STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Healthcare at Daughters of Miriam	155 Hazel Street Clifton, NJ 07011

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # NJ183033 Based on interviews, medical record reviews, and review of other pertinent facility documents, it was determined that the facility failed to ensure that the physician was consulted and notified immediately of resident's change in condition and follow the facility's policy and protocol with regard to notification of changes. This deficient practice was identified for 1 of 3 residents, (Resident #443), reviewed. This deficient practice was evidence by the following: A review of the admission Record (an admission summary) revealed that Resident #443 was admitted to facility with diagnoses which included but were not limited to; Parkinson's Disease without dyskinesia, without mention of fluctuations, other Alzheimer's Disease, multiple myeloma (a cancer of plasma cells, a type of white blood cell that normally produces antibodies) not having achieved remission, type 2 diabetes mellitus without complications, nonrheumatic aortic (valve) insufficiency, aneurism of the ascending aorta, without rupture, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review Resident #443's progress notes (PN) revealed that on [DATE] at approximately 3:10 PM, Resident #443's responsible party (RP) informed Licensed Practical Nurse #1 (LPN#1) that the resident looked dehydrated. The PN revealed that the resident was observed, and vital signs were obtained. The PN further revealed, MD called at around 4:24 PM no answer and unable to leave voice message. The PN revealed that the resident was encouraged to drink fluids and eat but consumed less than 25 percent. Further review of the above PN revealed no further attempts by LPN #1 to contact Resident #443's physician until 10:59 PM when the physician was notified that Resident #443 expired at 10:57 PM. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted with LPN #1 on [DATE] at 11:38 AM. LPN #1 stated that she was caring for Resident #443 on evening shift on [DATE], LPN #1 stated she was notified by Resident #443's RP that the resident appeared dehydrated. LPN #1 stated that she assessed the resident, and their vital signs were okay, but the resident's skin turgor was poor. LPN #1 further stated that she called the resident's physician to discuss the resident's appetite and skin turgor, and to propose intravenous (IV) fluids for the resident and LPN #1 did not receive a call back after she called the physician and left a voice message. LPN #1 did not recall the name of the physician she attempted to contact but stated that her practice was to call the physician listed on the resident's profile. LPN #1 further stated that it was her practice to notify the Nursing Supervisor (NS) if she was unable to reach a resident's physician regarding a concern. An interview was conducted with LPN #2 on [DATE] at 12:11 PM. LPN #2 stated that she was working as the NS on [DATE] when Resident #443 expired. LPN #2 stated that it was the expectation that nurses reported anything that was outside of a resident's baseline to the NS, the physician should have been called, and then any new orders followed. LPN #2 further stated that if staff was unable to reach a resident's physician, the Medical Director should have been called. On that same date and time, LPN #2 stated that if a resident was dehydrated, the first steps would be to call the physician if the resident was not in acute distress. LPN #2 stated that on [DATE], the nurse assigned to Resident #443 attempted to contact the resident's physician but got no answer and left a voice message. LPN #2 stated that LPN #2 made her aware of Resident #443's condition because she was the NS. LPN #2 stated that she instructed LPN #1 to send a text message to the physician instead of calling but was unsure if LPN #1 was able to reach the resident's physician by text. LPN #2 stated that it was important that nurses reported concerns because it could lead to a resident declining if they did not get what they needed. LPN #2 further stated that was important to have clear lines of communication so that facility staff could do everything that needed to be done for residents. An interview was conducted with the Assistant Director of Nursing (ADON) on [DATE] at 1:03 PM. The ADON stated that staff, including agency staff, were instructed to go to Unit Managers if they had concerns about residents, and on the weekend they should call the NS. The ADON stated that if a nurse was unable to reach a physician, they should notify the NS who would then call the Medical Director. The ADON reviewed the PN regarding Resident 443's RP's concern about dehydration. The ADON stated, It does not appear that (LPN #1) followed our process for physician notification when there were concerns for dehydration. A review of the facility's Notification of Changes Policy, reviewed/revised [DATE], revealed under Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician [.] when there is a change requiring notification. Under Definitions: the policy revealed that the need to alter treatment significantly means a need to stop a form of treatment, or commence a new form of treatment to deal with a problem. Further review of the policy revealed under Compliance Guidelines, Circumstances requiring notification include: [.] 3. Circumstance that require a need to alter treatment. This may include: a. New treatment. NJAC 8:39-13.1 (d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. COMPLAINT #: NJ173918 Based on interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete, available, accurate, and readily accessible medical records. This deficient practice was identified for 4 of the 38 residents reviewed, (Residents #131, #162, #175, and #493). This deficient practice was evidenced by the following: 1. On 2/7/25 at 11:47 AM, the surveyor observed Resident #162 seated in a wheelchair outside their room with a right leg prosthesis in use. The surveyor reviewed the medical records of Resident #162, and revealed the following: The admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; dehiscence of amputation stump (a rare medical condition where the surgical incision site from a previous amputation reopens or separates, exposing the underlying tissues and bones), acquired absence of right leg below the knee, encounter for orthopedic aftercare following surgical amputation, and type 2 diabetes mellitus without complications. A review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool, with an assessment reference date (ARD) of 12/21/24, under Section C Cognitive Patterns revealed a brief interview for mental status (BIMS) score of 9 of 15, which reflected that the resident had moderately impaired cognition. A review of the Progress Notes (PN) revealed that the physician's visit notes were all late entries, created on 2/11/25, for an effective date from 9/20/24 through 1/14/25. On 2/12/25 at 1:29 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Regional Director of Clinical Services (RDCS), and the Director of Nursing (DON), and the surveyor notified them of the concerns above regarding late entries of the physician. On 2/18/25 at 11:25 AM, the survey team met with the RDCS, DON, and the LNHA. The RDCS stated that the monthly physician visit notes should be done within the 1st 90 days and then every 60 days thereafter. 2. On 2/7/25 at 11:33 AM, the surveyor observed Resident #175's outside door with a posted sign for Enhanced Barrier Precautions (EBP were measures implemented in healthcare settings to prevent the transmission of infections, particularly in situations where standard precautions alone may not be sufficient) and the resident was not inside the room. On that same date and time, the Certified Nursing Aide (CNA) informed the surveyor that the resident was in therapy. The CNA further stated that Resident #175 was cognitively impaired, and no unusual behavior. (continued on next page)

