with progressive nature of *NJ Ex Order 26. 4B1* .This resident□s medications, mental health and care plan were reviewed and revised on	

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F 692	Continued From page 50 physician's orders; e.) obtain NJ Exec Order 26.4b1 to verify a significant NJ Exec Order change; and f.) monitor the effectiveness of interventions for a resident with a NJ Exec Order 26.4b1. The deficient practice was identified in 3 of 7 residents (Residents #3, #35, and #92) reviewed for NJ Exec Order 26.4b This deficient practice was evidenced by the following: 1. On 1/6/25 at 12:06 PM, the surveyor observed Resident #35 lying in bed, who was NJ Exec O and NJ Exec Order 26.4b1 to the surveyor's greeting. The resident stated, "NJ Ex Order 26. 4B1." The surveyor observed the lunch meal trays had just arrived on the unit, and Resident #35 received their lunch tray which was set up by the nursing staff. On 1/7/25 at 11:13 AM, the surveyor observed Resident #35 lying in bed with an NJ Exec Order 26.4b1 that was within the resident's reach. Resident #35 stated to the surveyor "NJ Ex Order 26. 4B1." At that time, the US FOIA (b)(6) entered the room, spoke with the resident, and went to get assistance for the resident. On 1/8/25 at 9:30 AM, the surveyor reviewed the electronic medical records (EMR) of Resident #35. A review of the Admission Record (AR; an admission summary) reflected the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26. 4B1	F 692	Interdisciplinary team had a conference call with resident #35's responsible party on NJ Ex Order 26. 4B1 to discuss advance care planning due NJ Exec Order 26.4b1 and the options for NJ Exec Order 26.4 and alternative means of NJ Exec Order 26.4b were discussed such as NJ Ex Order which resident's representative NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 was added on on NJ Exec Order 26.4b1 Weekly NJ Exec Order 26.4 initiated on NJ Ex Order 26. 4B1. NJ Exec Order 26.4b1 count on NJ Exec Order 26.4b Interdisciplinary team, along with the physician reviewed Resident #92's current medical and NJ Exec Order 26.4b1 in relation to NJ Exec current NJ Exec Order 2 on NJ Ex Order 26. 4B1. NJ Exec Order 26.4b reassessment revealed that the NJ Exec Order 2 has been NJ Exec Order since NJ Ex Order 26. 4B1. NJ Exec Order 26.4b1 NJ Exec Order 2 committee started. This resident's medications, mental health and NJ Exec Order 26.4b care plan were reviewed and revised on NJ Ex Order 26. 4B1. On NJ Ex Order 26. the following interventions were initiated: Offer culturally preferred snacks such as baked sweet potatoes, hard boiled eggs, and assorted NJ Exec Order 26 pastries between meals. NJ Exec Order 26.4b1. NJ Exec Order daily. Resident #3 was discharged back to the Assisted Living on NJ Ex Order 26. 4B1 with NJ Exec Order . U.S. FOIA (b) (6) will continue to follow up this resident at the Assisted Living. Residents #35, #92 & #3 were not	

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F 692	Continued From page 51 NJ Ex Order 26. 4B1 [redacted] A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], reflected a Brief Interview Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident had NJ Ex Order 26. 4B1 [redacted]. A review of NJ Exec Order 26.4b1 [redacted] revealed the resident was [redacted] and was coded for having a weight loss of [redacted] or more in the NJ Exec Order 26.4b1 or loss of [redacted] or more in the NJ Exec Order 26.4b1 and was not on a physician prescribed NJ Exec Order 26.4b1 regimen. A review of Resident #35's [redacted] revealed: [redacted] or a NJ Ex Order 26. 4B1 in NJ Exec Order 26.4b1) [redacted] ([redacted] or a [redacted] loss NJ Exec Order 26.4b1) There were no documented weights for Resident #35 for NJ Ex Order 26. 4B1 [redacted] and there were no	F 692	NJ Exec Order 26.4b1 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. All residents weights were reviewed for trends and weight changes. Measures to ensure were/will be put into place to assist this area of concern: Per diem U.S. FOIA (b) (6) [redacted] was hired on NJ Ex Order 26. 4B1 [redacted]. A full time [redacted] was added to the staffing budget. Facility will continue to recruit a full time [redacted]. [redacted] were educated on 1/10/2025 and 1/24/2025 about timeliness of documentation and reporting of missing weights to the U.S. FOIA (b) (6) [redacted].	

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F 692	Continued From page 52 corresponding notes or orders in the medical record as to why the resident's [NJ Exec Order 26.4] were not obtained. The resident had a *NJ Ex Order 26. 4B1* [redacted] in [NJ Exec Order 26.4b1] NJ Exec Order 26.4b1) with no documentation of the resident's [NJ Exec Order 26.4b1] until it reached [NJ Ex Order 26. 4B1]. A review of Progress Notes (PN) revealed: A Nutrition/Dietary Note dated [NJ Exec Order 26.4], written by the Registered Dietician (RD #1), documented the resident was noted with [NJ Exec Order 26.4b1] and had *NJ Ex Order 26. 4B1* [redacted] upon admission. RD #1 indicated that the resident was on a *NJ Ex Order 26. 4B1* [redacted] and [NJ Exec Order 26.4b1] may be expected. An Interdisciplinary Care Plan (IDCP) Note dated [NJ Exec Order 2], written by RD #1, documented a quarterly [NJ Exec Order 26.4b] assessment that cultural foods were provided. The resident's [NJ Exec Order 2] was "[NJ Ex Order 26.]" since admission, and the resident's [NJ Exec Order] was [NJ Ex Order 26. 4B1]. The [U.S. FOIA] indicated to continue the current [NJ Exec] for the resident and to monitor [NJ Exec Order 26.4b1]. An IDCP Note dated effective [NJ Exec Order 26.], written by RD #1, included the resident's [NJ Exec Order 2] on [NJ Exec Order 26.4], was [NJ Ex Order 26.]. and the resident's current [NJ Exec Order 2] on [NJ Exec Order 26.4], was [NJ Ex Order 26. 4B1]. RD #1 documented that she spoke with the Resident's Representative (RR #1) about the [NJ Exec Order 26.4b1] who indicated the resident had a history of [NJ Exec Order 26.4b1] at meals, [NJ Exec Order 26.4b1] [redacted], and that [NJ Exec Order 26.4b1] was noted with "*NJ Ex Order 26. 4B1*." RD #1 indicated that Resident #35 had [NJ Ex Order 26. 4] upon admission, a *NJ Ex Order 26. 4B1* [redacted] was	F 692	Designated staff were educated and trained on 1/14/2025 about taking residents weights weekly and as needed. Monthly weights are rotated by specific weeks of the month per unit to spread out monthly weight assessments. [U.S. FOIA] [redacted] are responsible and ensuring that weekly and monthly weights, including reweights, are consistently taken timely. The Weights Committee are meeting weekly to discuss weight changes. [U.S. FOI] communicates with physicians to discuss nutrition plan; *U.S. FOIA (b) (6)* [redacted] assists in communicating with the physician. [U.S. FOI] is documenting weight changes or status and interventions as discussed at the meeting on the same day. *U.S. FOIA (b) (6)* will be notified with any significant weight variances. Designated staff responsible for weighing residents were trained on proper weighing residents on 1/16/25. All residents were re-weighed from 1/16/25 through 2/4/25 by facility trained staff with the supervision of the Dietician to establish a new weight baseline for all residents.	

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F 692	Continued From page 53 in use, and the team was made aware of the NJ Exec Order 26.4b1 RD #1 recommended a NJ Exec Order 26.4b1 weekly NJ Exec Order 26.4 for four weeks, a NJ Exec Order 26.4b1 at lunch, and a NJ Exec Order 26.4b1 twice a day at 10:00 AM and 2:00 PM. A U.S. FOIA (b) (6) PN dated NJ Exec Order 26.4b1, documented the resident had NJ Exec Order 26.4b1. The note indicated a calorie count for three days, weekly weights for four weeks, and laboratory tests were ordered for the next day. A NJ Exec Order 26.4b1 Note dated NJ Exec Order 26.4b1, documented the results of the NJ Exec Order 26.4b1 count that the resident was eating between NJ Ex Order 26. 4B1 of NJ Exec Order and referred to a NP note regarding the resident's NJ Exec Order 26.4b1 The note included the U.S. FOI recommended to continue NJ Exec Order 26.4b1, monitor weekly NJ Exec Order 26.4 and the resident's NJ Exec Order 26.4b1 status. A review of Physician's Orders (PO) for Resident #35 included: A PO dated NJ Exec Order 26, for a NJ Ex Order 26. 4B1 . A PO dated NJ Exec Order 26.4, for NJ Ex Order 26. 4B1 ; give one tab by mouth one time a day for NJ Ex Order 26. 4B1. The order was discontinued (d/c) on NJ Exec Order 26.4b1. A PO dated NJ Ex Order 26. 4B1, to give a NJ Exec Order 26.4b1 two times a day for NJ Exec Order 26.4b1 and record the percentage consumed. A PO dated NJ Ex Order 26. 4B1, to give NJ Exec Order 26.4b1 one time a	F 692	How the concern will be monitored and title of person responsible for monitoring: Minimum Data Set Nurse/Designee will review and audit at least 3 residents listed on the Weights Committee with significant weight change weekly for 3 months to ensure that RD has documented weight changes timely, follow up on new intervention and recommendations. Results of this audit and observation will be discussed in the morning clinical meeting for immediate resolution. Registered Dietician/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) x 3 and will be a part of quarterly QA where recommendations will be made for continued monitoring.	

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F 692	Continued From page 54 day for [NJ Exec Order 26.4b1] and record the percentage consumed. A PO dated [NJ Ex Order 26. 4B], for a [NJ Exec Order 26.4b1] every shift for three days and to ensure [NJ Exec Order 26] count paper was completed after each meal or snack, including [NJ Exec Order 26.4b1] A PO dated [NJ Ex Order 26. 4B], with a start date of [NJ Ex Order 26. 4B1], and an end date of [NJ Ex Order 26. 4B1], to document the resident's weights weekly for four weeks every day shift every Tuesday. These interventions were implemented after the resident lost [NJ Ex Orde] lbs. since admission to the facility. A review of the [*NJ Ex Order 26. 4B1*] electronic Medication Administration Record (eMAR) for the weekly weights for four weeks order entries revealed the following: The [NJ Exec Order 26.4b1] entry was left blank. A review of the corresponding PN did not include the resident's [NJ Exec Order 2] or any documentation as to why the resident's [NJ Exec Order 2] was not obtained. The [NJ Exec Order 26.], entry was signed '[NJ E]' by the [U.S. FOIA (b) (6)] which indicated to "Other/See PN." A review of the corresponding PN did not include a note regarding the resident's [NJ Exec Order 26] The surveyor continued to review the PN which revealed the next documented note the [U.S. FOI] wrote regarding the resident's [*NJ Ex Order 26. 4B1*] was a [NJ Exec Order 26.4b1] Note dated [NJ Exec Order 26.4b1]. The note indicated it was for a follow-up for a [NJ Ex Or] ; that the resident [NJ Exec Order 26.4b] [NJ Ex Order 26. 4B1]. on [NJ Exec Order 26.4], and [NJ Ex Order 26. 4B1]. on [NJ Exec Order 26.4]. RD #1	F 692		

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F 692	Continued From page 55	F 692		

documented that [redacted] persisted despite [redacted] interventions and that [redacted] may also be attributed to [redacted]. RD #1 indicated a [redacted] would be completed to confirm the [redacted] The [redacted] did not include the missing [redacted] from [redacted], and did not assess the effectiveness of the interventions added on [redacted] which were implemented after the resident had a [redacted] since admission to the facility. There was no evidence that the [redacted] continued to monitor the resident's [redacted] status as documented in the [redacted] Note.

A review of the [redacted] Note dated [redacted] documented the [redacted] committee met to review [redacted] for Resident #35. The [redacted] included the resident's [redacted] on [redacted] was [redacted]. The [redacted] recommended to continue the current [redacted] interventions which included [redacted] at breakfast, a [redacted] twice a day, and a [redacted] at lunch. The resident's [redacted] status will continue to be monitored.

A review of an IDCP Note dated [redacted], written by RD #2, indicated that cultural foods were provided and the resident's [redacted] was between [redacted]. Weekly [redacted] were ordered on [redacted]. RD #2's recommendations included to continue current [redacted] interventions and monitor [redacted] status.

An additional review of the Physician's Orders included a PO dated [redacted], with a start date of [redacted], for weekly [redacted] every Monday.

A review of the corresponding [redacted]

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	315438	A. BUILDING _____ B. WING _____	C 01/10/2025

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

(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
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and NJ Exec Order 26.4b1 electronic Treatment Administration Record (eTAR) revealed the following weights:

NJ Exec Order 26.4b1 : NJ Ex Orde lbs.
NJ Exec Order 26.4b NJ Ex Order 2 lbs.
NJ Exec Order : NJ Ex Orde lbs.

A review of the individualized comprehensive care plan (ICCP) included a focus area dated NJ Ex Order 26. 4B, that the resident was at risk for NJ Exec Order 26.4b1 and was revised on NJ Ex Order 26. 4B, to include actual NJ Exec Order 2 loss and NJ Exec Order 26.4b1. Interventions included to monitor NJ Exec Order 26.4b1 status initiated on NJ Ex Order 26. 4B; communicate with the [RR #1] initiated on NJ Ex Order 26. 4B; and to provide NJ Exec Order 26.4b1 and NJ Exec Order 2 initiated on NJ Ex Order 26. 4B.

On 1/8/25 at 10:37 AM, the surveyor interviewed the U.S. FOIA (b) (6) assigned to care for Resident #35, who stated that the facility's protocol was for residents to be NJ Exec Order 26.4B once a NJ Exec Order 26 and the NJ Exec Order 2 was documented in the NJ Exec Order 26.4 section of the EMR. The U.S. FOI stated that if the resident had a PO for NJ Exec Order 26.4 obtained more frequently, the NJ Exec Order 26.4 were documented on the eMAR or eTAR and may also be included in the NJ Exec Order 26.4 section. The U.S. FOI further stated Resident #35 sometimes did not like to eat at mealtime; that they consumed approximately NJ Ex Order 26. 4B1 of meals; and in between meals, they informed staff that they were hungry.

On 1/8/25 at 10:56 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding NJ Exec Order 26.4B who stated that the resident's NJ Exec Order 26.4 were obtained at least monthly and more frequently if there was a PO. The U.S. FOIA (b) (6) stated the nursing staff obtained monthly NJ Exec Order 26.4 in the

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first seven days of the month. The [U.S. FOIA (b) (6)] further explained that she or the assigned nurses informed the [U.S. FOIA (b) (6)] which residents needed to be [NJ Exec Order 26.4B] that day, and the [U.S. FOIA (b)] informed the nurse or [U.S. FOIA (b) (6)] of the residents' obtained [NJ Exec Order 26.4] that they documented in the [NJ Exec Order 26.4] section of the EMR. The [U.S. FOIA (b) (6)] stated the list was given to the [U.S. FOI] to review. The [U.S. FOIA (b) (6)] stated if there was a significant [NJ Exec Order 2] discrepancy from the previous [NJ Exec Order 26] the resident was reweighed to confirm accuracy. The [U.S. FOIA (b) (6)] stated if the resident NJ Exec Order 26.4b1 amount of [NJ Exec Order 26] the [U.S. FOI] and [U.S. FOIA (b) (6)] were notified for recommendations. The [U.S. FOIA (b) (6)] stated if a [NJ Exec Order 2] could not be obtained for a resident, the nurses documented the reason why it was not completed.

At that time, the surveyor and the [U.S. FOIA (b) (6)] reviewed the [NJ Exec Order 26.4] for Resident #35, and the [U.S. FOIA (b) (6)] confirmed there were no [NJ Exec Order 26.4] in [NJ Ex Ord] . The [U.S. FOIA (b) (6)] could not speak to why there were no [NJ Exec Order 26.4] for those months, and the [U.S. FOIA (b) (6)] acknowledged there should have been documentation for why the resident's [NJ Exec Order 26.4] were not obtained. The [U.S. FOIA (b) (6)] confirmed the resident had a *NJ Ex Order 26. 4B1* that was attributed to a *NJ Ex Order 26. 4B1* and was a '*NJ Ex Order 26. 4B1*."