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The surveyor reviewed the medical records of Resident #175 and revealed:

A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; urinary tract infection site not specified, ESBL (Extended-spectrum beta-lactamases are a type of enzyme or chemical produced by some bacteria. ESBL enzymes make some antibiotics ineffective in treating bacterial infections) resistance, other retention of urine, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, other specified anxiety disorders, unspecified protein-calorie malnutrition, and chronic obstructive pulmonary disease (COPD, is a type of progressive lung disease characterized by chronic respiratory symptoms and airflow limitation).

A review of the most recent comprehensive MDS (cMDS), with an ARD of 11/20/24, revealed a BIMS score of 3 of 15, which reflected that the resident's cognitive status was severely impaired. The cMDS also reflected that Resident #175 did not receive influenza vaccination in the facility, the pneumococcal vaccination was not up to date, and the pneumococcal vaccination was not offered.

A review of the December 2024, January 2025, and February 2025 electronic Medication Administration Record (eMAR) with physician orders (PO) revealed:

-A PO with a start date of 12/12/24 and discontinued (d/c) on 1/13/25 for Quetiapine fumarate tablet (tab) 25 mg (milligram), give one tab by mouth at bedtime (HS) for psychosis.

-A PO with a start date of 1/14/25 and d/c on 2/1/25 for Trazodone HCL (hydrochloride) tab 50 mg, give 1/2 tab (25 mg) by mouth at HS for depression.

-A PO with a start date of 2/5/25 for Trazodone 50 mg, give ½ (25 mg) tab by mouth at HS for depression.

-A PO with a start date of 2/6/25 for Quetiapine fumarate tab 25 mg, give ½ tab by mouth two times a day for psychosis.

Further review of the medical records revealed that there was no documented evidence that influenza and pneumococcal vaccinations were offered and declined by the resident or by the Resident Representative (RR) or education was provided. There was no evidence that the consent was offered and signed by the resident or the RR to start on psychoactive medications.

On 2/10/25 at 9:22 AM, the surveyor discussed with the LNHA, DON, and Assistant DON (ADON) regarding the expectation that the survey team must have access to residents' medical records as part of the survey process and the facility to provide asked documents timely, and the LNHA acknowledged.