On 1/8/25 at 11:18 AM, the surveyor interviewed RD #1 about the facility's [NJ Exec Order 2] protocol, who stated the [NJ Exec Order 26.4] for all residents were taken once a month unless otherwise indicated in a PO. RD #1 stated all [NJ Exec Order 26.4] were documented in the weights section of the EMR, and she ran a report daily to review the [NJ Exec Order 26.4B] RD #1 stated if there was a discrepancy in the weight or a [NJ Ex Order 26. 4B1]

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F 692	Continued From page 58 NJ Ex Order 26. 4B1, a new NJ Exec Order 2 was obtained immediately. At that same time, the surveyor notified RD #1 of the concern for Resident #35's NJ Ex Order 26. 4B1 and the missing weekly NJ Exec Order 26.4 on NJ Exec Order 26.4b1 and NJ Ex Order 26. 4B. RD #1 stated she would review the EMR and provide additional information. On 1/8/25 at 1:01 PM, the surveyor notified the U.S. FOIA (b) (6) of the concern for Resident #35's NJ Ex Order 26. 4B1 and missing NJ Exec Order 26.4 identified for the resident. The U.S. FOIA (b) (6) stated they would review and provide further responses the next day. On 1/9/25 at 10:37 AM, the U.S. FOIA (b) (6), RD #1, and the U.S. FOIA (b) (6) met with the survey team. The U.S. FOI stated that he examined the resident yesterday (NJ Ex Order 26.) as per facility request and the U.S. FOI stated that the resident had NJ Ex Order 26. 4B1 at home with care regimen, a history of NJ Ex Order 26. 4B1 which the resident received a course of NJ Ex Order 26. 4B1. The U.S. FOI added that the resident was a 'NJ Ex Order 2 ' NJ Ex Order 26. 4B1," and was observed eating that morning their super cereal at breakfast and two-thirds of eggs. The NJ Ex Or stated their current weight was probably their baseline and would recommend to NJ Ex Order 26. 4B1 and NJ Ex Order 26. 4B1. The surveyor asked why the NJ Ex Order 26. 4B1 were not lowered prior to surveyor inquiry, and there was no response. At that time, the surveyor asked about the missing weights from NJ Ex Order 26. 4B1,	F 692		

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F 692	Continued From page 59 and the concern for the NJ Ex Order 26. 4B1 that was identified in NJ Ex Order 26. 4B1 based on the NJ Exec Order 26.4B RD #1 acknowledged the resident's NJ Ex Order 26. 4B1 and the missed monthly NJ Exec Order 26.4B RD #1 stated that her assessments were not only based on the resident's NJ Exec Order 26.4B that she did rounds on the units to observe the resident and the nursing staff informed her if there were concerns with the resident's intake. The surveyor asked RD #1 if she had reviewed the four weekly NJ Exec Order 26.4 requested in NJ Ex Order 26. 4B1 for Resident #35 after the NJ Ex Order 26. 4B1 was identified, and RD #1 stated she reviewed the NJ Exec Order 26.4 on NJ Ex Order 26. 4B1. The U.S. FOO stated the resident's NJ Exec Order 26.4 were NJ Exec Order and acknowledged there were some missing NJ Exec Order 26.4B Additional, RD #1 stated a NJ Exec Order 26.4b1 was completed, and the team discussed the resident being on a NJ Ex Order 26. 4B. There was no additional information provided by the facility. 2. On 1/6/25 at 12:30 PM, the surveyor observed Resident #92 lying on their bed with their eyes closed. The resident had a meal tray unopened on their bedside table. On 1/7/25 at 11:25 AM, the surveyor observed Resident #92 sitting up at the side of their bed with their breakfast tray on the bedside table in front of them. The resident was NJ Exec O and did not respond to the surveyor's greeting. Resident #92 was eating eggs that were on their breakfast meal tray. On 1/9/25 at 9:20 AM, the surveyor reviewed the EMR of Resident #92.	F 692		

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A review of the AR reflected Resident #92 was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26. 4B1 [redacted].

A review of the most recent quarterly MDS dated NJ Ex Order 26. 4B1, indicated a BIMS score of [redacted] out of 15, which indicated the resident had NJ Ex Order 26. 4B1 [redacted]. A review of Section K revealed the resident was coded for having a NJ Exec Order 26.4b1 of [redacted] or more in the NJ Exec Order 26.4b1 or loss of [redacted] or more in the NJ Exec Order 26.4b1 and was not on a physician-prescribed NJ Exec Order 26.4b1 regimen. The resident's [redacted] was coded [redacted] in the MDS.

A review of Resident #92's [redacted] revealed:

[redacted]

A review of PN revealed the following:

A [redacted] Assessment dated [redacted], written by RD #1, documented that RR #2 was present, the resident's food preferences were reviewed

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and per the resident's history, their [redacted] had been [redacted] The resident's current [redacted] was [redacted] and their [redacted]) was within normal limits. The note included recommendations to continue to monitor the resident's [redacted] status and for the resident to continue a [redacted].

A [redacted] Note dated [redacted], written by RD #1, documented that the resident had a [redacted] with a [redacted] of [redacted] on [redacted], and a [redacted] of [redacted] on [redacted]. RD #1 indicated recommendations were to "[redacted]", [redacted] at breakfast, and [redacted] dinner.

A review of the Physician's Orders did not include a PO for [redacted].

A review of an IDCP Note dated [redacted], written by RD #1, indicated a [redacted] follow-up was pending, [redacted] notes, provided liberalized diet, and to continue to monitor.

A review of a [redacted] Note dated [redacted], written by RD #1, indicated a reweigh was pending and [redacted] was reviewed with the IDCP team. The [redacted] indicated recommendations for a [redacted] to be given twice a day, a [redacted], weekly [redacted] for four weeks, liberalize [redacted] at breakfast, and [redacted] at dinner.

A review of the corresponding Physician's Orders included the following POs:

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A PO dated [redacted], for a *NJ Ex Order 26. 4B1* [redacted].

A PO dated [redacted], to obtain [redacted] one time only for one day.

A PO dated [redacted], to give a NJ Exec Order 26.4b1 two times a day for [redacted] mouth and record the percentage consumed.

A PO dated [redacted], for NJ Exec Order 26.4b1 count every shift for three days and to ensure [redacted] was completed after each meal or snack, including [redacted]

A PO dated [redacted], for weekly [redacted] for four weeks every day shift on Wednesday.

The interventions that were implemented on [redacted], which to give a health shake twice a day, a NJ Exec Order 26.4b1, and weekly [redacted] for four weeks were added 48 days after the resident had a *NJ Ex Order 26. 4B1* of [redacted]. on [redacted]. The resident also had continued [redacted] with an additional [redacted]. from *NJ Ex Order 26. 4B1*. There was no PO for [redacted] at breakfast or [redacted] at dinner.

A review of a [redacted] Note dated [redacted] written by RD #1, documented the results of a NJ Exec Order 26.4b1 count indicated that the resident was meeting estimated nutritional needs. The [redacted] recommended to continue current [redacted] interventions, NJ Exec Order 26.4b1 [redacted] twice a day, and to continue to monitor [redacted] trends.

A review of a NJ Exec Order 26.4b1 Note dated

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F 692	Continued From page 63 12/18/24, written by RD #1, documented the resident had a [redacted] gain with an improved [redacted] status. The [redacted] recommended to continue current nutrition interventions. A review of a NJ Exec Order 26.4b1 Note dated [redacted], written by RD #1, documented a [redacted] committee meeting took place to review the resident's NJ Exec Order 26.4b1 loss. The resident had a [redacted] gain with an improved [redacted] status. The note indicated a message was left for RR #2. The [redacted] recommended to continue the current nutrition interventions and to continue to monitor. A review of the NJ Ex Order 26. 4B1 eMAR which revealed that on [redacted], the resident was documented with a weight of [redacted]. A review of the NJ Exec Order 26.4b1 eMAR which revealed the following weights: [redacted] on [redacted] [redacted] on [redacted] [redacted] on [redacted] [redacted] on [redacted] A review of the ICCP included a focus area dated [redacted], for the resident being at risk for [redacted] and revised on [redacted], to reflect an NJ Exec Order 26.4b1. Interventions included to: monitor [redacted] status initiated on [redacted]; regular [redacted] initiated on [redacted], and [redacted] twice a day initiated on [redacted]. The ICCP did not include [redacted] at breakfast and [redacted] at dinner. On 1/9/25 at 11:39 AM, the surveyor interviewed RD #1 about Resident #92's [redacted] from NJ Ex Order 26. 4B1 that was not	F 692		

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documented as assessed until [NJ Exec Order 26.4b] RD #1 stated she would review her notes to provide a response to the surveyor's questions. The surveyor requested any documentation for any weight committee meetings for the resident.

On 1/9/25 at 2:10 PM, RD #1 provided [NJ Exec Order 2] committee meeting sign-in sheets for [NJ Exec Order 26.4] and [NJ Exec Order 26.4b]. The sheet for [NJ Exec Order 26.4] did not include Resident #92. A review of the untitled form dated [NJ Exec Order 26.4b1] included the name, title, and signature of staff who attended the meeting and the name of the residents discussed in the meeting which included Resident #92. The meeting was attended by RD #1, a MDS staff, [U.S. FOIA (b) (6)] of [NJ Exec Order 26.4], and the [U.S. FOIA (b)]. RD #1 did not provide any [NJ Exec Order 2] committee meetings for [NJ Ex Order 26. 4B1], and provided no additional information regarding Resident #92's [NJ Exec Order 26.4b1]

On 1/9/25 at 12:50 PM, the surveyor informed the [U.S. FOIA (b) (6)] of the above concerns for Resident #92's [NJ Ex Order 26. 4B1] between [NJ Ex Order 26. 4B1], and requested additional information.

On 1/10/25 at 11:15 AM, the [U.S. FOIA (b) (6)] met with the survey team. The [U.S. FOIA (b) (6)] stated there was no additional response or information regarding the concern for Resident #92.

3. On 1/7/25 at 9:08 AM, the surveyor observed Resident #3 in bed and watching television. The surveyor attempted an interview but the resident declined.

A review of Resident #3's medical records

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revealed:

A review of the AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to; NJ Ex Order 26. 4B1 [redacted].

A review of the most recent quarterly MDS dated NJ Ex Order 26. 4B1, reflected a BIMS score of [redacted] out of 15, which indicated the resident was NJ Ex Order 26. 4B1 [redacted].

A review of the weights revealed:

NJ Exec Order 26.[redacted]: NJ Ex Order 26. 4B1.
NJ Exec Order 26.4b[redacted]: NJ Ex Order 26. 4B1. ([redacted] or NJ Ex Order 26. 4B1 in a month)
NJ Exec Order 26.4b[redacted]: NJ Ex Order 26. 4B1.
NJ Exec Order 26.[redacted]: NJ Ex Order 26. 4B1.
NJ Exec Order [redacted]: NJ Ex Order 26. 4B1.

A review of the resident's Admission NJ Exec Order 26.4b1 Assessment dated NJ Exec Order 26.4b[redacted], included that RD #1 identified that the resident was NJ Ex Order 26. 4B1. and the resident's NJ Exec Order 26.4b1 was NJ Ex Order 26. 4B1 and the NJ Exec O[redacted] was NJ Ex Order 26. 4B1. The resident was on a NJ Ex Order 26. 4B1 [redacted]. The U.S. POI[redacted] identified the resident reported having a NJ Ex Order 26. 4B1.

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F 692	Continued From page 66 A review of the Nutritional Assessment dated [redacted] at 1:24 PM, revealed that the resident's current [redacted] was [redacted], and that [redacted] was expected with the resident was on a [redacted]. The resident's [redacted] was [redacted] and was [redacted] The [redacted] recommended a [redacted] and to continue monitoring the resident's [redacted] status. There was no [redacted] Note to address the [redacted] on [redacted], or a [redacted] On 1/9/24 at 1:00 PM, the surveyor interviewed RD #1, who stated Resident #3 had [redacted] that contributed to their [redacted]. RD #1 stated that she saw the resident after their re-admission on [redacted], and she was waiting for the resident to be [redacted] that the [redacted] could have happened during the resident's hospitalization. RD #1 acknowledged that the resident had a [redacted] on [redacted], and that the resident should have been [redacted], and that she should have written a [redacted] Note to address the [redacted] or [redacted] The [redacted] stated that the resident's [redacted] was now [redacted] and that she was monitoring the resident's [redacted] On 1/9/24 at 1:30 PM, the surveyor discussed the above concerns with the *U.S. FOIA (b) (6)* [redacted]. No further information was provided. A review of the facility's "Weight Assessment and Intervention Policy" with a last revised date of October 2024, include: Policy Statement: The multidisciplinary team	F 692		

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F 692	Continued From page 67 [MDT] will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Policy Interpretation and Implementation: Weight Assessment 1. The nursing staff will measure the resident's weight on admission, the next day, and weekly for four weeks thereafter. If no weight concerns are noted, weights will be measure monthly thereafter. 2. Weights will be recorded in the Weights and Vitals tab in the EMR. 3. Any weight change of 5% or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will immediately notify the RD. 4. The RD will respond within 24 hours of receipt of notification. 5. The RD will review the unit's weight record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change have been met. 6. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month- 5% weight loss is significant; greater than 5% is severe. b. 3 months-7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months-10% weight loss is significant; greater than 10% is severe. Analysis: 1. Assessment information shall be analyzed by the MDT and conclusions made regarding the: a. The resident's target weight range including rationale if different from ideal body weight. b. Approximate calorie, protein, and other nutrient	F 692		

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	315438	A. BUILDING _____ B. WING _____	C 01/10/2025

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F 692	Continued From page 68 needs compared with the resident's current intake. c. Relationship of current medical condition or clinical situation and recent fluctuations in weight. d. Whether and to what extent weight stabilization or improvement can be anticipated. 2. The physician and the MDT will identify conditions and medication that may be causing anorexia, weight loss or increasing the risk of weight loss. Care Planning 1. Care planning for weight loss or impaired nutrition will be an MDT effort. 2. Individualized CP should address to the extent possible: a. The identified causes of weight loss. b. Goals and benchmarks for improvement. c. Time frames and parameters for monitoring and reassessment. NJAC 8:39 - 11.2(e)(1)(f), 17.1(c), 17.2(c)(d), 27.1(a)	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY	F 695	How the corrective action will be accomplished for any resident affected by	2/10/25

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F 695	Continued From page 69 Based on observation, interview, and record review, it was determined that the facility failed to follow a Physician's Order in accordance with professional standards of practice for 2 of 4 residents, Resident #58 and Resident #105), reviewed for NJ Ex Order 26. 4B1. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 1/6/25 12:08 PM, the surveyor observed Resident #58 in bed with eyes closed, with an	F 695	deficient practice: Residents #58 and #105 had their NJ Ex Order 26. 4B [redacted] set according to physician orders. Residents #58 and # 105 NJ Exec Order 26.4B [redacted] with this deficient practice. How we identified other residents/areas that could potentially be affected: All residents identified with oxygen have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: All residents who have oxygen orders will have proper settings according to physician orders. Primary nurses were in-serviced on 1/8/2025 and 01/17/25 on oxygen delivery to correspond to the physician's order. Primary nurses will check O2 settings at	

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F 695	Continued From page 70 NJ Ex Order 26. 4B1 [redacted]. The surveyor reviewed the Admission Record (AR; or face sheet; an admission summary) which revealed that the resident had been admitted to the facility with diagnosis that included NJ Ex Order 26. 4B1 [redacted]. A review of the Significant Change Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted], revealed that the resident had a score of [redacted] out of 15 on the Brief Interview for Mental Status (BIMS), which indicated that the resident had NJ Ex Order 26. 4B1 [redacted]. The MDS also reflected that the resident received NJ Ex Order 26. 4B1 [redacted]. A review of the physician order (PO) for Resident #58 revealed a PO, dated NJ Exec Order 26.4b1 for NJ Ex Order 26. 4B1 [redacted]. On 1/7/25 at 10:30 PM, the surveyor observed Resident #58 in bed with eyes closed, with an NJ Ex O [redacted] at NJ Ex Order 26. 4B1 [redacted]. The Surveyor was joined by Licensed Practical Nurse #1 (LPN#1) confirmed NJ Ex O [redacted] was running at NJ Ex Order 26. 4B1 [redacted]. LPN #1 could not state why the NJ Ex O [redacted] was not set correctly according	F 695	eye level every shift to ensure accuracy of oxygen delivery. How the concern will be monitored and title of person responsible for monitoring: Nursing Supervisors/Designee will review and audit at least 5 residents per week for 3 months to ensure that resident's oxygen delivery corresponds to the physician order. Any negative findings of this audit and observation will be addressed immediately. 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.	