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that same time, LPN/UM#1 was unable to locate the resident's vaccination consent forms and psychoactive signed consent. LPN/UM#1 had checked the resident's paper chart and electronic medical records and stated that he did not find evidence that the consent for vaccinations and psychotropic were done. LPN/UM#1 had no response when asked why the resident did not have consent for psychotropic use and vaccinations. A review of the electronic medical records revealed that the COVID-19 vaccine, Prevnar-20 (pneumococcal vaccine), and influenza consents status were pending. Later, LPN/UM#1 stated that the Infection Preventionist Nurse (IPN) would probably have the vaccination consent forms. Both the surveyor and LPN/UM#1 went to the IPN's office. In the IPN's office, the IPN stated that she only had a few in her binder of vaccination consent forms that were signed because some of them were on the residents' charts. The IPN further stated that it was the responsibility of the admission nurse to get consent as part of their admission packet. The IPN showed the binder and confirmed that there was no consent for Resident #175. The IPN further stated that the vaccines should be offered to all residents. On 2/10/25 at 1:05 PM, LPN/UM#1 informed the surveyor that he found the vaccines and psychotropic consents of Resident #175 in the copying machine because the admission person scanned it during admission and probably forgot it in the copying machine when they were scanning it. On 2/18/25 at 1:47 PM, the survey team met with the LNHA, DON, RDCS, Regional Nurse, and LPN/UM#1 for an exit conference, the LNHA did not provide additional information. 2. On 2/10/25 at 1:07 PM, the surveyor observed Resident #131 lying in their bed using a tablet. The resident was alert, oriented and verbally responsive. The resident stated that they used to smoke, and that the facility was now a smoke free facility. Resident #131 stated that they didn't need to smoke, they were ok with not smoking and had no concerns with the facility. On 2/10/25 at 1:15 PM, the surveyor interviewed LPN#2, who was assigned to care for Resident #131. LPN#2 stated Resident #131 use to smoke prior to update of smoke free facility policy and that the resident did not smoke anymore. LPN#2 verbalized no concern for the resident. On 2/10/25 at 1:26 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who stated that Resident #131 did not smoke anymore after the implementation of the smoke free policy. The RN/UM stated the interdisciplinary team (IDT) met with the resident to inform and educate the resident of the update policy, and the resident was agreeable. On 2/13/25 at 9:49 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #131. A review of the AR documented that the resident had diagnoses that included but were not limited to, anemia and thrombocytopenia (blood has lower than normal number of platelets. A review of the qMDS with an ARD of 1/29/25, indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 11:31 AM, the surveyor interviewed the RN/UM about documentation about the IDT meeting with the resident about the facility's updated smoking policy and the resident agreeable. The RN/UM stated that the documentation should be found in the resident's medical records. The surveyor notified the RN/UM that documentation and agreement was not found in Resident #131's medical records. The RN/UM stated she would ask the Social Worker (SW) if they had a copy. On 2/13/25 at 11:51 AM, the RN/UM stated that the LNHA had the agreement and would provide to the surveyor. On 2/13/25 at 12:46 PM, the surveyor interviewed the LNHA who stated that the IDT had a meeting with Resident #131 about the facility's updated policy in October 2024. The LNHA provided copy of a progress note for the IDT meeting. A team care plan meeting note dated 10/9/24, indicated the IDT meeting with Resident #131 which documented that the resident was educated on the updated facility policy of being smoke free and verbalized understanding. Resident #131 was agreeable, would discontinue smoking, denies need for counseling, and expressed interest in alternate assistance with smoking cessation. The note documented that nursing/IDT would follow up. The surveyor asked the LNHA about follow up on the alternate assistance with smoking cessation. The LNHA stated nicotine patch, and psychology was offered to the resident. The LNHA was to provide additional information regarding the follow up for the alternate assistance with smoking cessation. On 2/13/25 at 2:18 PM, the surveyor notified the LNHA, the DON, and the RDCS of the concern of the care planning of smoking and there being no documentation of cessation interventions in chart. On 2/14/25 at 1:07 PM, the surveyors met with the DON and the LNHA. The LNHA provided an untitled document letter dated 10/15/24 which indicated the resident had refused cessation interventions. The surveyor asked the LNHA where the document was located and if it was in the resident's medical record. The LNHA replied the document was not in the medical record and stated it was filed in his office. There was no additional documentation provided by the facility. 