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F 695	Continued From page 71 to the PO at [redacted].	F 695		

2. On 1/7/25 at 12:10 PM, the surveyor observed resident #105 in bed with eyes closed, with an [redacted] at a set between [redacted].

The surveyor reviewed the AR which revealed that the resident had been admitted to the facility with diagnosis that included [redacted].

A review of the Annual MDS, with an ARD of [redacted], revealed that the resident had a score of [redacted] out of 15 on the BIMS, which indicated that the resident had [redacted]. The MDS also revealed that the resident received [redacted].

A review of the PO for Resident #105 revealed a PO, dated [redacted], for [redacted].

On 1/9/25 at 10:37 AM, the survey team met with the [redacted] to review concern. The [redacted] stated all [redacted] setting should be set per PO.

On 1/9/25 at 12:04 PM the surveyor observed Resident #105's [redacted] at a rate of [redacted]. The surveyor interviewed the [redacted]. The surveyor showed the [redacted] the resident's [redacted] setting. The [redacted] agreed that it looked like [redacted]. The [redacted] adjusted the rate to [redacted].

On 1/9/25 at 12:10 PM the surveyor interviewed

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F 695	Continued From page 72 LPN#2 assigned to resident #105. The surveyor asked LPN#2 what the NJ Ex Order 26. 4B1 should be set for. LPN#2 proceeded to check the PO and stated NJ Ex Order 26. 4. The surveyor showed LPN#2 the NJ Ex Order 26. 4B1, LPN#2 stated it looked like NJ Ex Order 26. 4. On 1/9/25 at 12:53 PM, the survey team met with the U.S. FOIA (b) (6) for response to concerns. The U.S. FOIA (b) stated that the staff may be looking at the gauge at a down angle and not reading the rate correctly. A review of the facility's Oxygen Administration Policy, with a revised date of 10/2010, that was provided by the U.S. FOIA (b) (6) revealed that the preparation guidelines it states, 1. Verify that there is a PO for this procedure. Review the PO for facility protocol for NJ Ex O administration. On 1/10/25 at 1:30 PM, the survey team met with the U.S. FOIA (b) (6) for an exit conference. The facility did not provide any further pertinent information.	F 695		
F 698 SS=D	NJAC 8:39- 27.1 (a) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 698	How the corrective action will be	2/10/25

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F 698	Continued From page 73 review, it was determined that the facility failed to a.) complete the NJ Ex Order 26. 4B1 Communication Record, NJ Exec Order 26.4b1 and/or NJ Ex Order 26. 4B1 for 7 of 16 days and b.) ensure a resident was placed on a NJ Ex Order 26. 4B1 as recommended by the NJ Ex Order 26. 4B1 or documented the reason the recommendation was not followed for 1 of 1 resident reviewed for NJ Ex Order 26. 4B, Resident #76. This deficient practice was evidenced by the following: On 1/6/25 at 11:43 AM, the surveyor interviewed Resident #76 who was seated in a NJ Ex Order 26. 4B1 in the resident's room. Resident #76 stated that they received NJ Ex Order 26. 4B1 3 times a week. The surveyor asked Resident #76 if they were on a NJ Ex Order 26. 4B1. Resident #76 stated yes. A review of Resident #76's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26. 4B1 [redacted]. A review of Resident #76's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which reflected that the resident's NJ Ex Order 26. 4B1. Further review	F 698	accomplished for any resident affected by deficient practice: Resident #76 NJ Ex Order 26. 4B1 recommendation was obtained on NJ Exec Order 26.4b1 and it was communicated with the physician. An order for NJ Ex Order 26. 4B1 [redacted] was obtained and entered. Resident #76 was not negatively affected with this deficient practice. How we identified other residents/areas that could potentially be affected: All residents on hemodialysis have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Nurses were in-serviced on 01/17/25 about the procedure of filling, reviewing, and acknowledging pre-and-post dialysis information of residents, and communicating with physician and clinical	

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F 698	Continued From page 74 indicated the resident was receiving NJ Ex Order 26. 4B1 services while a resident. On 1/8/25 at 10:01 AM, the surveyor interviewed Resident #76's U.S. FOIA (b) (6) regarding the process of the communication between the facility and the NJ Ex Order 26. 4B1. The U.S. FOIA stated that the resident had a binder filled with NJ Ex Order 26. 4B1 NJ Exec Order 26.4b1 and that the facility filled out the top section of the NJ Exec Orde prior to the resident going to the NJ Ex Order 26. 4B and the bottom section when the resident returned from the NJ Ex Order 26. 4B1. She added that the NJ Ex Order 26. 4B1 filled out the middle section. The surveyor asked the U.S. FOIA if the expectation was that all 3 sections were to be filled out. The U.S. FOIA stated that all 3 sections should be filled out. The surveyor then asked to view Resident #76's binder. A review of Resident #76's NJ Exec Orde included the following: The NJ Exec Order dated NJ Ex Order 26. 4B1 did not have the NJ Ex Order 26. 4B1 section on the form filled out. Some of these forms did not have a section on the form labeled for NJ Ex Order 26. 4B1. The NJ Exec Order dated NJ Exec Order 26.4b1 did not have the NJ Ex Order 26. 4B1 section filled out by the facility. The U.S. FOIA confirmed that some of the NJ Exec Order were not filled out completely. On 1/8/25 at 10:59 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding the process for NJ Exec Orde The U.S. FOIA (b) stated that the	F 698	dietician as needed. The primary nurse will complete the communication form pre and post dialysis. The primary nurse will review recommendations upon the resident's return to ensure that the recommendations and complete information are communicated to the physician or Interdisciplinary team members timely. The clinical dietician will review preadmission records and communicate with dialysis dietician upon admission to ensure that fluid restriction recommendations are in place. The admitting nurse will review admission medical records and transcribe fluid restrictions orders accurately. The Unit Manager will bring the pre-admission intake form that was implemented on 01/17/25 to capture clinical acuities and needs at the morning meeting for further review. How the concern will be monitored and title of person responsible for monitoring: Minimum Data Set Coordinator/Designee will review and audit all residents receiving	

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F 698	Continued From page 75 resident had a [redacted] binder which contained forms for the facility nurse to fill out prior to going to the [redacted], a section for the [redacted] to fill out and a section for the facility nurse to fill out when the resident returned to the facility after the [redacted]. The surveyor showed the [redacted] Resident #76's incomplete [redacted] The [redacted] stated that the [redacted] should have been filled out. On 1/8/25 at 11:53 AM, the surveyor reviewed Resident #76's electronic medical record which revealed the following: A review of an uploaded document to the miscellaneous tab included a Progress Note (PN) from the sister facility that Resident #76 resided at prior to the residents transfer to the resident's current facility. A review of the PN with an effective date of [redacted] included the following: Patient returned from [redacted] around 7:45 pm with communication to monitor [redacted] and maintain [redacted] is being monitored, patient is [redacted] with [redacted] at times. re-education provided. Will continue to monitor. A review of the PN with an effective date of [redacted] included the following: Picked up by ambulance for extra [redacted] ...Resident on strict [redacted]. A review of Resident #76's Physician Order (PO) Summary Report did not include an order for a [redacted]. A review of Resident #76's [redacted] assessment dated [redacted] included the following: [redacted].	F 698	dialysis weekly for 3 months to ensure all pre and post hemodialysis communication records are complete and that recommendations are followed up. Unit Managers/Designee will audit that all residents on dialysis have accurate fluid restriction orders. Results of this audit and observation will be promptly addressed and discussed at the daily clinical meeting for immediate resolution. Director of Nursing (DON)/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be part of quarterly QA where recommendations will be made for continued monitoring.	

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F 698	Continued From page 76 A review Resident #76's [NJ Exec Order 26.4b] assessment dated [NJ Exec Order 26.4b] included the following under plan/recommendation: re-admission [NJ Exec O]... [NJ Ex Order 26.] [redacted] during hospitalization, [NJ Ex Order 26. 4B1] on admission, risk of [NJ Exec Order 26.4b1] - [NJ Exec O] [redacted] .... A review of Resident #76's [NJ Exec Order 26.4b] note dated [NJ Exec Order 26.4b1] included the following: Spoke with [U.S. FOI] [redacted] at [NJ Exec] center. [NJ Exec Order 26.4b1] "[NJ Ex Order 26. 4B1]" at times. Noted with [NJ Exec Order 26.4b1] [redacted]. On 1/8/25 at 01:41 PM, the surveyor notified the *U.S. FOIA (b) (6)* [redacted] the concern that 7 of 16 [NJ Exec Order] for Resident #76 were not filled out completely. On 1/9/25 at 9:36 AM, the surveyor, via phone call on speaker, interviewed the *U.S. FOIA (b) (6)* [redacted] of Resident #76's [NJ Exec Order 26.] center. The [U.S. FOI] stated that the recommendation for Resident #76 was a *NJ Ex Order 26. 4B1* [redacted]. The surveyor asked if there should be an order for the *NJ Ex Order 26. 4B1*. The [U.S. FOI] stated that she did not know how the facility managed a [NJ Ex Orde] [redacted]. The [U.S. FOI] stated that she would expect that Resident #76 would be on a *NJ Ex Order 26. 4B1* and that she was pretty sure she spoke with the facility's [NJ Exec Order 26.4b] about the *NJ Ex Order 26. 4B1*. On 1/9/25 at 9:40 AM, the surveyor via phone call on speaker, interviewed the [NJ Exec Order 26.] center's *U.S. FOIA (b) (6)* [redacted] regarding Resident #76. The [U.S. FOIA (b) (6)] stated that Resident #76's [NJ Exec O] order at the center included a *NJ Ex Order 26. 4B1* [redacted]. The [U.S. FOIA (b) (6)] stated that she had started in [NJ Exec Order 26.4b] and that the previous [NJ Exec Order 26.4b1]	F 698		

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assessment had a NJ Ex Order 26. 4B1. The U.S. FOIA (b) (6) stated that she checks in with the facility NJ Exec Order 26.4b1 each month with labwork (laboratory work).

On 1/9/25 at 11:23 AM, in the presence of the survey team and U.S. FOIA (b) (6) stated that education was provided to staff regarding filling out NJ Exec Order 2

On 1/9/25 at 11:39 AM, the surveyor interviewed the facility's U.S. FOIA (b) (6) regarding the process for a NJ Ex Order 26. 4B1 t. The U.S. FOI stated that she started with a regular nutrition assessment and that she communicated with the U.S. FOIA (b) (6). The surveyor asked if Resident #76 was on a NJ Ex Order 26. 4B1. The U.S. FOI stated that Resident #76 was not on a NJ Ex Order 26. 4B1. She stated that she spoke with the U.S. FOIA (b) (6) on NJ Ex Order 26. 4B1 and that she had said that the resident's NJ Exec Order 2 NJ Exec O was a little high at times. The surveyor asked the U.S. FOI if a NJ Ex Order 26. 4B1 was discussed. The U.S. FOI stated that she did not write in her note about a discussion. She added that she does not initiate a NJ Ex Order 26. 4B1 unless it was ordered by the physician or recommended by the U.S. FOIA (b) (6).

On 1/9/25 at 11:51 AM, the surveyor interviewed Resident #76 who confirmed that he/she was on a NJ Ex Order 26. 4B1.

On 1/9/25 at 11:52 AM, the surveyor interviewed Resident #76's U.S. FOIA regarding a NJ Ex Order 26. 4B1. The U.S. FOIA stated that the resident was not on a NJ Ex Order 26. 4B1. The surveyor asked the U.S. FOIA what the process was when a resident was admitted from the hospital and/or another facility. The U.S. FOIA stated that the nurse that admitted the resident would review the papers that came from the

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hospital or other facility and would confirm with the physician if an order for [redacted] would be continued.

On 1/9/25 at 12:03 PM, the surveyor interviewed Resident #76's [redacted] regarding the resident and if the resident was on a [redacted] or if it was recommended. The [redacted] stated that he did not believe it was recommended. He added that it was patient preference and if the resident wanted to eat more and enough [redacted] was coming out during [redacted]. The [redacted] stated that he rather the resident eat their food and not be on restriction and that if the resident wanted to drink something then they should have it. He added that he may be going against the [redacted] wishes.

On 1/9/25 at 12:20 PM, the surveyor requested from the [redacted] Resident #76's hospital record and transfer forms from the facility that the resident resided at prior to the hospitalization. The surveyor also requested the [redacted] that were not in Resident #76's [redacted] binder prior to [redacted].

On 1/9/25 at 12:49 PM, the surveyor notified the [redacted], the concern that Resident #76's order for a [redacted] from the previous facility was not addressed by the new current facility and the recommendation for a [redacted] was not followed.

On 1/9/25 at 12:55 PM, the surveyor reviewed the facility provided PO Summary Report from Resident #76's previous facility which included an order for [redacted] in 24 hours.

A review of Resident #76's electronic medical

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

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F 698	Continued From page 79 record did not include any documentation that addressed an assessment for the continuation or discontinuation of a [NJ Ex Order 26. 4B1] order for Resident #76. On 1/10/25 at 11:21 AM, in the presence of the survey team, [U.S. FOIA (b) (6)] stated that they had missed the order that Resident #76 was on a [NJ Ex Order 26. 4B1]. She added that they did not see any communication from the [NJ Ex Order 26. 4B1] regarding a [NJ Ex Order 26. 4B1]. The [U.S. FOIA (b)] stated that the facility could not find the [NJ Exec Order] that were prior to the ones that were in the binder that the surveyor reviewed. The [U.S. FOIA (b)] stated that the [U.S. FOI] did not feel that the resident needed a [NJ Ex Orde] anymore. The facility did not provide any further information. A review of the facility's Care of the Resident Receiving Dialysis Treatments Policy, with a reviewed date of 10/2024 included the following: Policy: To prevent complications such as fluid overload, infection or clotting of the access area, or hemorrhage in residents receiving dialysis. Policy Explanation and Procedures 1. Monitor for signs of fluid overload secondary to little or no renal function: a. Monitor feet and hands for edema b. Monitor for elevated blood pressure, shortness of breath or chest pains ... 9. Dialysis communication form will be sent with the resident on each visit. 10. Upon return from dialysis, the nurse will complete the post dialysis information located on the bottom of the dialysis communication record.	F 698		

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F 698	Continued From page 80 N.J.A.C. 8:39-27.1 (a)	F 698		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews, and record review, it was determined that the facility failed to ensure that the responsible physician supervising the care of residents conducted face-to-face visits and wrote progress notes at least once every sixty days from *NJ Ex Order 26. 4B1* according to the facility's policy and procedure. This deficient practice was identified for 1 of 38 residents, Resident #187 was reviewed for physician visits and was evidenced by the following:	F 712	How the corrective action will be accomplished for any resident affected by deficient practice: Resident #187 NJ Exec Order 26 at the facility on NJ Ex Order 26. 4B1.	2/10/25

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F 712	Continued From page 81 The surveyor reviewed the closed hybrid (paper and electronic) medical records of Resident #187 and revealed: Resident#187's Admission Record (or face sheet; an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to [redacted]. The most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, revealed in Section A Identification Information the reason for completing the assessment or tracking record was coded #12 for [redacted]. A review of Resident #187's hybrid medical records revealed that the Physician's Progress Notes (PN) were done on [redacted]. A review of the PN dated [redacted] for SBAR (S - Situation, B - Background, A - Assessment, R - Recommendation; can be used to communicate information between healthcare professionals, that is, from nurse to physician or allied healthcare professional, as well as when relaying information to a patient or their caregivers) that	F 712	How we identified other residents/areas that could potentially be affected: All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Physicians were all verbally reminded between the dates of [redacted] and follow up email was sent on 1/28/2025 about the regulatory documented face-to-face visits. Medical Records Coordinator/Designee audited current residents between the dates of 1/13/2025-1/17/2025. Monthly visit notes are current for the month of January 2025. Residents with physicians who were not compliant were re-assigned to physician's of their choice. Those physicians who did not comply with regulatory visits will not be assigned new residents. Physicians and Administrator will be notified by Medical Records Coordinator/Designee of non compliance for immediate resolution.	

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F 712	Continued From page 82 was electronically signed by the U.S. FOIA (b) (6) regarding the change in condition of Resident #187 for NJ Exec Order 26.4b1 The PN included that the Physician was notified and with orders. Further review of the hybrid medical records of the resident revealed that there were no other Physician visit notes except for the above dates on NJ Exec Order 26.4b1. On 1/8/25 at 12:59 PM, the survey team met with the U.S. FOIA (b) (6) . The surveyor notified the U.S. FOIA (b) (6) of the above concerns that the physician did not have routine PN and visit notes according to the requirements. At that same time, the U.S. FOIA (b) (6) stated that the residents for LTC (Long Term Care) should be seen by the physician monthly and as needed in between. The U.S. FOIA (b) (6) further stated that she reviewed the facility's policy and there was no clear cut when they should document during the visit, "NJ Ex Order 26. 4B1 ." The surveyor asked for the facility's policy with regard to physician services. On 1/8/25 at 2:17 PM, the U.S. FOIA (b) confirmed that the facility had an issue with the Physician's visits and PN which was why some Physician's residents were given to other physicians and the physicians were aware of the concerns. At that same time, the U.S. FOIA (b) checked and reviewed the closed records of the resident, and	F 712	How the concern will be monitored and title of person responsible for monitoring: Medical Records Coordinator/Designee will audit at least 20 medical records each month for 3 months to ensure that physicians are documenting face-to-face visits at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. Medical Records Coordinator/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be a part of QAPI where recommendations will be made for continued monitoring.	

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F 712	Continued From page 83 stated that she did not see any documentation from the Physician in the PN except for the previously identified on NJ Exec Order 26.4b1 A review of the facility's Physician Services with a revised date of NJ Exec Order 26.4b1 that was provided by the US FOIA (b)(6) revealed: Policy Interpretation and Implementation: 2. The resident's attending Physician is responsible for prescribing new therapy, ordering a transfer to the hospital, conducting routine visits, delegating and supervising follow-up visits from Nurse Practitioners or Physician Assistants, etc., to ensure that the resident receives quality care and medical treatments. 3. Physician orders and PN shall be maintained in accordance with current OBRA (Omnibus Budget Reconciliation Act; a set of regulations that improve quality of care in nursing homes) regulations and facility policy. 4. Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy ... 9. After the initial 30-day visit, all visits must then occur at 30-day intervals up until 90 days after the admission date. After the first 90 days, a visit must be conducted at least every 60 days thereafter ... 10. For the first 90 days, the Medicaid beneficiary shall be visited and examined every 30 days. Thereafter, with written justification, the interval between visits may be extended for up to 60 days. 11. Additional visits shall be made when significant clinical changes in the Medicaid beneficiary's condition require medical intervention.	F 712		

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F 712	Continued From page 84 On 1/10/25 at 11:45 AM, the survey team met with the U.S. FOIA (b) (6) [redacted] for an exit conference, and there was no additional information provided by the facility. NJAC 8:39-23.2(d)	F 712		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		2/10/25

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F 732	Continued From page 85 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to ensure the daily report of licensed nurses, certified nursing assistant staffing, and the resident census was posted at the beginning of the current shift for 2 of 5 days during the survey. This deficient practice was evidenced by the following: On 1/6/25 at 11:03 AM, upon entry to the facility, Surveyor #1 observed a Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the main entrance. The NHRCSR posted was dated 12/16/24, for the [7:00 AM to 3:00 PM] day shift. There was no NHRCSR for 1/6/25 posted. On 1/7/25 at 8:29 AM, upon entry to the facility, Surveyor #2 observed a NHRSCR posted at the front desk by the main entrance. The NHRCSR posted was dated 1/5/25 for the day shift. There was no NHRCSR for 1/7/25 posted. On 1/8/25 at 11:32 AM, Surveyor #1 interviewed the U.S. FOIA (b) (6) . The U.S. FOI stated	F 732	How the corrective action will be accomplished for any resident affected by deficient practice: U.S. FOIA (b) (6) was not aware that staffing report has to be current daily. U.S. FOIA (b) (6) was trained on 1/13/25 regarding updating and posting staffing report daily. Prior to survey visit, staffing coordinator was the only person responsible for updating and posting the daily staffing report. All nursing supervisors were trained (1/13/25) in updating and posting the daily staffing report and currently responsible for posting and updating the staffing report in addition to the staffing coordinator. U.S. FOIA (b) (6) was not aware that staffing report has to be current daily. Receptions was trained (1/13/25) in posting the staffing sheets daily. No residents were affected by this	

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F 732	Continued From page 86 when she came into work around 7:00 AM, she would confirm if any callouts, would update staffing data in the computer for the NHRCSR and then would post at reception desk. The [redacted] further explained she posted the NHRCSR for the next shift at 3:00 PM. The surveyor asked who was responsible for posting the NHRCSR for the night [11:00 PM to 7:00 AM] shift. The [redacted] replied that the supervisor who was working that shift. The surveyor asked about if the [redacted] worked on the weekends. The [redacted] replied she did not. The surveyor asked who was responsible for posting the NHRCSR on the weekends. The [redacted] stated that no one does on the weekends. The surveyor informed the [redacted] about the observations of the NHRCSR posted on 1/6/25 and 1/7/25. The [redacted] could not speak to why the NHRSCR was dated 12/16/24 on *NJ Ex Order 26. 4B1* [redacted], she stated it was a misunderstanding. The [redacted] explained that the [redacted] told her it was to be the day before and then after it was corrected. The [redacted] was not sure about the regulations about the posting of the NHRSCR. On 1/8/25 at 1:01 PM, Surveyor #1 notified the *U.S. FOIA (b) (6)* [redacted] about the concern of the NHRCSR for the current day and shift not being posted on two days. The [redacted] stated the expectation was for the NHRCSR to be posted for today's date. Surveyor #1 discussed with the facility that the [redacted] stated no one was responsible for posting the NHRCSR on the weekends. The [redacted] stated she would follow up and provide additional information. On 1/9/25 at 11:25 AM, the [redacted] stated the [redacted]	F 732	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. Measures to ensure were/will be put into place to assist this area of concern: The *U.S. FOIA (b) (6)* [redacted] was in-serviced on 1/8/2025 and 01/13/25 on the timeliness of posting daily staffing reports and will be responsible for daily posting. The Nursing Supervisor will check and update daily staffing on weekends and overnight shifts. Receptionists will ensure that current staffing information is posted during their shift. The nursing supervisors and *U.S. FOIA (b) (6)* [redacted] were in-serviced	

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F 732	Continued From page 87 was educated yesterday on the right way to post the NHRCSR, including that the report for the current date should be posted. Surveyor #1 asked about who was responsible for posting the NHRSCR on the weekend. The [redacted] replied moving forward the nursing supervisors would be posting. On 1/10/25 at 10:19 AM, Surveyor #1 asked for a policy regarding NHRCSR posting. The [redacted] stated there was no facility policy and that regulations were followed. NJAC 8:39-41.2	F 732	on this protocol on 01/13/25. Daily log of ensuring timely posting of staffing reports was initiated on [redacted]. How the concern will be monitored and title of person responsible for monitoring: Receptionist will audit daily and notify Administrator or Nursing Supervisor when staffing information posted during their shift is not current. This audit will be done for 3 months. Results of this audit and observation will be discussed by the Receptionist with the Administrator, Assistant Administrator or Director of Nursing for immediate resolution. Administrator/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be a part of quarterly QAPI where recommendations will be made for continued monitoring.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		2/10/25

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F 761	Continued From page 88 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medication per manufacturer specifications and standards of practice. This deficient practice was identified in 3 of 4 medication carts and 2 of 2 refrigerators observed on the 2nd and 3rd floors of the facility. 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 licensed practical nurse is defined as performing tasks and	F 761	How the corrective action will be accomplished for any resident affected by deficient practice: The thermometers in the affected refrigerators were immediately replaced. Loose medications found in medication carts were disposed of and the nurses were educated 01/08/25 and 1/17/2025. Open undated medications such as insulin pens were discarded appropriately and immediately.	

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F 761	Continued From page 89 responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 1/8/25 at 11:24 AM, the surveyor began to inspect selected medication (med) storage areas in the facility. The surveyor observed the following: The surveyor in the presence of U.S. FOIA (b) (6) [redacted] inspected the med cart identified as Cart 1 located on 3 West. The surveyor observed 1 foil package of budesonide inhalant suspension (a med that is inhaled to reduce lung inflammation) that did not reflect a date when the foil was originally opened. The surveyor also observed NJ Exec Order 26.4b1 (an insulin delivery system) and 3 unidentified tablets (tabs) located in the bottom of the 2nd drawer. The budesonide foil package label reflected once the foil envelope was opened, use the vials within 2 weeks and an area to write the date. The surveyor verified with the [redacted] that there was no date on either the foil package or the [redacted] and if the [redacted] could identify the loose tabs. The [redacted] stated the budesonide should have a date opened and the [redacted] should have a date when put in the cart. The [redacted] could not identify the tabs. The surveyor in the presence of the U.S. FOIA (b) (6) [redacted], accessed the med storage room located on 3 West and the refrigerator located within. The surveyor observed the temperature (temp) of the refrigerator to be 27 degrees Fahrenheit (F),	F 761	How we identified other residents/areas that could potentially be affected: All residents receiving pills any type of medications requiring labeling of dates upon opening have the potential to be affected. All medication refrigerators were checked on 1/10/2025 for accuracy of thermometer readings. All medication carts were checked on 1/10/2025 for proper labeling of opened medications and proper disposing of loose pills. Measures to ensure were/will be put into place to assist this area of concern: Nurses were promptly educated on proper medication storage and labeling, and dating of insulin pens on 01/08/25 and 1/17/2025. All nurses were promptly educated on how to dispose of loose pills in medication carts on 01/08/25 and 1/17/2025.	

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F 761	Continued From page 90 which was outside of the accepted range of 36 degrees to 46 degrees F. The surveyor observed a temp log sheet which reflected a temp entry for the day of 38 degrees F. The surveyor in the presence of the U.S. FOIA (b) (6) nurse, inspected the med cart identified as cart 1 located on the 2nd floor. The surveyor observed 1 NJ Exec Order 26.4b1 with no date written on it. The surveyor asked the US FOI if the NJ Exec Order 26.4b1 should have a date when placed in the cart. The U.S. FOI stated, yes, there should be one written on it when taken out of the refrigerator. The surveyor in the presence of the U.S. FOIA (b) (6), accessed the med storage room located on the 2nd floor and the refrigerator located within. The surveyor observed that there were 2 thermometers located within the refrigerator. One reflected a temp of 33 degrees F, which is outside of the accepted range of 36 degrees to 46 degrees F and one reflected a temp of 44 degrees F. The surveyor verified this discrepancy with the U.S. FOIA (b) (6). The surveyor in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) inspected the med cart identified as Cart located on 3 East, 2nd floor. The surveyor observed 2 foil packages of ipratropium/albuterol vials (a med that is inhaled to reduce lung congestion) that did not reflect a date when the foil was originally opened. The surveyor also observed 2 unidentified tabs located in the bottom of the 2nd drawer. The ipratropium/albuterol foil package label reflected once the vials were removed from the foil pouch to use within 1 week. The surveyor verified with	F 761	Nursing Supervisors/Designee will continue to educate all nurses on how to properly dispense medications to try to prevent to have loose pills in medication carts. Ongoing education will continue on how to store and label medications. The 11-7 supervisor will check the medication refrigerators nightly to ensure proper medication refrigerator thermometer temperature. The 11-7 shift nurses will check the medication carts for loose pills and will discard immediately if any are found. How the concern will be monitored and title of person responsible for monitoring: Nursing Supervisors/Designee will audit medication carts for proper storage, labeling of medications; and dating of insulin pens on one unit weekly for 3 months. Nursing Supervisors /Designee will audit 2 refrigerators weekly for 3 months. Results of this audit and observation will be addressed for immediate resolution. DON/Designee will present findings in	

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F 761	Continued From page 91 the U.S. FOIA (b) (6) and the [redacted] that there was no date on the foil packages and could not identify the loose tabs. On 1/8/25 at 1:01 PM, the surveyor met with the U.S. FOIA (b) (6) [redacted] to discuss the concerns with med storage. On 1/9/25 at 10:38 AM, the survey team met with the U.S. FOIA (b) (6) [redacted]. The [redacted] stated that the thermometers in the affected refrigerators were replaced, the medications (meds) under concern were disposed of and the staff educated. On 1/9/25 at 1:44 PM, The surveyor interviewed the facility U.S. FOIA (b) (6) [redacted] by telephone and discussed the med storage concerns. The surveyor asked the [redacted] if the meds observed by the surveyor should have appropriate dates on the labels. The [redacted] agreed that they should be dated. The surveyor asked the [redacted] what the proper temp range for med refrigerators was. The [redacted] stated it should be between 36 degrees F and 46 degrees F. The surveyor asked the [redacted] about loose unlabeled meds in a med cart. The [redacted] stated there should be no loose meds in the carts. The surveyor reviewed the manufacturer packaging information for ipratropium/albuterol inhalation vials, budesonide inhalation vials, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The manufacturer label for [redacted] reflected: Once removed from the foil pouch, the individual vials should be used within one week. The packaging information for budesonide, under	F 761	monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be a part of quarterly QAPI where recommendations will be made for continued monitoring.	

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F 761	Continued From page 92 storage and handling, reflected: When an envelope has been opened, the shelf life of the unused ampules is 2 weeks when protected. The manufacturer packaging information for [redacted] and [redacted] reflected that they should be disposed of after 28 days at room temp. On 1/10/25 at 11:26 AM, the survey team met with the [redacted]. No further information related to med storage was provided. The surveyor reviewed the facility policy titled Storage of Meds with a revision date of June 2024. The policy reflected: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. 8. Drugs shall be stored in an orderly manner ... The policy did not reflect any pertinent information in relation to dating opened packaging of nebulizer solutions, dating of any insulin delivery system or temp maintenance of med refrigerators.	F 761		
F 809 SS=D	NJAC 8:39-29.4(d)(g) Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in	F 809		2/10/25

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F 809	Continued From page 93 the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure bedtime (HS) snacks were offered. This deficient practice was identified for 5 of 5 residents (Resident #124, Resident #53, Resident #140, Resident #70, Resident #189) during the Resident Council group meeting and was evidenced by the following: On 1/7/25 at 12:49 PM, the surveyor conducted a resident group meeting with five residents who were alert and oriented and were selected by the facility to attend the group meeting. All five residents at the group meeting stated that the HS snacks were not offered. All five residents also stated they would like to have a HS snack. The surveyor reviewed the Resident Council meeting minutes in the last 3 months from October 2024 through December 2024. The minutes did not address HS snacks.	F 809	How the corrective action will be accomplished for any resident affected by deficient practice: Resident #124, Resident #53, Resident #140 and Resident #70, were offered evening snacks daily and recorded on their electronic medical records. Resident #189 was discharged home on [redacted]. All residents have the potential to be affected by this deficient practice.	

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F 809	Continued From page 94 On 1/8/25 at 1:20 PM, the survey team met with the [redacted] to discuss the above concern. The [redacted] stated HS snacks must be offered to the residents but was unable to provide further information for any accountability if the HS snacks were offered to the residents. On 1/9/25 at 10:37 AM, the [redacted] provided the surveyor with a facility policy titled "Food, Dining Service and HS Snacks" with a reviewed date of 6/2024. Under the policy, it stated, "Snacks will be offered between meals and at HS," "Nursing staff are responsible for offering snacks." There was no system in place or documented evidence to show that residents who wanted HS snacks were offered. There was no additional information provided. NJAC 8.39-17.2(f) 1(ii)	F 809	How we identified other residents/areas that could potentially be affected: Alert and oriented residents and caregivers were interviewed regarding being offered bedtime snacks. Measures to ensure were/will be put into place to assist this area of concern: Receptionists started to make announcements via public address (PA) system in the evening between 7:30pm and 7:45pm that evening snacks are available for residents and are being passed around. Nursing staff were in-serviced on 01/17/25 on passing evenings snacks when announcement is made. Mobile snack cart was provided to each unit to allow the nursing assistants to offer snacks at bedside. Nursing Assistants will document on each resident's electronic health medical records that evening snacks was offered, and if resident took the snack. Evening Supervisor/Designee will make rounds at bedtime to ensure that evening snacks are being offered to residents.	