3. A review of the facility AR revealed that Resident #493 was admitted with diagnoses which included but were not limited to; cerebral infarction (stroke), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, benign prostatic hyperplasia (prostate enlargement), and urinary incontinence. A review of the MDS, revealed Resident #493 had a BIMS score of 12 of 15, which indicated moderate cognition impairment and Resident #493 was dependent for toileting hygiene. A review of Care Plan (CP), initiated 4/8/2024, included at risk of skin breakdown related to (r/t) incontinence bowel and bladder (B&B). Interventions included but were not limited to keep skin clean and dry, provide protective/preventive skin care, toilet with appropriate staff assistance as needed (prn), and provide incontinence care prn. A review of CP initiated on 4/13/24 included at risk for constipation r/t constipation, decreased mobility. Interventions included but were not limited to record bowel movement patterns each day and describe amount, color, and consistency. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #493's 5/2024 Certified Nurse Aide (CNA) Intervention/Task Report sheet for Bladder incontinence revealed that Resident #493's assigned CNA(s) did not document, on each shift, whether Resident #493 had urinary incontinence = 0-Continent, 1-Incontinent, 2-Did not void, 3-Continence not rated due to Indwelling Catheter, 4- Continence not rated due to Condom Catheter, 5 - Continence not rated due to Urinary Ostomy. The Bladder Continence intervention had missing signatures for 5/1/24, 5/2/24, 5/3/24, 5/7/24, 5/8/24, 5/9/24, 5/10/24, 5/11/24, 5/12/24, 5/13/24, 5/15/24, 5/16/24, 5/18/24, 5/21 - 5/31/24 for 7am-3pm shift. Bladder Continence signatures were missing for 5/1/24, 5/4/24, 5/5/24, 5/9/24, 5/10/24, 5/13/245/18/24, 5/23/24, 5/27/24 for 3pm-11pm shift. The Bladder Continence intervention/task had missing signatures for 5/2/24 and 5/3/24 for 11pm-7am shift Further review of the above revealed a total of 35 missed opportunities out of 93. A review of Resident #493's 5/2024 Certified Nurse Aide (CNA) Intervention/Task Report sheet for Bowel Management revealed that Resident #493's assigned CNA(s) did not document, on each shift, whether Resident #493 had bowel continence = 0-Continent, 2- No bowel movement, 3- Continence not rated due to Ostomy; Size of Bowel Movement (BM) = 1-None, 2 - Small, 3 - Medium, 4 - Large; Consistency of BM = 1 - Formed/Normal, 2 - Loose/Diarrhea, 3 - Constipated/hard, 4 - Putty like. Bowel Management intervention/task had missing signatures for 5/1/24, 5/2/24, 5/3/24, 5/7/24, 5/8/24, 5/9/24, 5/10/24, 5/11/24, 5/12/24, 5/13/24, 5/15/24, 5/16/24, 5/18/24, 5/21-5/31/24 for 7am-3pm. Bowel Management intervention/task had missing signatures for 5/1/24, 5/4/24, 5/5/24, 59-5/10/24, 5/13/24, 5/18/24, 5/23/24, 5/27/24 for 3pm-11pm shift. Bowel Management intervention/task had missing signatures for 5/2/24 and 5/3/2. for 11pm-7am shift. A review of the above revealed a total of 35 missed opportunities out of 93. During interview with the surveyor on 2/13/2024 at 12:29 PM, with current LPN/UM#1 on 1-East, confirmed that there were missing signatures for the dates mentioned and stated that it was important that there were no blanks because resident's bowel and bladder regimen should be monitored to prevent any further change in health for example constipation for the bowel and to ensure resident was voiding with no issue. LPN/UM#1 further stated that it was also important to sign and check for resident's skin integrity. He also stated that he did not know what the Xs meant. During an interview with the surveyor on 2/13/204 at 1:30 PM, with assigned Licensed Practical Nurse/Unit Manager #2 (LPN/UM#2) during the mentioned time on 1-East, confirmed that there were blanks and that it was important that there were no blanks to ensure the tasks were completed. LPN/UM#2 further stated that if the resident is not checked then skin can start to excoriate, and resident can attempt to get up which could lead to a fall. LPN/UM#2 stated that she does not know what the X meant. During an interview with the surveyor on 2/14/204 at 1:29 PM, with the DON, she confirmed that there were blanks and stated that there should not be any blanks. She further stated that it was important to sign to show that the care was provided and that it was very concerning. The DON stated that she did not know what the X meant. During an interview with the surveyor on 2/18/204 at 11:53 AM, with the RDCS, the RDCS confirmed that there were blanks, she stated that there should be no blanks on the ADL sheets. She further stated that it was important to document so we know the type of care that was provided. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility's Incontinence Policy, reviewed/revised 12/3/24, revealed: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Resident that are incontinent of bladder or bowel will receive appropriate treatment . NJAC 8:39-23.2 (a)(b); 27.1, 35.2 (a)(c)(d) 4,5,6,13