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F 809	Continued From page 95	F 809	How the concern will be monitored and title of person responsible for monitoring: Assistant Director of Nursing (ADON)/Designee will audit 10 electronic medical records for POC documentation per week for 3 months. ADON/Designee will interview 10 residents weekly to ensure that the snacks are being offered at bedtime. Results of this audit and observation will be discussed by the ADON/Designee with the Administrator, Assistant Administrator or Director of Nursing (DON) for immediate resolution. ADON/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be a part of quarterly QAPI where recommendations will be made for continued monitoring.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		2/10/25

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F 812	Continued From page 96 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 1/6/25 at 11:16 am, the surveyor in the presence of the [redacted] observed the following during the kitchen tour: 1. The surveyor observed in storage container 5 open bags of bread: 1 gluten free bread, 1 whole wheat bread, 2 rye breads, and 1 white bread all were missing open and use by labels. The [redacted] could not state why the opened bags of bread were missing labels but acknowledged all opened items need to have an open and use by label.	F 812	How the corrective action will be accomplished for any resident affected by deficient practice: All bread opened and non-labeled were discarded immediately. All dented cans were discarded immediately. All boxes and food in the walk-in freezer above 18 inches from the ceiling were cleared. Maintenance assistant cleaned the fan promptly. All staff working in the kitchen/dietary department who were wearing earrings that can dangle removed them immediately.	

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F 812	Continued From page 97 2. The surveyor observed in dry storage room #1, one 6 pound (lb.) 10 ounce (oz) can of fruit mix with a large dent. The can was in the regular rotation with 5 other cans of fruit mix. The [redacted] stated any dented cans should be removed from the regular rotation of canned items. 3. The Surveyor observed in the walk-in refrigerator, the fans had a black colored dust-like substance as well as 6 boxes were stored above 18 inches (in) from the ceiling. The [redacted] stated they would contact the maintenance department for clean the fan and they would remove all boxes that were being stored too high. 4. The surveyor observed in the walk-in freezer, 12 boxes stored above 18 in from the ceiling. The [redacted] stated they would remove all boxes that were being stored too high. 5. The surveyor observed 3 Dietary Aides (DA) with large hoop earrings. [redacted] stated they should not be wearing earrings that can dangle as that us against their policy. On 1/7/25 the [redacted] provided the surveyor with multiple kitchen policies. The Labeling and Dating of Dry, refrigerated and Freezer Food Items policy with a revised date of 10/2024 states under the policy section, "All food products shall be dated upon receipt or when they are prepared and when they are opened." The Food Storage policy with a revised date of 10/2024, states under the procedure section, "7 ...d. Food will be stored and handled to maintain the integrity of the packaging until ready for use.", "10. Food should be stored a minimum, of 6 inches above the floor, 18 inches from the ceiling." The General	F 812	Residents were not negatively affected by 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. Measures to ensure were/will be put into place to assist this area of concern: All dietary staff were in-serviced on 01/07/25 and re-in serviced on the week of 01/27/25 on labeling/dating bread once opened, all dented cans will be removed from regular rotation immediately, all boxes/food are stored below 18 inches from the walk-in refrigerator ceiling at all times, and dangling earrings are prohibited in the kitchen. Maintenance cleaning schedule and log of walk-in refrigerator fan was implemented on 01/27/25.	

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F 812	Continued From page 98 Sanitation of Kitchen policy with a revised date of 10/2024 stated under the policy section, "Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule." The Employee Hygiene for Food Safety policy with a revised date of 10/2024 states under the procedure section, "5. Keep jewelry to a minimum. Only a plain band ring such as a wedding band, and watch can be worn." On 1/8/25 at 12:59 PM, the survey team met with the U.S. FOIA (b) (6) to review concerns. The U.S. FOIA (b) (6) stated the kitchen concerns have been addressed and the staff have all been re-in-serviced. No additional information provided. On 1/10/25 at 1:30 PM, the survey team met with the U.S. FOIA (b) (6) for an exit conference. The facility did not provide any further pertinent information. NJAC 8:39-17.2(g)	F 812	Director of food services/Designee will conduct ongoing education to staff. Director of Food Services/Designee will round the kitchen ongoing to make sure all policies are followed by staff. Upon delivery of canned food, any identified dented cans are taken out of the rotation and placed in dented can's bin to be returned. Director of food services creates daily stickers with dates and placed on the prep table next to the bread. How the concern will be monitored and title of person responsible for monitoring: Director of Food Services/Designee will do weekly audits for 3 months in the kitchen related to these identified concerns. Results from audit and observation will be addressed promptly and discussed in the morning meeting for immediate resolution. Director of Sood services/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be a part of quarterly QAPI where recommendations	

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F 812	Continued From page 99	F 812	will be made for continued monitoring.	
F 836 SS=C	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by:	F 836		2/24/25

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F 836	Continued From page 100 Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in facility name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. .. (2) All other changes in enrollment must be reported within 90 days." On 1/6/25 at 8:40 AM, upon arrival of the survey	F 836	How the corrective action will be accomplished for any resident affected by deficient practice: The Operator(s) applied for the Change of Ownership (CHOW) in August 2022. Outstanding issues holding up the CHOW were resolved on January 2, 2025 After CHOW is approved, we will notify CMS immediately. No residents were affected. How we identified other residents/areas that could potentially be affected: All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: The Operator(s) applied for the Change of Ownership (CHOW) in August 2022 and cleared all outstanding issues on January 2, 2025. They have been made aware of this deficient practice on 1/10/2025.	

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F 836	Continued From page 101 team to the facility, the surveyor observed a signage outside the facility not in accordance to the approved CMS facility name. A review of various documents and facility policies that were provided by the [redacted] the facility name as part of the facility's policies and documents were not in accordance to the approved CMS facility name. On 1/7/25 at 10:13 AM, the Surveyor met with the [redacted] to discuss the facility medical documents did not match the documentation according to what they were licensed for. The [redacted] stated the facility was now managed by [name of company], not aware of any issue with the name change, but would contact the [redacted] of the company for clarification. On 1/8/25 at 12:59 PM, the surveyor met with the [redacted] to discuss the licensed facility name and facility name on medical documents. [redacted] stated the application for name change was awaiting approval with the State but have not received approval at this time and they cannot apply with CMS until they get state approval. The surveyor asked if the facility had filed a 855B form to CMS and the [redacted] explained that they have not done the 855B form. A review of the facility license that was issued by the New Jersey Department of Health Division of Certificate of Need and Licensing with an issue date of January 8, 2024, and an expiration date of February 28, 2025, revealed the name licensed to operate was the approved CMS facility name and not according to the newly acquired company	F 836	How the concern will be monitored and title of person responsible for monitoring: Operator(s)/Designee will continue to follow up until change of ownership is completed by New Jersey Department of Health and CMS approval is obtained. The Administrator will continue to follow up weekly by email with the Operator(s)/Designee until the change of ownership is completed by New Jersey Department of Health. The Administrator will present the outcome of weekly follow up 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.	

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F 836	Continued From page 102 name. On 1/10/25 at 1:30 PM, the survey team met with the *U.S. FOIA (b) (6)* for an exit conference. The facility did not provide any further pertinent information.	F 836		
F 880 SS=D	NJAC 8:39-5.1 (a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		2/10/25

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	315438	A. BUILDING _____ B. WING _____	C 01/10/2025

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F 880	Continued From page 103 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 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of	F 880	How the corrective action will be	

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F 880	Continued From page 104 medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for 4 of 11 staff (3 Housekeepers and 1 Certified Nursing Aide) and b.) ensure nebulizer machine was properly stored and follow appropriate infection control practices to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and the facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ... Before moving from work on a soiled body site to a clean body site on the same patient ... After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. According to the CDC information on the Sequence for putting on PPE revealed: 2. Mask or respirator oSecure ties or elastic bands at middle of head and neck oFit flexible band to nose bridge oFit snug to face and below chin..	F 880	accomplished for any resident affected by deficient practice: 4 staff members who failed to follow the infection control policy while wearing incorrectly personal protective equipment (PPE) were promptly re-educated on proper use of PPE. The NJ Ex Order 26. 4B1 found on the floor was immediately removed and discarded. The medical records of the two residents in the room were reviewed, both did not have an order for NJ Ex Order 26. 4B1 . No resident was negatively 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 staff members who incorrectly wear or use PPE. Measures to ensure were/will be put into	

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F 880	Continued From page 105 How to safely remove PPE: There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials ... Here is one example. Remove all PPE before exiting the patient room... 1. On 1/6/25 at 11:24 AM, the [redacted] informed the surveyor that the last day of [redacted] was "[redacted]" On 1/8/25 at 9:03 AM, the surveyor observed 3 Housekeepers (HKs) inside the elevator with surgical masks not properly worn, their masks were not covering their mouth and nose. The surveyor and 3 HKs exit the elevator to the 1st-floor unit. On 1/8/25 at 9:12 AM, the surveyor upon exiting the elevator, observed the [redacted] in the hallway wearing a surgical mask not covering her mouth and nose and with gloves while holding a plastic bag. Upon seeing the surveyor, the [redacted] removed her gloves while walking in the hallway and did not perform hand hygiene. The surveyor interviewed the [redacted] in the nursing station in the presence of the [redacted]. The surveyor observed the [redacted] with 3 surgical masks in use and was below her nose and halfway covering her mouth. At that same time, the [redacted] informed the surveyor that she had come out of room 101 and cleaned the floor because it was wet. The surveyor asked about the gloves in the hallway and her masks, the [redacted] was unable to directly respond to the	F 880	place to assist this area of concern: All staff members were in-serviced on 1/17/2025 on appropriate us of face masks and gloves per facility policy. Department heads and supervisors on all shifts will continue to identify staff members who are not compliant on proper use of PPE and will be promptly educated. Ongoing infection control education with all staff members will continue. Unit Clerks/Designee will inspect resident's rooms for any [redacted] on the floor and report to the nurse. How the concern will be monitored and title of person responsible for monitoring: Department heads will take turns weekly to audit 10 staff members on proper use of PPE and randomly check 10 rooms for any [redacted] on the floor. Results of this audit and observation will be discussed in the morning clinical meeting to identify trends. Infection Preventionist/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be a part of	

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F 880	Continued From page 106 surveyor's questions and the U.S. FOIA (b) (6) immediately educated the U.S. FOIA (b) (6) that it was not appropriate for the U.S. FOIA (b) (6) to wear gloves in the hallway and that the U.S. FOIA (b) (6) should have removed it inside the resident's room and performed hand hygiene. The U.S. FOIA (b) (6) also stated that the U.S. FOIA (b) (6) had a small face and that was why the masks were falling off but otherwise, the U.S. FOIA (b) (6) should have her mask worn properly covering her nose and mouth, and not wear more than one mask at the time. The surveyor also notified the U.S. FOIA (b) (6) of the above concerns with the 3 Housekeepers. On 1/8/25 at 10:03 AM, the surveyor observed Housekeeper #1 (HK#1) with a surgical mask not properly worn, it was below the chin. The surveyor asked HK#1 about the mask and U.S. FOIA (b) (6) smiled at the surveyor and left. The U.S. FOIA (b) (6) did not respond when asked why the mask was below her chin and not properly covering her nose and mouth. On 1/8/25 at 12:59 PM, the survey team met with the U.S. FOIA (b) (6) . The surveyor notified of the concerns regarding the 3 Housekeepers and U.S. FOIA (b) (6) about PPE and hand hygiene. On 1/9/25 at 10:37 AM, the survey team met with the U.S. FOIA (b) (6) . The U.S. FOIA (b) (6) stated that the U.S. FOIA (b) (6) and 3 Housekeepers observed with masks under their chins were educated and they have a history of educating in the past the above mentioned employees. A review of the facility's PPE-Face Masks Policy with a revised/reviewed date of 10/2024 that was	F 880	quarterly QAPI where recommendations will be made for continued monitoring.	

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F 880	Continued From page 107 provided by the [redacted] revealed that there was no information about the proper way of wearing a face mask. A review of the facility's PPE-Gloves Policy with a revised/reviewed date of 10/2024 that was provided by the [redacted] revealed: Policy Interpretation and Implementation: 2. Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed ... 8. Wash your hands after removing gloves ... A review of the facility's Handwashing/Hand Hygiene Policy with a revised/reviewed date of 10/2024 that was provided by the [redacted] revealed: Policy Statement: The facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 5. Employees must wash their hands for at least 20 seconds using antimicrobial or non-microbial soap and water under the following conditions: f. after handling soiled or used linens, dressings, bedpans, catheters, and urinals;.. u. after removing gloves or aprons; and v. after completing duty ... 7. Hand hygiene is always the final step after removing and disposing of PPE ... On 1/10/25 at 11:45 AM, the survey team met with the *U.S. FOIA (b) (6)* [redacted] for an exit conference, and the facility did not provide additional information.	F 880		

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F 880	Continued From page 108 2. On 1/6/25 at 12:06 PM, during the initial tour on the 1st floor, the surveyor observed a [NJ Ex Order 26, 4B1] [redacted] with black substance around it, and was next to the garbage can inside the resident's room. On 1/6/25 at 12:10 PM, the surveyor showed the neb machine to the *U.S. FOIA (b) (6)* [redacted] who stated she was not aware who the neb machine belonged to. The [U.S. FOIA] further stated to the surveyor that the neb was soiled and was not supposed to be placed on the floor. On 1/8/25 at 1:20 PM, the survey team met with the *U.S. FOIA (b) (6)* to discuss the above concern. The [US FOIA (b)(6)] acknowledged that the [NJ Ex Ord] [redacted] was not supposed to be on the floor. There were no further information provided.	F 880		
F 919 SS=D	NJAC 8:39-19.4(a)(1),(l,n) Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY	F 919	How the corrective action will be	2/10/25

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F 919	Continued From page 109 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to ensure resident call devices were within reach of the residents for 1 of 35 sampled residents (Resident #79). This deficient practice was evidenced by the following: On 1/8/2025 at 9:21 AM, the surveyor observed Resident #79 lying in bed with the call bell tied to the right side rails out of the resident's reach. The Licensed Practical Nurse (LPN#1) stated that the call device should be within the resident's reach. On 1/8/25 at 12:36 PM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #79, which revealed the following: A review of the Admission Record (an admission summary) reflected that Resident #79 was admitted with diagnoses that included but were not limited to a [redacted]. A review of the recent significant change status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) (the last day of the observation period) of [redacted] indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident had an [redacted].	F 919	accomplished for any resident affected by deficient practice: Resident #79's call bell was immediately clipped to resident's bedsheet. Resident #79 was not negatively affected with this deficient practice. How we identified other residents/areas that could potentially be affected: All residents identified with the capacity to use the call bell have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: All staff were educated on 1/17/2025 to keep call bells within the resident's reach and clipping them on the sheets to secure placement. Unit managers and supervisors are	

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F 919	Continued From page 110 A review of the Care Plan revealed a Focus area of [NJ Exec Order 26.4b1] related to impaired balance. Interventions included, but were not limited to, making sure the call light was within reach. On 1/10/2025 at 9:15 AM, the surveyor observed Resident #79 lying in bed with the call bell on the floor. The call device was out of the resident's reach. The surveyor interviewed LPN #2, who was outside the resident's room and stated that the call bell should not be on the floor. LPN #2 picked up the call device from the floor and clipped it to the resident's bedsheet. On 1/10/25 at 9:30 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] to discuss the above concern regarding the call bell not being within reach of the resident. The [U.S. FOIA (b) (6)] stated that it should be clipped to the resident's bed sheets, but if not, it could [NJ Exec] on the floor. The [U.S. FOIA (b) (6)] added that the call bell should not be tied to the [NJ Exec Order 26.4b1] otherwise, the resident cannot reach it. A review of the "Answering the call light" policy with a revised procedure dated 10/2024 under "General Guidelines 5. When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident." NJAC 8:39-29.1(a)	F 919	rounding at the beginning and end of their shifts on all shifts to ensure all resident's call bells are within reach. How the concern will be monitored and title of person responsible for monitoring. Department Heads/Designee will audit 5 residents per shift weekly for 3 months to ensure that the call bells are within the residents' reach and secured in place. Results of this audit and observation will be addressed for immediate resolution. Assistant Director of Nursing (ADON)/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be a part of quarterly QAPI where recommendations will be made for continued monitoring.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 921		2/10/25

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F 921	Continued From page 111 This REQUIREMENT is not met as evidenced by: Complaint #NJ172916 Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a safe, functional, sanitary, and comfortable environment in 1 of 1 laundry room in accordance with the facility procedures. This deficient practice was evidenced by the following: On 1/10/25 at 8:40 AM, Surveyor #1 (S#1) toured the laundry area on the 1st floor and there were four staff. The surveyor observed the folding area for personal clothing with two personal cellphones on top of the clean folded clothing and there was a radio/cassette recorder on top of the clean folded linens and incontinent pads (cloth). On that same date and time, during the tour with the U.S. FOIA (b) (6), the surveyor observed used gloves on top of personal clothing washer, white gown, face towel, linen on the floor next to a big washer. There was an accumulation of grayish substances on the floor and dried brownish substances, as per the U.S. FOI, the floor was dusty and was not sure about the brownish discoloration on the floor, and the white gown, face towel, and the linen on the floor next to the washer were considered dirty and were separated from other dirty laundry earlier when the washer was loaded. At that same time, the U.S. FOI informed the surveyor that there were only two of washers and dryers that were operational, the one dryer was broken	F 921	How the corrective action will be accomplished for any resident affected by deficient practice: Cassette/radio recorder and personal cell phones were removed immediately from the clean folding area. Bins were placed next to the washing machines for dirty laundry. The laundry platform was cleaned and sanitized. A binder holder was placed on the wall on 1/20/25 for laundry binders. The personal washing machine was cleaned and sanitized promptly. Broken machines in the laundry area were appropriately tagged on 1/10/2025. Follow up with vendor/service provider was made on 1/27/25. Deposit for new dryer was made on 1/10/2025 and estimated delivery date is 3/12/2025. How we identified other residents/areas that could potentially be affected:	

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F 921	Continued From page 112 more than a month and will be replaced soon, and the other broken dryer had been broken for months and unable to state how long. On 1/10/25 at 8:49 AM, S#1 and the U.S. FOIA (b) (6) went back to the laundry area. The surveyor asked about the cassette recorder/radio near the clean folded linens, and he stated that it should not be there and asked the laundry staff to remove it. He also stated that the personal cellphones should not be placed near the folded personal clothing, and he asked the staff to remove it. At that same time, in the dirty area of the laundry, the used gloves which were on top of the washer were removed by the [redacted] and stated that it should have been discarded to garbage. The [redacted] confirmed to the [redacted] that the gown, face towel and linen were considered dirty; the [redacted] stated that they should not have been on the floor. Furthermore, S#1 asked the [redacted] if there were issues or concerns about overflowing dirty laundry in the residents' rooms that he was aware of. The [redacted] responded yes, there were concerns because some of their washers and dryers were broken and that he had requested new machines. The surveyor asked for the order requisition slips and for any complaints and he said he will get back to the surveyor. On 1/10/25 at 9:00 AM, The [redacted] provided to the Surveyor #2 (S#2) an invoice dated 4/9/24 which revealed a repair for laundry equipment. The U.S. FOIA (b) (6) confirmed of laundry issues. The [redacted] provided an additional invoices which revealed laundry equipment repairs have been	F 921	All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: All staff in the laundry area were educated on 1/20/25 to maintain a safe, functional, sanitary, and comfortable environment for the residents. This included ensuring all used gloves/personal protective equipment (PPE) are put in the garbage immediately after use, personal items will not be placed on clean folding area, and any items for washing should be placed in appropriate bin. U.S. FOIA (b) (6) was reeducated on 1/27/25 about tagging equipment when broken. A communication slip will be consistently sent to the laundry indicating that resident□s laundry will be done at the facility. Nursing Assistants were in-serviced on 1/28/2025 about sending labeled soiled clothes to laundry regularly. Assistant Administrator/Designee will do weekly rounding of the laundry area,	

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F 921	Continued From page 113 ongoing since 3/31/23 to the current date. On 1/10/25 at 9:01 AM, S#1 interviewed the [redacted] and notified of the concerns in the laundry area and what [redacted] stated regarding the broken machines. S#1 asked the [redacted] if there were grievance for overflowing laundry that she remembered and she stated yes. The [redacted] further stated that the U.S. FOIA (b) (6) [redacted] complained, and "[redacted]" did not know that were supposed to do laundry and "[redacted]" said sorry. S#1 asked the [redacted] what was the responsibility of the facility if the nurses, Certified Nursing Assistants (CNAs), Housekeepers went to the residents' room every day and saw the overflowing laundry. The [redacted] stated that the staff should had reported it and that there should be no overflowing laundry. S#1 asked if that was considered grievance that the [redacted] complained about laundry, and the [redacted] responded yes, and the surveyor asked for the copy of grievances for that overflowing laundry, and the [redacted] stated that she would get back to the surveyor. On 1/10/25 at 10:00 AM, S#2 reviewed grievances for 2024, which was provided by the U.S. FOIA (b) (6) [redacted]. A grievance dated on 4/27/24 and 3/1/24 reflected concerns that the laundry basket were overflowing with dirty clothes. On 1/10/25 at 10:48 AM, S#2 requested from the [redacted] for the most current facility Policy and Procedure for Laundry and Laundry Equipment Maintenance. On 1/10/25 at 11:09 AM, the [redacted] responded, "We have no policy on the laundry equipment maintenance. We fix the equipment as they come	F 921	residents□ laundry, and education of staff to ensure it maintains a safe, functional, sanitary, comfortable environment for all residents and address any issues immediately. How the concern will be monitored and title of person responsible for monitoring: U.S. FOIA (b) (6) [redacted] will audit laundry area weekly for 3 months and address areas of concerns promptly. Results of weekly audits will be discussed in the morning meeting to identify trends. Assistant Administrator/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be a part of quarterly QAPI where recommendations will be made for continued monitoring.	

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 01/10/2025

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F 921	Continued From page 114 along." On 1/10/25 at 11:15 AM, the [redacted] stated, "We understand that older equipment breaks down, the organization has ordered new equipment but due to financial limitation at that time, we just fixed it, now we can have new machines. The overflowing laundry, the staff should be sending that laundry that were overflowing down to the laundry room. We will educate the laundry department with infection control, cell phone, soiled clothes with the clean towels." On 1/10/25 at 11:41 AM, S#2 interviewed the [redacted], who stated, "The left dryer is completely broken for five months now, not working, it keeps breaking. The right dryer has been broken since I came here. We are getting a new washing machine one dryer and one washing machine next week." On 1/10/25 at 11:47 AM, S#2 notified the [redacted] of the above concerns and findings. A review of the most current facility policy and procedure titled "Laundry and Bedding, Soiled" revealed, "Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen." A review of the facility's Policy and Procedure Maintenance Reporting, reviewed on 12/2024, that was provided by the [redacted] revealed:	F 921		

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F 921	Continued From page 115 The facility maintains systems to report and resolve all maintenance related concerns, to sustain a safe and comfortable environment.....If the item is deemed unrepairable, Maintenance will tag the equipment, take it out of service, and will arrange to order new parts/equipment.	F 921		
F 947 SS=E	NJAC-8:39-21.1(d)(e)(j), 31.2(e) Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview, and review of facility documentation, it was determined that the facility failed to ensure that a U.S. FOIA (b) (6) received at least 12 hours of mandatory in-service training for 4 of 5 U.S. FOIA (b) education	F 947	How the corrective action will be accomplished for any resident affected by deficient practice: A U.S. FOIA (b) (6) education	2/10/25

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F 947	Continued From page 116 reviewed (CNA #1, CNA #2, CNA #3, and CNA #4). The deficient practice was evidenced by the following: On 1/9/25 at 1:26 PM, the surveyor reviewed the provided in-service education for five randomly selected CNAs for the 2024 year, which revealed the following: CNA #1 with a date of hire (doh) on [redacted], had 1 hour and 50 minutes of in-service training from date of hire anniversary dates. CNA #2 with a doh on [redacted], had 5 hours and 55 minutes of in-service training from date of hire anniversary dates. CNA #3 with a doh on [redacted], had 8 hours and 20 minutes of education from date of hire anniversary dates. CNA #3 was on leave between [redacted]. CNA #4 with a doh on [redacted], had 8 hours and 20 minutes of education from date of hire anniversary dates. On 1/9/25 at 1:54 PM, the surveyor interviewed the [redacted] about CNA education. The surveyor asked who was responsible for CNA education. The [redacted] stated that a new [redacted] was hired in [redacted] and would be responsible for CNA education. The surveyor asked who was previously responsible for ensuring CNA education was completed. The [redacted] replied she believed the [redacted] was and that the [redacted] could further speak about it. The surveyor	F 947	class was provided to CNAs #1, #2, #3, and #4 and now have 12 hours of mandatory in-service training. How we identified other residents/areas that could potentially be affected: All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Continuing education and mandatory courses will be facilitated by [redacted] at least monthly for all CNA's to receive their education hours and ensure they completed in a timely manner. Monthly flyer was posted on 1/28/25 as a visual reminder to increase compliance with education and will continue to be posted every time a class is being held.	

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F 947	Continued From page 117 discussed concern with the 4 of 5 CNAs reviewed not meeting the annual 12 hours of mandatory in-service training. The [U.S. FO] stated the facility was aware of the concern as a Quality Assurance Performance Improvement (QAPI) was initiated prior to the survey on 12/23/24 to address mandatory 12 hours of CNA education not being met by some of the staff. On 1/9/25 at 2:01 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] about CNA education. The [U.S. FOIA (b) (6)] stated the previous [U.S. FOIA (b) (6)] who was responsible for overseeing CNA education left in August 2024 and did not return. The surveyor asked who was responsible for oversight after the [U.S. FOIA (b) (6)] left in [NJ Ex Order 26. 4B]. The [U.S. FOIA (b) (6)] replied that the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] would have been responsible. The surveyor discussed the concern for 4 of the 5 CNAs reviewed not having at least 12 hours of mandatory in-service education training. The [U.S. FOIA (b) (6)] acknowledged the concern of CNA in-service training not being met. The [U.S. FOIA (b) (6)] stated an audit was done and a QAPI initiated at the end of December as it was found that the staff were not meeting the 12 hours of in-service training requirements. On 1/10/25 at 11:15 AM, the surveyor notified the [U.S. FOIA (b) (6)] about the concern for 4 of the 5 CNAs reviewed who did not complete at least 12 hours of mandatory in-service training. The [U.S. FOIA (b) (6)] acknowledged the concern. There was no additional information provided by the facility. A review of the facility's Staff Education, dated [NJ Ex Order 26. 4B]. The policy revealed the following:	F 947	Staff education tracking form is monitored by Assistant Administrator/Designee weekly to ensure all new and existing employees are receiving education/training timely. How the concern will be monitored and title of person responsible for monitoring: Assistant Administrator /Designee will audit education binder monthly to ensure all CNAs are getting at least 12 hours of mandatory in-service training timely. Assistant Administrator/Designee will present findings in monthly Quality Assurance Performance Improvement (QAPI) for 3 months and will be a part of quarterly QAPI where recommendations will be made for continued monitoring.	

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F 947	Continued From page 118 2. The facility will ensure that nurses aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, identified through resident assessment, and described plan of care... 6. Staff will demonstrate competency with the following training requirements including: preventing and reporting abuse neglect, and exploitation, dementia management, and infection control... 11. The amounts and types of training will also be based on the facility assessment. N.J.A.C. 8:39-43.17(b)	F 947		

New Jersey Department of Health

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaints # NJ172916 and # NJ172122 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 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.	S 560	How the corrective action will be accomplished for any resident affected by deficient practice: All efforts to hire facility Certified Nursing Aide(s) C.N.A 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 were secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for	2/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/31/25

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S 560	Continued From page 1 Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.	S 560	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 residents 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. Measures to ensure were/will be put into place to assist this area of concern: Contracts with additional staffing and hiring agencies were secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience,	

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S 560	Continued From page 2 (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... 1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 4/7/2024 and ending 4/20/2024 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for residents on 14 of 14 day shifts as follows: -04/07/24 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs. -04/08/24 had 11 CNAs for 142 residents on the day shift, required at least 18 CNAs. -04/09/24 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs. -04/10/24 had 9 CNAs for 142 residents on the day shift, required at least 18 CNAs.	S 560	online job listings, job fairs, referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. CNA trainees will be screened, hired and sent to facility sponsored and State approved CNA class. 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. Corporate Staffing Director will monitor staffing needs daily to ensure facility is compliance with staffing requirements. The salaried employees are offered bonuses and incentives to help cover open shifts. The facility will work with sister facilities to help cover open positions. How the concern will be monitored and title of person responsible for monitoring: 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	

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S 560	Continued From page 3 -04/11/24 had 11 CNAs for 145 residents on the day shift, required at least 18 CNAs. -04/12/24 had 12 CNAs for 145 residents on the day shift, required at least 18 CNAs. -04/13/24 had 11 CNAs for 145 residents on the day shift, required at least 18 CNAs. -04/14/24 had 11 CNAs for 150 residents on the day shift, required at least 19 CNAs. -04/15/24 had 12 CNAs for 149 residents on the day shift, required at least 19 CNAs. -04/16/24 had 9 CNAs for 149 residents on the day shift, required at least 19 CNAs. -04/17/24 had 13 CNAs for 149 residents on the day shift, required at least 19 CNAs. -04/18/24 had 10 CNAs for 149 residents on the day shift, required at least 19 CNAs. -04/19/24 had 12 CNAs for 151 residents on the day shift, required at least 19 CNAs. -04/20/24 had 9 CNAs for 151 residents on the day shift, required at least 19 CNAs. 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 12/22/2024 and ending 1/4/2025 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for residents on 14 of 14 day shifts as follows: -12/22/24 had 12 CNAs for 182 residents on the day shift, required at least 23 CNAs. -12/23/24 had 13 CNAs for 182 residents on the day shift, required at least 23 CNAs. -12/24/24 had 15 CNAs for 181 residents on the day shift, required at least 23 CNAs. -12/25/24 had 18 CNAs for 181 residents on the day shift, required at least 23 CNAs. -12/26/24 had 15 CNAs for 181 residents on the	S 560	will be made for continued monitoring.	

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S 560	Continued From page 4 day shift, required at least 23 CNAs. -12/27/24 had 14 CNAs for 181 residents on the day shift, required at least 23 CNAs. -12/28/24 had 12 CNAs for 181 residents on the day shift, required at least 23 CNAs. -12/29/24 had 16 CNAs for 181 residents on the day shift, required at least 23 CNAs. -12/30/24 had 14 CNAs for 176 residents on the day shift, required at least 22 CNAs. -12/31/24 had 15 CNAs for 176 residents on the day shift, required at least 22 CNAs. -01/01/25 had 14 CNAs for 176 residents on the day shift, required at least 22 CNAs. -01/02/25 had 13 CNAs for 176 residents on the day shift, required at least 22 CNAs. -01/03/25 had 15 CNAs for 180 residents on the day shift, required at least 22 CNAs. -01/04/25 had 11 CNAs for 180 residents on the day shift, required at least 22 CNAs. On 1/10/25 at 9:01 AM, Surveyor #1 (S#1) interviewed the Licensed Nursing Home Administrator (LNHA), in the presence of Surveyor #2, regarding the facility's nurse staffing protocols. The LNHA stated she was aware of the New Jersey mandated regulations and the facility tried to follow the mandated staffing. The LNHA further explained that the mandated regulation was for the facility to have 1 CNA to 8 residents for the morning shift, 1 CNA to 10 residents for the evening shift, and 1 CNA to 14 residents for night shift. The LNHA acknowledged that staffing had always been an issue, especially on the weekends. The LNHA stated that the facility was sending new hire staff for CNA classes and utilized agency staffing to assist with staffing levels. On 1/10/24 at 11:46 AM, S#1 informed the LNHA,	S 560		

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S 560	Continued From page 5 the Director of Nursing, and the Assistant Administrator, of the above concerns for staffing. There was no additional information provided by the facility. A review of the facility provided policy titled, "Staffing" with a last revised date of June 2024, under Policy Statement revealed: "Our facility provides adequate staffing to meet needed care and services of our resident population." Under Policy Interpretation and Implementation revealed, "Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met."	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.	S1405		2/10/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1405	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and a review of pertinent facility provided documentation, it was determined that the facility failed to ensure that newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment, or within 30 days if a Registered Nurse (RN) completed an assessment upon employment for 3 of 10 (Staff #1, #2, and #3) new employee files reviewed. This deficient practice was evidenced by the following: The surveyor reviewed ten randomly selected newly hired employee files. The review for physical examinations for 3 of the 10 new employees revealed the following: Staff #1, a Registered Nurse (RN), hired on [NJ Exec Order 2], had a physical examination signed by the Physician and RN on [NJ Exec Order 26.4b]. Staff #2, an Activity Aide, hired on [NJ Ex Order 26. 4b], had a physical examination signed by the Physician and RN on [NJ Exec Order 26.4]. Staff #3, a Social Service staff, hired on [NJ Ex Order 26. 4b], had a physical examination signed by the Physician and RN on [NJ Exec Order 26.4b].	S1405	How the corrective action will be accomplished for any resident affected by deficient practice: All newly hired employees will receive no less than an Registered Nurse (RN) assessment upon employment and an examination by an Physician, Advanced Practice Nurse (APN), or Licensed Physician Assistant (LPA) within 30 days. Staff # 1, 2, 3 started orientation in the facility 3 days before they were assessed by a physician. Staff #1 was examined and cleared by the Physician on 4/11/24. Staff #2 was examined and cleared by the Physician on 8/15/24. Staff #3 was examined snd cleared by the Physician on 10/24/24. Residents were not negatively affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62219	A. BUILDING: _____ B. WING _____	C 01/10/2025

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

(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) COMPLETE DATE
S1405	Continued From page 7 On 1/9/25 at 12:22 PM, the surveyor interviewed the Human Resources Coordinator (HRC), who stated physical examinations for new hires would be completed during the orientation process and that she was responsible. The HRC stated she preferred for staff to have physicals completed prior to starting but that the facility policy was they had up to 30 days. The HRC was not sure of the state regulations for newly hired staff physical examinations. On 1/9/25 at 1:48 PM, the Licensed Nursing Home Administrator (LNHA) and Regional Human Resources (RHR) provided the surveyor the facility policy for New Hire Procedure. The RHR reviewed and showed the state regulation (NJAC 8:39-19.5) to the surveyor and stated it was understood that physicals could be done within 30 days and the policy had been previously updated to reflect that. The LNHA stated that staff were in orientation at the beginning of employment and did not start right away on the units. On 1/9/25 at 12:50 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Assistant Administrator (AA) were informed of the concern with the 3 of 10 new hire staff physicals reviewed. A review of the undated facility policy titled, "New Hire Procedure" under Procedure revealed: " ...Orientation may begin before the Health Examination is completed but must be completed within 30 days of hire, or 2 weeks prior to the first day of employment ..." On 1/10/25 at 11:15 AM, the DON, LNHA, and AA met with the survey team. There was no additional information provided by the facility.	S1405	How we identified other residents/areas that could potentially be affected: All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: The Human Resources (HR) Coordinator was educated on the state regulations 1/9/25 for newly hired employees. Newly hired employees will not be allowed to start work until at least an RN assessment is completed, and physician assessment must be completed within 30 days. New employee checklist is updated on 1/28/25 to include RN assessment, to ensure that all new employees are not allowed to start without one. How the concern will be monitored and title of person responsible for monitoring:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62219	A. BUILDING: _____ B. WING _____	C 01/10/2025

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S1405	Continued From page 8	S1405	HR Coordinator/Designee will audit every new hire to ensure newly hired employees will have this requirement before starting. HR Coordinator/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.	
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day	S1680		2/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1680	Continued From page 9 Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports for	S1680	How the corrective action will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1680	Continued From page 10 the weeks of 12/22/2024 and 1/4/2025, it was determined that the facility failed to provide at least minimum staffing levels for 5 of 14 days. The required staffing hours and actual staffing hours were as follows: 1. For the week of 12/22/24 Required Total Staffing Hours: 481.75 -12/22/24 had 424 actual staffing hours, for a difference of -57.75 hours. -12/28/24 had 440 actual staffing hours, for a difference of -41.75 hours. 2. For the week of 12/29/24 Required Total Staffing Hours: 471.75 -01/01/25 had 432 actual staffing hours, for a difference of -39.75 hours. -01/02/25 had 464 actual staffing hours, for a difference of -7.75 hours. -01/04/25 had 448 actual staffing hours, for a difference of -23.75 hours. On 1/10/25 at 9:01 AM, Surveyor #1 (S#1) interviewed the Licensed Nursing Home Administrator (LNHA), in the presence of Surveyor #2, regarding the facility's nurse staffing protocols. The LNHA stated she was aware of the New Jersey mandated regulations, including acuity and the facility tried to follow the mandated staffing. The LNHA acknowledged that staffing had always been an issue, especially on the weekends. The LNHA stated that the facility was sending new hire staff for CNA classes and utilized agency staffing to assist with staffing levels. On 1/10/24 at 11:46 AM, S#1 notified the LNHA, the Director of Nursing, and the Assistant	S1680	accomplished for any resident affected by deficient practice: All efforts to hire facility Certified Nursing Aide(s) C.N.A 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 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: Due to the nature of the deficiency, all residents have the potential to be affected by staff shortage.	

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S1680	Continued From page 11 Administrator, of the above concerns for staffing. There was no additional information provided by the facility.	S1680	Measures to ensure were/will be put into place to assist this area of concern: Contracts with additional staffing and hiring agencies 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, there are daily and weekly meetings with the staffing coordinator. CNA trainees will be screened, hired and sent to facility sponsored and State approved CNA class. Offer bonuses and incentives to staff to help cover open positions. The Director of Nursing will review daily staffing with staffing coordinator and develop a plan to address staffing issues or concerns identified. When there are staffing concerns, the staff nurses and nurse managers work as CNAs for the day to meet the residents□ needs. Corporate Staffing Director will monitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62219	A. BUILDING: _____ B. WING _____	C 01/10/2025

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S1680	Continued From page 12	S1680	staffing needs daily to ensure facility is compliance with staffing requirements based on census and resident acuities. Director of Nursing and staffing coordinator will meet daily to discuss and plan staffing based on census and acuities. Director of Nursing and staffing coordinator will meet daily to ensure RN coverage daily. How the concern will be monitored and title of person responsible for monitoring: Staffing Coordinator/Designee will review staffing schedules weekly to ensure adequate staffing for all shifts. The results of these reviews will be submitted to Quality Assurance Performance Improvement (QAPI) for review. 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.	

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 _____	R-C 03/06/2025

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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite revisit was conducted for the 1/10/2025 Recertification survey. The facility was found to be in substantial compliance with the implementation of their POC.	{F 000}		

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

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 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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315438 Y1	A. Building B. Wing Y2	3/6/2025 Y3

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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 02/10/2025	ID Prefix F0921 Reg. # 483.90(i) LSC	Correction Completed 02/10/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315438 Y1	A. Building B. Wing Y2	3/6/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0584	Correction	ID Prefix F0640	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(f)(1)-(4)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/10/2025
ID Prefix F0641	Correction	ID Prefix F0657	Correction	ID Prefix F0661	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/10/2025
ID Prefix F0684	Correction	ID Prefix F0689	Correction	ID Prefix F0690	Correction
Reg. # 483.25	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/10/2025
ID Prefix F0692	Correction	ID Prefix F0695	Correction	ID Prefix F0698	Correction
Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/10/2025
ID Prefix F0712	Correction	ID Prefix F0732	Correction	ID Prefix F0761	Correction
Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/10/2025

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315438 Y1	A. Building B. Wing Y2	3/6/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0809	Correction	ID Prefix F0812	Correction	ID Prefix F0836	Correction
Reg. # 483.60(f)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70(a)-(c)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/24/2025
ID Prefix F0880	Correction	ID Prefix F0919	Correction	ID Prefix F0921	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(g)(1)(2)	Completed	Reg. # 483.90(i)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/10/2025
ID Prefix F0947	Correction				
Reg. # 483.95(g)(1)-(4)	Completed				
LSC	02/10/2025				

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/10/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62219 Y1	A. Building B. Wing Y2	3/6/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/10/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: JECT12

STATE FORM: REVISIT REPORT (11/06)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62219 Y1	A. Building B. Wing Y2	3/6/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/10/2025	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 02/10/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 02/10/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315438	A. BUILDING 02 B. WING	01/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/08/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/08/25 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Atrium Post Acute Care of Park Ridge is a three-story building that was built in 1997. It is composed of Type II protected construction. The facility is divided into 13 smoke compartments. The generator powers 40% of the building per the Maintenance Director. The number of occupied beds was 180 out of 210.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT	K 222		2/10/25

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

Electronically Signed | 01/31/2025

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 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.

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	315438	A. BUILDING **02** B. WING _____	**01/10/2025**

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K 222	Continued From page 1 LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies	K 222		

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K 222	Continued From page 2 installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure delayed egress exit doors unlocked and sounded an audible signal in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 19.2.2.2.4 and 7.2.1.6.1.1. This deficient practice had the potential to affect staff and 24 residents. Findings include: Observations on 01/08/25 at 9:39 AM of the designated exit door located by Room 221 revealed the delayed-egress lock failed to release after 15 seconds when pressure was applied to the door. Signage on the door indicated the locks would unlock 15 seconds after pressure was applied and that an alarm would sound; however, neither occurred. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and revealed the facility was unaware the delayed egress locks were not functioning. NJAC 8:39-31.1(c), 31.2(e)	K 222	How the corrective action will be accomplished for any resident affected by deficient practice: Door security vendor came on 1/22/2025 to correct delayed-egress lock release issues with new locks. No residents were affected by this deficient practice. How we identified other residents/areas that could potentially be affected: All exit doors are potentially affected; therefore all residents have the potential to be affected by this by this deficient practice.	

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K 222	Continued From page 3	K 222		

Measures to ensure were/will be put into place to assist this area of concern:

U.S. FOIA (b) (6) inserviced the *U.S. FOIA (b) (6)* to ensure all egress doors release after 15 seconds when pressure is applied to the door on 1/13/2025.

U.S. FOIA (b) (6) inserviced all second floor staff on using the code to release the door in case of a fire on 1/13/2025.

All exit doors have been tested for proper functioning of delayed-egress lock release and audible signal on 1/31/2025.

Monthly inspection of all exit doors will be completed by the *U.S. FOIA (b) (6)* as part of the preventive maintenance routine.

How the concern will be monitored and title of person responsible for monitoring:

The outcome of monthly inspection findings will be discussed with the *U.S. FOIA (b) (6)* for immediate attention if needed.

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K 222	Continued From page 4	K 222	The maintenance Director/Designee will present monthly findings at the monthly Safety Meetings for 3 months and will be part of quarterly Quality Assurance Performance Improvement (QAPI) where recommendations will be made for continued monitoring.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the fire alarm remote annunciator panel properly functioned for one of two annunciator panels on the third floor and failed to ensure the fire alarm system was tested and maintained in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 9.6.1.3 and NFPA 72 (2010) Chapter 14. This deficient practice had the potential to affect all 180 residents. Findings include: An observation on 01/08/25 at 11:54 AM revealed the remote annunciator at the Nurses' Station on Three East did not have power to it.	K 345	How the corrective action will be accomplished for any resident affected by deficient practice: Fire security vendor was called on 1/8/2025 to evaluate and repair the remote enunciator at the Nurses□ Station 3 East. Follow up email was sent on 1/30/2025. Repair of the remote enunciator was completed on 3/4/25. Fire security company that provides annual fire and inspection services, including fire drill company completed the “interface equipment” section on report.	3/11/25

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K 345	Continued From page 5 During an interview at the time of the observation the U.S. FOIA (b) (6) confirmed the finding and revealed the facility had scheduled repairs to be made. A review of the facility's "Fire Alarm Annual Inspection and Test Reports" for the previous two years revealed magnetic locking devices installed at designated exits throughout the facility were not identified in the reports. The section titled "Interface Equipment" was blank. A review of the facility's "Fire Drill Reports," revealed the magnetic locking devices were not identified on the reports. The facility had a mixture of delayed egress locks and bracelet activated locking devices installed at exits. During an interview on 01/08/25 at 6:00 PM, the U.S. FOIA (b) (6) confirmed the finding and stated the facility was unable to locate the missing documentation. He stated the facility's magnetic locks were tied to the fire alarm; however, documentation of their testing could not be located. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K 345	Fire security company identified all magnetic locking devices installed at designated exits throughout the facility on 3/11/25. No residents were affected by this deficient practice. How we identified other residents/areas that could potentially be affected: All other remote annunciators have the potential to be affected by this deficient practice. All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Repair Log of equipment related to Life and Safety concerns will be kept in the Maintenance Director's office. Maintenance Director/Designee will do weekly review and follow-up will be made and logged until appropriate repair or	

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K 345	Continued From page 6	K 345	action is completed. Inspection and test reports by any vendor will be inspected for completion by the Maintenance Director/Designee. Missing information will be addressed immediately. How the concern will be monitored and title of person responsible for monitoring: *U.S. FOIA (b) (6)* was inserviced by the *U.S. FOIA (b) (6)* on routine review of required inspections that need to be done monthly and review of repair log on 1/29/2025. Review of Repair Log of equipment related to Life and Safety concerns will be made monthly by the *U.S. FOIA (b) (6)*. Findings will be discussed with the *U.S. FOIA (b) (6)* for immediate attention if needed. The Maintenance Director/Designee will present monthly findings at the monthly Safety Meetings for 3 months and will be part of quarterly Quality Assurance Performance Improvement (QAPI) where recommendations will be made for continued monitoring.	

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K 353	Continued From page 7	K 353		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all 180 residents at the facility. Findings include: A review of the facility's test and inspection records for the wet sprinkler system, provided by the facility, revealed the facility failed to document the sprinkler inspection for the fourth quarter of	K 353	How the corrective action will be accomplished for any resident affected by deficient practice: Sprinkler systems inspection was completed on 1/10/2025 and this document is now on file. Inspection of the fire sprinkler riser has been completed on 1/10/2025 and the inspection tag has been updated. No residents were affected by this deficient practice.	2/10/25

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K 353	Continued From page 8 2024. Inspection reports for 07/30/24, 05/01/24, and 01/22/24 were the only reports provided. This documentation was requested by the surveyor at the entrance conference, during documentation review, and before the exit conference. An observation on 01/08/25 at 3:11 PM of the fire sprinkler riser, revealed that the fourth quarter of 2024 was not documented on the inspection tag. Inspection dates of 07/30/24, 05/01/24, and 01/22/24 were noted on the tag. During an interview at the time of the observation, the *U.S. FOIA (b) (6)* confirmed the findings and stated the facility was unable to provide documentation of sprinkler system inspections for the fourth quarter of 2024. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K 353	How we identified other residents/areas that could potentially be affected: All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: Vendor inspection schedule was made to monitor all types of regulatory inspections. The *U.S. FOIA (b) (6)* was provided education by the *U.S. FOIA (b) (6)* on 1/29/2025 about routine review of required inspections in the facility at least monthly. The *U.S. FOIA (b) (6)* will review the required inspections quarterly and address any concerns promptly.	

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K 353	Continued From page 9	K 353	How the concern will be monitored and title of person responsible for monitoring: A review of the required inspections will be made monthly by the U.S. FOIA (b) (6) [redacted]. Findings will be discussed with the Administrator for immediate attention if needed. The Maintenance Director/Designee will present monthly findings at the monthly Safety Meetings for 3 months and will be part of quarterly Quality Assurance Performance Improvement (QAPI) where recommendations will be made for continued monitoring.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to maintain smoke barriers to resist the passage of smoke in accordance with NFPA 101	K 372	How the corrective action will be accomplished for any resident affected by deficient practice:	2/28/25

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K 372	Continued From page 10 Life Safety Code (2012 edition), Section 8.5. This deficient practice had the potential to affect all 180 residents. Findings include: An observation on 01/08/25 at 9:22 AM of the smoke barrier located inside the Infection Preventionist's Office revealed a three-inch unsealed gap along the top of the smoke wall at the metal deck and wall joint. An observation on 01/08/25 at 9:32 AM of the smoke barrier located by the Day Room and Room 209 revealed a three-inch unsealed gap along the top of the smoke wall at the metal deck and wall joint. An unsealed two-inch overcut around a group of wires was also observed. An observation on 01/08/25 at 10:02 AM of the smoke barrier located inside the Storage Room on the first floor revealed a three-inch unsealed gap along the top of the smoke wall at the metal deck and wall joint. An observation on 01/08/25 at 10:40 AM of the smoke barrier located in the Corridor by Room 100 revealed a four-inch unsealed overcut at the top of a duct penetration above the ceiling. An observation on 01/08/25 at 11:44 AM of the smoke barrier located in the Corridor by Room 310 revealed a three-inch unsealed overcut at the bottom of a duct penetration above the ceiling. An observation on 01/08/25 at 12:03 PM of the smoke barrier located in the Corridor by Room 411 revealed a two-inch unsealed overcut around a blue wire penetration above the ceiling.	K 372	General contractor came and completed the following work on 2/20/25: •For the infection preventionist's office fire sealant was applied to seal the three-inch gap along the top of the smoke wall at the metal deck and wall joint. •For the smoke barrier located by the day room and room 209, fire sealant was installed to seal the three-inch gap along the top of the smoke wall at the metal deck and wall joint and sealed the two-inch overcut around a group of wires. •For the smoke barrier located inside the storage room on the first floor, fire sealant was installed to seal the three-inch gap along the top of the smoke wall at the metal deck and wall joint. •For the smoke barrier located in the corridor by room 100, fire sealant was installed to seal a four-inch overcut at the top of the duct penetration above the ceiling. •For the smoke barrier located at the corridor by room 310, fire sealant was installed to seal the three-inch overcut at the bottom of a duct penetration above the ceiling. •For the smoke barrier located in the corridor by room 411, fire sealant was installed to seal a two-inch overcut around the blue wire penetration above the ceiling.	

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K 372	Continued From page 11 During interviews at the time of each observation, the US FOIA (b)(6) confirmed the findings and stated the facility was unaware of the unsealed gaps in the smoke barriers. NJAC 8:39-31.1(c), 31.2(e)	K 372	No residents were affected by this deficient practice. How we identified other residents/areas that could potentially be affected: All smoke barriers will be inspected on 2/3/2025 for penetrations/unsealed gaps. Any negative findings will be corrected by 2/28/2025. All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: *U.S. FOIA (b) (6)* inserviced US FOIA (b)(6) assistants on how to identify unsealed gaps/penetrations for all smoke barriers on 1/13/2025. Quarterly inspection of all smoke barriers will be done by the *U.S. FOIA (b) (6)*	

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K 372	Continued From page 12	K 372	*U.S. FOIA (b) (6)* as part of preventive maintenance routine. How the concern will be monitored and title of person responsible for monitoring: The outcome of quarterly inspection findings will be discussed with the *U.S. FOIA (b) (6)* for immediate attention if needed. The Maintenance Director/Designee will present findings at the monthly Safety Meetings for 3 months and will be part of quarterly Quality Assurance Performance Improvement (QAPI) where recommendations will be made for continued monitoring.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum	K 374		2/10/25

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 13 clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke doors to resist the passage of smoke in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 8.5. The deficient practice had the potential to affect 70 residents. Findings include: An observation on 01/08/25 at 10:09 AM of the smoke door located at the Storage Room on the First Floor revealed the door was held open with a door stopper device that was not tied to the fire alarm system. An observation on 01/08/25 at 11:38 AM of the smoke doors located by Room 309 revealed a two-inch gap between the edges of the doors when closed, allowing a passage for smoke to get through. An observation on 01/08/25 at 11:45 AM of the smoke doors located by Room 323 revealed a three-inch gap between the edges of the doors when closed, allowing a passage for smoke to get through. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the findings and stated the facility was unaware the doors were not closing smoke tight, and that hold-open devices were required to be tied to the fire alarm system.	K 374	How the corrective action will be accomplished for any resident affected by deficient practice: The stopper device holding Storage room door on the First Floor that was not tied to the fire alarm system was immediately removed. Astragals will be attached to the meeting edge of the smoke doors to seal off identified gaps located by Rooms 309 and 323 by 2/10/2025. No residents were affected by this deficient practice. How we identified other residents/areas that could potentially be affected: All smoke doors have the potential to be affected, and all residents have the potential to be affected by this deficient practice.	

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K 374	Continued From page 14 NJAC 8:39-31.2(e)	K 374	Measures to ensure were/will be put into place to assist this area of concern: All department heads were in-serviced by the *U.S. FOIA (b) (6)* on maintaining smoke doors to resist passage of smoke by not using any stopper device or objects to hold the door from freely closing on 1/30/2025. All smoke doors in the facility were inspected on 1/30/2025 to ensure compliance. No additional smoke doors were identified with this concern. *U.S. FOIA (b) (6)* will do monthly inspections of all smoke doors to ensure compliance. How the concern will be monitored and title of person responsible for monitoring: The outcome of monthly smoke door inspection findings will be discussed with the *U.S. FOIA (b) (6)* for immediate attention if needed. The *U.S. FOIA (b) (6)* will present monthly findings at the monthly Safety Meetings for 3 months and will be	

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K 374	Continued From page 15	K 374	part of quarterly Quality Assurance Performance Improvement (QAPI) where recommendations will be made for continued monitoring.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain their elevator in accordance with NFPA 101 (2012), Section 9.4. The deficient practice had the potential to affect all 180 residents. Findings include: An observation on 01/08/25 at 11:33 AM of the	K 531	How the corrective action will be accomplished for any resident affected by deficient practice: The blinking light telephone line on the elevator by the lobby was repaired on 1/22/2025, telephone line is now hooked up to the Fire Department. Elevator inspection report dated 2/27/25, indicates	2/27/25

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K 531	Continued From page 16 elevator by the Lobby revealed a blinking light next to the following signage: "Blinking indicates call answered help is on the way" When the U.S. FOIA (b) (6) pressed the emergency button there was no answer, and it stopped ringing after one ring. During an interview at the time of the observation, the U.S. FOIA (b) (6) stated the light had been blinking for two days. According to the U.S. FOIA (b) (6) the facility was trying to get someone out to repair it. The facility failed to provide written records of the monthly operation of the fire fighters' service. During an interview on 01/08/25 at 6:02 PM, the U.S. FOIA (b) (6) confirmed the finding and stated the facility could not locate the missing documentation. NJAC 8:39-31.2(e)	K 531	emergency signals and communication was satisfactory for Elevator 2 (elevator B). No residents were affected by this deficient practice. How we identified other residents/areas that could potentially be affected: All elevators have the potential to be affected by this deficient practice. All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: U.S. FOIA (b) (6) inserviced U.S. FOIA (b) (6) on elevator emergency button must be tested monthly to ensure operation of the fire fighters service on 1/13/2025. Monthly inspection of the elevators and testing of call bell service will be done by	

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K 531	Continued From page 17	K 531	the *U.S. FOIA (b) (6)* . Monthly written reports from the Firefighter□s Service will be obtained and retained by the Maintenance Director/Designee. How the concern will be monitored and title of person responsible for monitoring: The outcome of monthly inspection findings will be discussed with the *U.S. FOIA (b) (6)* for immediate attention if needed. The Maintenance Director/Designee will present monthly findings at the monthly Safety Meetings for 3 months and will be part of quarterly Quality Assurance Performance Improvement (QAPI) where recommendations will be made for continued monitoring.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K 761		2/10/25

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K 761	Continued From page 18 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain written records of the inspection and testing of fire doors in accordance with NFPA 101 (2012) Section 19.7.6 and NFPA 80 (2010) Section 5.2.1. The deficient practice had the potential to affect all 180 residents. Findings include: A review of the facility's Life Safety Code documentation revealed no documented evidence the facility's fire doors had been inspected and tested. During an interview on 01/08/25 at 3:56 PM, the *U.S. FOIA (b) (6)* confirmed the finding and stated the facility was unable to provide the written records for the inspection and testing of the facility's fire doors. NJAC 8:39-31.2(e) NFPA 80	K 761	How the corrective action will be accomplished for any resident affected by deficient practice: Annual inspection and testing of fire doors by a Certified National Fire Protection Association (NFPA) inspector was made on 1/30/2025 on all fire and smoke barrier doors in the facility. A written record of this annual inspection is now retained in the Maintenance Office. No residents were affected by this deficient practice. How we identified other residents/areas that could potentially be affected: All fire and smoke doors have the potential to be affected by this deficient practice, and all residents have the potential to be affected by this deficient practice.	

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K 761	Continued From page 19	K 761		

Measures to ensure were/will be put into place to assist this area of concern:

Inspection and testing of fire doors by a certified NFPA inspector will be requested and scheduled once a year by the Maintenance Director/Designee.

How the concern will be monitored and title of person responsible for monitoring:

Inspection schedule log will be monitored and maintained by the U.S. FOIA (b) (6) [redacted] monthly for all types of regulatory inspections.

The U.S. FOIA (b) (6) [redacted] was provided education by the U.S. FOIA (b) (6) [redacted] on 1/29/2025 about routine review of required inspections in the facility at least monthly.

The U.S. FOIA (b) (6) [redacted] will review the required inspections quarterly and address any concerns promptly.

The U.S. FOIA (b) (6) [redacted] will

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K 761	Continued From page 20	K 761	present monthly findings at the monthly Safety Meetings for 3 months and will be part of quarterly Quality Assurance Performance Improvement (QAPI) where recommendations will be made for continued monitoring.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of testing and performance data for electrical receptacles at patient bed locations as required by NFPA 99 (2012), Section 6.3.4. The deficient practice had	K 914	How the corrective action will be accomplished for any resident affected by deficient practice: Electrical company tested all electrical	3/10/25

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K 914	Continued From page 21 the potential to affect all 180 residents. Findings include: A review of the facility's Life Safety Code Survey Binder and Electrical Reports revealed no documented evidence the facility's electrical receptacles at resident bed locations were tested to determine their performance data. Observations revealed the facility had a mixture of hospital grade receptacles and non-hospital grade receptacles in resident rooms. During an interview on 01/08/25 at 6:00 PM, the *U.S. FOIA (b) (6)* confirmed the finding and stated the facility was unable to locate the missing documentation. NJAC 8:39-31.2(e) NFPA 99	K 914	receptables at patient bed locations and provided documentation of performance data on 3/10/2025. No residents were affected by this deficient practice. How we identified other residents/areas that could potentially be affected: All electrical receptacles at patient bed locations have the potential to be affected. All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern: *U.S. FOIA (b) (6)* in-serviced *U.S. FOIA (b) (6)* on ensuring documentation of of testing and performance data for electrical recepacles at all patient bed locations on 1/13/2025 Testing and performance data for all	

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K 914	Continued From page 22	K 914	electrical receptacles at patient bed locations will be requested to include performance data by 3/10/2025. Additional testing will be done as needed based on documented performance data. The *U.S. FOIA (b) (6)* will ensure that annual electrical testing includes documented performance data. How the concern will be monitored and title of person responsible for monitoring: A review of the required inspections will be made monthly by the *U.S. FOIA (b) (6)* . Findings will be discussed with the *U.S. FOIA (b) (6)* for immediate attention if needed. The *U.S. FOIA (b) (6)* will present monthly findings at the monthly Safety Meetings for 3 months and will be part of quarterly Quality Assurance Performance Improvement (QAPI) where recommendations will be made for continued monitoring.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		3/11/25

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K 918	Continued From page 23 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observations, record review, and interview, the facility failed to meet the Emergency Electrical System requirements of	K 918	How the corrective action will be accomplished for any resident affected by deficient practice: Generator service came on 3/6/25 to	

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K 918	Continued From page 24 NFPA 110 Emergency and Standby Systems (2010 Edition). The deficient practice had the potential to affect all 180 residents. Findings include: Observations on 01/08/25 at 11:00 AM revealed there was not a remote manual stop station installed for the EPS on the premises where the prime mover was located outside of the building as required by NFPA 110 (2010) Section 5.6.5.6. This deficiency was also cited during the Life Safety Code Survey conducted on 08/29/23 under K-918. A review of the facility's "Annual Generator Inspection," dated 06/13/23 revealed the following deficiencies: "a) Generator not sitting on a flat platform b) Generator wires rubbing on sharp metal and plastic broken c) Corrosion on output leads at main breaker d) Oil leak at turbo e) Batteries are from 9/2019 and have exceeded the 30-month life-span required by NFPA 110 f) Fuel supply lines are leaking and need to be replaced g) Radiator needs to be pressure washed to remove debris h) Air filter needs to be replaced" Observations on 01/08/25 at 11:00 AM and 4:15 PM of the generator revealed the deficiencies had not been corrected. These deficiencies were also cited during the Life Safety Code Survey conducted on 08/29/23 under K-918. During an interview at the time of the observations, the *U.S. FOIA (b) (6)*	K 918	install a remote manual stop station for the emergency power supply (EPS). Other corrections made were as follows: a) Generator service came on 3/7/25 to level up the platform on which the generator was on and braced and welded with metal support for stability b) New wire grommet and hose were installed on 3/11/2025 to protect generator wires c) Corrosion on output leads at main breaker was cleaned on 3/11/2025 d) Oil leak at turbocharger was corrected on 3/11/2025. Stacking on turbo was cleared by running 4-hour load bank, securing oil lines and connections, and is now free of leak e) New batteries were installed on 3/11/2025 f) Fuel lines were replaced on 3/11/2025 and is now free of leak. All other connections were checked and tightened g) Radiator was power washed on 2/17/2025 is now free of debris h) Air filter was replaced on 3/11/2025 Annual test and inspection of the generator was completed on 2/17/2025, and was verified that everything was working correctly.	

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K 918	Continued From page 25 confirmed the findings and stated the facility had not corrected the deficiencies cited on the previous survey. The U.S. FOIA (b) (6) also stated the facility had not corrected the deficiencies identified on the generator inspection and test report. A review of the facility's "Generator Testing and Inspection Reports" provided by the facility revealed the facility failed to conduct the annual test and inspection of the generator in 2024. During an interview on 01/08/25 at 4:05 PM, the U.S. FOIA (b) (6) confirmed the finding and stated the facility was unable to locate the annual test and inspection of the generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	No residents were affected by 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. Measures to ensure were/will be put into place to assist this area of concern: U.S. FOIA (b) (6) in-serviced U.S. FOIA (b) (6) on ensuring any comments on generator inspection reports must be addressed timely on 3/7/2025. Repair Log of equipment related to Life and Safety concerns will be kept in the Maintenance Director□s office. Weekly review and follow-up will be made and logged until appropriate repair or action is	

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

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K 918	Continued From page 26	K 918	completed. Inspection and test reports by any vendor will be inspected for completion by the *U.S. FOIA (b) (6)* [redacted]. Missing information will be addressed immediately. How the concern will be monitored and title of person responsible for monitoring: Review of Repair Log of equipment related to Life and Safety concerns will be made monthly by the *U.S. FOIA (b) (6)* [redacted]. Findings will be discussed with the *U.S. FOIA (b) (6)* [redacted] for immediate attention if needed. The *U.S. FOIA (b) (6)* [redacted] will present monthly findings at the monthly Safety Meetings for 3 months and will be part of quarterly Quality Assurance Performance Improvement (QAPI) where recommendations will be made for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315438	A. BUILDING **02** B. WING _____	R **03/14/2025**

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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{E 000}	Initial Comments	{E 000}		
{K 000}	INITIAL COMMENTS Census: 175 An onsite revisit was conducted to verify the facility's Plan of Correction regarding the 1/10/25 Recertification/LSC survey. The facility was found to be in compliance.	{K 000}		

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

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 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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315438 Y1	A. Building 02 - PLAZA REGENCY AT PARK RIDGE B. Wing Y2	3/14/2025 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	02/10/2025	LSC K0345	03/11/2025	LSC K0353	02/10/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	02/28/2025	LSC K0374	02/10/2025	LSC K0531	02/27/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0761	02/10/2025	LSC K0914	03/10/2025	LSC K0918	03/11/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO