STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315021	A. Building B. Wing	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38327 Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to a.) treat each resident with respect and dignity in a manner that promotes their quality of life during breakfast and b.) provide privacy during med administration for 1 of 6 residents, (Resident #39), observed during medication pass administration. This deficient practice was evidenced by the following: On 2/10/25 at 8:44 AM, during the medication administration pass observation, the surveyor observed the Licensed Practical Nurse (LPN), prepared medications (meds) for Resident #39, and brought them inside the dining area in the 2 East unit. The surveyor observed that there was a total of five residents inside the dining area eating their breakfast including Resident #39. The LPN also checked Resident #39's blood pressure inside the dining room. After the LPN administered the meds, the surveyor interviewed the LPN outside the dining room. The surveyor asked the LPN if it was appropriate to administer and check the blood pressure of the resident inside the dining room where other residents were inside, and the resident was still eating. The LPN responded that it was the resident's preference. The surveyor asked the LPN if the resident's preference was in the resident's care plan (CP), and she responded that the surveyor had to ask the Unit Manager about the CP. On 2/10/25 at 8:55 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) regarding the concern with the LPN who administered meds and checked Resident #39's blood pressure inside the dining area with other residents, and the RN/UM responded that the resident had a behavior of swaying hands and at times some resident when they were in the dining room did not want to go back to the room to get their meds. The surveyor asked the RN/UM if the behavior of swaying hands and preference to have meds taken in the dining room were in the resident's CP, and the RN/UM responded no. The RN/UM further stated that she should have documented it in the CP of the resident about the behavior and resident's preferences. At that time, the surveyor asked the RN/UM to print the resident's CP and eMAR (electronic Medication Administration Record). (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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the provided CP by the RN/UM revealed that the resident's CP did not identify resident with behavior of swaying hands and preference of taking meds inside the dining room. There was no documented evidence in the CP that the resident had a behavior of declining to take meds in their room or preferred to take meds inside the dining room. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; essential hypertension (elevated blood pressure), type 2 diabetes mellitus without complications, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 2/1/25, under Section C Cognitive Patterns, a brief interview for mental status (BIMS) score of 13 out of 15, which reflected that the resident's cognitive status was intact. Section D for Mood and Section E for Behavior was coded 00, which reflected that the resident had no documented behavior. A review of the Progress Notes and assessment tab in the electronic medical records revealed that there was no documented evidence that the resident had an unusual behavior of swaying hands or preferences to take meds in the dining room. On 2/13/25 at 2:14 PM, the survey team met with the Licensed Nursing Home Administration (LNHA) and the Director of Nursing (DON), and the surveyor notified the above findings and concerns with Resident #39. On 2/14/25 at 1:07 PM, the survey team met with the LNHA and DON. The DON stated that the nurse (who did not identify) interviewed the resident and Resident #39 did not mind checking their blood pressure and taking meds inside the dining room. The DON confirmed that the interview of the nurse of Resident #39 was done after the surveyor's inquiry. A review of the facility's Resident Rights Policy, with a reviewed/revised date of 3/5/24, that was provided by the Regional Nurse revealed: Resident Rights: The resident has the right to a dignified existence, self-determination . 4. Respect and dignity . Policy Explanation and Compliance Guidelines: 11. The facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the facility to properly care for its residents . On 2/18/25 at 1:47 PM, the survey team met with the LNHA, DON, Regional Director of Clinical Services, Regional Nurse, and Licensed Practical Nurse/Unit Manager for an exit conference, and the LNHA did not provide additional information. NJAC 8:39-4.1(a)3,12; 27.3

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48781 Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure a licensed staff credentials were verified upon hire. This deficient practice was identified for 1 of 9 newly hired licensed staff reviewed. This deficient practice was evidenced by the following: On [DATE] at 1:30 PM, the surveyor reviewed ten randomly selected new employee files. The review for license verification/renewal for one of the new licensed employees, Social Worker (SW), revealed no license in her employee file. On [DATE] at 12:19 PM, the surveyor requested from the Regional Nurse, the SW's license. The Regional Nurse stated, She works full time as a SW. I think something with pending status on her license, the License Nursing Home Administrator (LNHA) will come in and give more information. On [DATE] at 12:56 PM, the LNHA provided the surveyor a New Jersey Division Consumer Affairs license verification printout dated [DATE] at 9:14 AM, which revealed license expiration date [DATE] and license status was inactive. The LNHA provided a second printout dated [DATE] at 9:16 AM, which revealed license status Reinstatement Pending. The verification was completed after surveyor inquiry. There was no documented evidence that the SW's license was verified prior to the date of hire of [DATE]. At that time, the LNHA stated to the surveyor, Her license erroneously expired, and her reinstatement was pending. The LNHA read an email from the Regional Human Resources (HR) Case Management dated [DATE] regarding user error when SW tried to renew her license who may have selected inactivate versus renew. The LNHA further stated that the HR should have gone online verified it and printed it upon hire. The LNHA also stated that We have HR and regional person responsible for employee file. Furthermore, the LNHA stated that the expectation was every employee should have license verified, and printed or in file upon hire. He further stated that it was important because employees need to have the correct licensing board and nothing against their license. He added that, Maybe the previous HR did not print it, should have been followed up upon hire, the expectation was to have the license in the employee file, and it should have been checked by the HR. The LNHA confirmed that the SW was hired on [DATE] with no license verification in the employee file. On [DATE] at 2:45 PM, the surveyor notified the LNHA and the Director of Nursing, and the Regional Director of Clinical Services, the concern regarding SW's license missing in the employee file. A review of the facility's Hiring Policy, dated ,d+[DATE], revealed, The Human Resources Director, is responsible for maintaining and ensuring the validity and current status of individual certification/licensure. NJAC 8:,d+[DATE].2, 40.1

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 38327 Based on the interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold notices for 1 of 1 resident, (Resident #175), reviewed for hospitalization s. This deficient practice was evidenced by the following: On 2/7/25 at 11:33 AM, the surveyor observed Resident #175's outside door with a posted sign for Enhanced Barrier Precautions (EBP are 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 surveyor reviewed the medical records of Resident #175 and revealed: A review of the Admission Record (an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; 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 Minimum Data Set (MDS), an assessment tool, revealed the following assessment reference dates (ARD) and Section A Identification Information: -ARD 11/20/24, had an unplanned discharge (d/c) to the hospital, and a return was anticipated. -ARD 12/5/24, had an unplanned d/c to the hospital, and a return was anticipated. -ARD 2/1/25, had an unplanned d/c to the hospital, and a return was anticipated. A review of the Progress Notes (PN) revealed the following Nurses Notes: -On 11/20/24 at 10:00 PM, Licensed Practical Nurse #1 (LPN#1) called the hospital at 9:58 PM and was notified that the resident would be admitted for diagnosis of suprapubic catheter malfunction. -On 12/5/24 at 2:02 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) spoke with the emergency room and was notified that the resident was admitted for UTI and suprapubic malfunction. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/1/25 at 7:11 PM, LPN#2 documented that the resident was admitted to the hospital with a diagnosis of ESBL of the urine. Further review of the medical records revealed that there was no documented evidence that the written notifications for bed hold notices were provided to the resident or resident representative on 11/20/24, 12/5/24, and 2/1/25. On 2/14/25 at 1:07 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyor notified of the concern regarding Resident #175's bed hold notices. On 2/18/25 at 10:40 AM, the LPN/UM, in the presence of the Regional Director of Clinical Services (RDCS), Regional Nurse, and LNHA provided the two binders for Bed Hold Notifications, the binders were for 2024 and 2025. A review of the provided binders revealed that there were no bed hold notices for dates 11/20/24, 12/5/24, and 2/1/25. On 2/18/25 at 11:20 AM, the DON flipped over the pages in the 2025 bed hold notices binder and the DON confirmed that there were no notices for Resident #175 for January and February 2025. The LNHA confirmed also that there were no other bed hold notices in the 2024 binder for the resident except for 11/24/24. Both the LNHA and DON also confirmed that there were no other binders for bed hold notices except for the 2024 and 2025 binders that were reviewed in the presence of the survey team. A review of the facility's Transfer or Discharge, Facility-Initiated Policy, with a revision date of October 2022, that was provided by the LNHA revealed: Notice of Transfer or Discharge (Emergent or Therapeutic Leave): 5. Notice of Facility Bed-hold and return policies are provided to the resident and representative within 24 hours of emergency transfer. 6. Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments. On 2/18/25 at 1:47 PM, the survey team met with the LNHA, DON, RDCS, Regional Nurse, and LPN/UM for an exit conference, the LNHA did not provide additional information. NJAC 8:39-4.1(a)31,32; 5.1; 5.2(a); 5.3

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 38327 Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure that a Significant Change in Status Assessment (SCSA) was completed for 1 of 38 residents, (Resident #18), reviewed for Minimum Data Set (MDS). This deficient practice was evidenced by the following: According to the CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, updated October 2024 showed: An SCSA must be completed within 14 days of determining a significant change from baseline. The resident's condition is not expected to return to baseline within two weeks. Comparison with the most recent comprehensive and quarterly assessments is crucial. Criteria for SCSA include two areas of decline or improvement, or IDT (Interdisciplinary team) recommendation. Documentation of criteria met is essential in the resident's medical record. Required for various scenarios like hospice enrollment, a consistent pattern of changes, etc. On 2/7/25 at 11:49 AM, the surveyor observed Resident # 18 in the activity room behind the 1 East nursing station seated in a wheelchair with other residents. The surveyor reviewed the medical records of Resident #18 and revealed: A review of the Admission Record (an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; effusion of left knee (swollen joint), essential hypertension (elevated blood pressure), and lymphedema (most common manifestation of lymphedema is soft tissue swelling). A review of the comprehensive MDS with an assessment reference date (ARD) of 7/11/24, revealed in Section C Cognitive Patterns a brief interview for mental status (BIMS) score of 13 of 15, which reflected an intact cognition. Section K: Nutrition reflected that the resident's weight was 157 pounds (lbs). A review of the quarterly MDS (qMDS) with an ARD of 10/4/24, revealed a BIMS score of 6 of 15, which reflected that the resident's cognitive status was severely impaired. Section K reflected that the resident's weight was 163 lbs. A review of the qMDS with an ARD of 12/27/24, revealed a BIMS score of 5 of 15, which reflected that the resident's cognitive status was severely impaired. Section K reflected that the resident's weight was 181 lbs. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Dietary Assessment and Documentation (admission assessment) that was electronically signed by Dietician #1 (D#1) on 7/5/24, reflected that the resident's weight was taken on 7/4/24, and it was 157.1 lbs. A review of the Dietary Assessment and Documentation (quarterly) that was electronically signed by D#2 on 10/4/24, reflected that the resident's weight was taken on 10/3/24, and it was 180 lbs. A review of the Nutrition Notes that was electronically signed by D#3 on 12/22/24, reflected that the resident's weight was 181.2 lbs, noted weights on November was 179.8 lbs, September was 163.2 lbs indicative of a significant 11%/18 lbs gain for three months. A review of the personalized Care Plan (CP) revealed that the resident had a history of planned significant weight gain that was identified on 1/20/25, revised focus CP that was revised by D#3. Further review of the personalized CP revealed that Resident #18 had a focus CP for dependent on staff for activities, cognitive stimulation, and social interaction related to Cognitive deficits that were revised on 7/23/202, by Activity Director. Further review of the medical records revealed that there was no documented evidence that the Interdisciplinary Team (IDT) met and decided that the SCSA would not be necessary to be done due to the above two changes in the resident's status, specifically for change in cognitive status from cognitively intact to severely impaired cognition for two qMDS, 10/4/24, and 12/27/24, and weight gain of more than 11% for three months. On 2/12/25 at 1:08 PM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN), who informed the surveyor that the facility followed the RAI manual for MDS and that there was no separate policy for MDS. The surveyor notified the MDSC/RN of the above findings and concerns. The surveyor asked the MDSC/RN if she should have done a SCSA due to the above findings, and she responded Yes. The MDSC/RN further stated that she would review Resident #18's records and would get back to the surveyor as to why the SCSA was not done. On 2/12/25 at 1:29 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns. On 2/14/25 at 11:25 AM, the MDSC/RN informed the surveyor that the resident's cognition fluctuated, and the team did not feel that it was necessary to make significant changes for the two quarters after the comprehensive MDS when the BIMS score declined from cognitively intact to severely impaired cognition. The surveyor asked the MDSC/RN if there was documentation that the team met and decided that the resident's BIMS fluctuated and not to proceed with significant change. The MDSC/RN was unable to provide a document that the team met and decided not to proceed with significant change. At that same time, the MDSC/RN further stated that it looks like the two quarters' BIMS scores were probably not accurate. The surveyor asked the MDSC/RN, if the team believed it was wrong, the assessment for cognitive status, and what the facility did to correct it, and the MDSC/RN did not respond. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 12:56 PM, the MDSC/RN informed the surveyor that the team did not feel that significant change was necessary because of the fluctuating cognitive status of the resident. The MDS Coordinator was unable to provide documentation that the facility met and decided not to proceed with significant change for Resident#18. A review of facility provided CP by Regional Nurse revealed that the CP for lymphedema was initiated on 2/14/25, after the surveyor's inquiry. On 2/18/25 at 1:47 PM, the survey team met with the LNHA, DON, Regional Director for Clinical Services, Regional Nurse, and Licensed Practical Nurse/Unit Manager at an exit conference, the LNHA did not provide additional information. NJAC 8:39-11.2(i)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 REPEAT DEFICIENCY Based on interviews and record review, it was determined that the facility failed to complete and transmit the Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, within 14 days as required, for 14 of 38 residents, (Residents #13, #18, #48, #60, #68, #77, #102, #103, #121, #162, #172, #175, #180, and #187), reviewed for MDS, in accordance with federal guidelines. This deficient practice was evidenced by the following: 1. Surveyor#1 (S#1) reviewed the medical records of the following residents and their MDS and revealed: A review of Resident #18's comprehensive MDS (cMDS) with an assessment reference date (ARD) of 7/11/24, was completed on 7/18/24. A review of Resident #77's cMDS with an ARD of 10/31/24, was completed on 11/12/24. A review of Resident #162's cMDS with an ARD of 9/27/24, was completed on 10/9/24. A review of Resident #175's cMDS with an ARD of 11/20/24, was completed on 12/3/24. A review of Resident #180's cMDS with an ARD of 12/9/24, was completed on 12/23/24. The above MDS of Residents #18, #77, #162, #175, and #180 completion dates were presented in the electronic medical records (EMR) in red. On 2/12/25 at 1:08 PM, S#1 interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) regarding the MDS of the above residents on which completion dates were presented in red. S#1 asked the MDSC/RN what the facility's protocol was for completing MDS and how many days the MDS should be completed, and the MDSC/RN responded that she had to get back to the surveyor. At that same time, the MDSC/RN informed the surveyor that the facility utilized the Resident Assessment Instrument (RAI) manual as the facility's guidelines for MDS and that the facility had no separate policy for MDS. On that same date and time, S#1 asked the MDSC/RN to review the above Residents # 18, #77, #162, #175, and #180's cMDS, determine if the facility completed the assessments according to the RAI manual, and provide the transmittal reports. On 2/12/25 at 1:29 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and S#1 notified them of the above findings and concerns regarding MDS of Residents #18, #77, #162, #175, and #180. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/25 at 1:51 PM, the MDSC/RN met with S#1 and provided a CMS's RAI 3.0 Manual (October 2024 version) that included the required assessment summary and specified days when to complete and submit the MDS. The MDSC/RN confirmed that the above MDS for Residents #18, #77, #162, #175, and #180 were completed beyond the required 14 days. A review of the provided documents by the MDSC/RN revealed: The 7/11/24 cMDS of Resident #18 was completed on 7/18/24. The Resident was admitted on [DATE], MDS should have been completed by 7/17/24. The 10/31/24 cMDS of Resident #77 was completed on 11/12/24. The resident was admitted on [DATE], MDS should have been completed by 11/9/24. The 9/27/24 cMDS of Resident #162 was completed on 10/9/24. The Resident was admitted [DATE], MDS should have been completed by 10/3/24. The 11/20/24 cMDS of Resident #175 was completed on 12/3/24. The Resident was admitted on [DATE], MDS should have been completed by 11/26/24. The 12/9/24 cMDS of Resident #180 was completed on 12/23/24. The Resident was admitted on [DATE], MDS should have been completed by 12/15/24. A review of the provided RAI Manual with an October 2024 version, that was provided by the MDSC/RN revealed that the admission (comprehensive) assessment completion date will be no later than the 14th calendar day of the resident's admission (admitted +13 calendar days). 48781 2. Surveyor#2 (S#2) reviewed the medical records of the following residents and their MDS and revealed: A review of Resident #13's quarterly MDS (qMDS) with an ARD of 12/14/24, was completed late on 12/30/24. A review of Resident #60's cMDS with an ARD of 12/21/24, was completed late on 12/26/24, and the care plan decisions were completed late on 12/31/24. A review of Resident #68's qMDS with an ARD of 9/11/24, was completed late on 9/26/24. A review of Resident #102's qMDS with an ARD of 12/30/24, was completed late on 1/17/25. A review of Resident #103's cMDS with an ARD of 11/6/24, was completed late on 11/14/24. A review of Resident #187's cMDS with an ARD of 1/14/25, was completed late on 1/30/25. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/25 at 9:43 AM, S#2 interviewed MDSC/RN, who stated, We go by the RAI manual, we complete them by 14 days from admission and the others 14 days from the ARD. She further stated that the MDSs were late because it was a big building and I am the only one doing the subacute. Sometimes they are late, I will make sure these are a priority going forward. On 2/14/25 at 1:39 PM, S#2 notified the DON and the LNHA regarding concerns with late MDSs completion. On 2/14/25 at 11:25 AM, the MDSC/RN provided the Final Validation Reports (CMS Submission Report) for the late MDSs which confirmed assessments were completed late. 46049 3. A review of Resident #48's cMDS with an ARD of 12/18/24, was completed late on 1/3/25. A review of Resident #121's cMDS with an ARD of 10/1/24, was completed late on 10/11/24. A review of Resident #121's qMDS, with an ARD 12/24/24, was completed late on 1/16/25. A review of Resident #172's cMDS with an ARD of 10/9/24, was completed late on 10/16/24. On 2/14/25 at 1:07 PM, Surveyor #3 (S#3) notified the LNHA and the DON of the identified late completion of the MDS assessments. A review of the facility's MDS Completion and Submission Timeframes Policy, revealed, Timeframes for completion .is based on the current requirements published in the Resident Assessment Instrument Manual. On 2/18/25 at 1:26 PM, the survey team met with the LNHA, DON, and Regional Director of Clinical Services. The LNHA did not provide additional information. NJAC 8:39 - 11.1

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38327 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 2 of 38 residents, (Residents #18 and #190), reviewed for MDS accuracy. This deficient practice was evidenced by the following: 1. On 2/7/25 at 11:49 AM, the surveyor observed Resident #18 in the activity room behind the 1 East nursing station seated in a wheelchair with other residents. The surveyor reviewed the medical records of Resident #18 and revealed: A review of the Admission Record (AR, an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; effusion of left knee (swollen joint), essential hypertension (elevated blood pressure), and lymphedema (most common manifestation of lymphedema is soft tissue swelling). A review of the quarterly MDS (qMDS) with an assessment reference date (ARD) of 10/4/24, revealed a brief interview for mental status (BIMS) score of 6 of 15, which reflected that the resident's cognitive status was severely impaired. Section K: Nutrition reflected that the resident's weight was 163 lbs. A review of the qMDS with an ARD of 12/27/24, revealed a BIMS score of 5 of 15, which reflected that the resident's cognitive status was severely impaired. Section K reflected that the resident's weight was 181 lbs. A review of the Dietary Assessment and Documentation (quarterly) that was electronically signed by Dietician #1 (D#1) on 10/4/24, reflected that the resident's weight was taken on 10/3/24, and it was 180 pounds (lbs). A review of the Nutrition Notes (NN) that was electronically by D#2 signed on 12/22/24, reflected that the resident's weight was 181.2 lbs, November weight of 179.8 lbs and September 163.2 lbs, indicative of a significant 11%/18 lbs gain for three months. A review of NN that was electronically signed by D#3 on 1/26/25, reflected that on 1/23/25, the weight was 179.9 lbs, on 12/3/24, the weight was 181.2 lbs, on 10/10/24, the weight was 183.5 lbs, and on 7/25/24, the weight was 158.9 lbs, and was noted with weight gain of 21 lbs or 13% for 182 days. The NN also included that the weight gain was unplanned and considered significant for Resident #18. On 2/12/25 at 1:08 PM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN), who informed the surveyor that the facility followed the RAI manual for MDS and that there was no separate policy for MDS. The surveyor notified the MDSC/RN of the above findings and concerns. The MDSC/RN stated that she would review Resident #18's records and would get back to the surveyor. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 1:29 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns that the qMDS ARD 10/4/24 Section K weight of 163 lbs did not match on what the Dietary Assessment and Documentation documented on 10/4/24 by D#1 that the weight obtained on 10/3/24 was 180 lbs. On 2/18/25 at 1:47 PM, the survey team met with the LNHA, DON, Regional Director for Clinical Services (RDCS), Regional Nurse, and Licensed Practical Nurse/Unit Manager at an exit conference, the LNHA did not provide additional information. 39885 2. On 2/14/25 at 9:11 AM, the surveyor reviewed the closed medical records for Resident #190. A review of Resident #190's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to dementia, hypertension (high blood pressure) and type 2 diabetes mellitus (a chronic condition that affects how the body uses sugar (glucose) for energy). A review of Resident #190's most recent Progress Note indicated that the resident was discharged (d/c) home with family. A review of Resident #190's most recent discharge return not anticipated (drna) MDS, reflected that the resident was d/c to a short term general hospital. The MDS was coded incorrectly. On 2/14/25 at 9:20 AM, the surveyor interviewed the first floor Unit Manager (UM) regarding Resident #190. The first floor UM stated that Resident #190 was d/c home. On 2/14/25 at 10:04 AM, the surveyor interviewed the MDSC/RN regarding Resident #190. The MDSC/RN stated that she was not the person that coded Resident #190's drna MDS. She reviewed the resident's medical record and confirmed that the MDS was coded incorrectly. On 2/14/25 at 1:54 PM, the surveyor notified the LNHA and the DON of the concern that Resident #190's drna MDS was coded incorrectly. On 2/18/25 at 11:50 AM, in the presence of the LNHA and RDCS, the DON stated that the MDS was coded in error and that it was corrected after surveyor inquiry. The LNHA did not provide any additional information. The facility did not have a policy regarding MDS. N.J.A.C. 8:39-11.2, 33.2 (d)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

39885

Complaint#: NJ175914

Based on observations, interviews, review of medical records, and facility documents, it was determined that the facility failed to develop and implement a comprehensive plan of care to meet residents' preferences and goals and address the resident's medical and psychosocial needs. This deficient practice was identified for 4 of 38 residents (Residents #111, #172, #180, and #442), reviewed for a care plan.

This deficient practice was evidenced by the following:

1. On 2/7/25 at 11:26 AM, the surveyor interviewed Resident #111 who was seated in a wheelchair, and stated that they had just returned from a physical therapy (PT)session. Resident #111 further stated that they had several falls and that they banged up knee and it was still bruised maybe because of diabetes. The surveyor observed a Fall Risk wrist band on Resident #111's wrist and that the resident's bed was low to the ground.

On 2/11/25 at 10:37 AM, the surveyor interviewed Resident #111's Licensed Practical Nurse #1 (LPN#1) regarding the process for fall risk assessment and falls. LPN#1 stated that a fall risk assessment was done on admission and that it may be done by the Unit Manager quarterly but was not sure. She added that PT saw the resident within 24 hours to determine if the resident was a fall risk. LPN#1 stated that most residents had a care plan (CP) that included risk for fall with interventions that included frequent checks and floor mats. LPN#1 further stated that if a resident had a fall then a risk management/incident report was done which included statements from staff. She added that an investigation for the cause was done and that the Unit Manager would update the CP with a new intervention.

A review of Resident #111's Admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; autistic disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave), type 2 diabetes mellitus (a chronic condition that affects how the body uses sugar (glucose) for energy) and hypertension (high blood pressure).

A review of Resident #111's most recent discharge return anticipated Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for decision making were moderately impaired.

A review of Resident #111's Progress Notes (PN) indicated that that in November 2024, the resident was transferred to the hospital for abnormal vital signs and elevated blood sugar.

A review of Resident #111's current active CP, with an initiated date of 11/19/24, included the following focus areas that were not individualized to the resident and complete:

I am at risk of skin breakdown r/t (related to)

(continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I have hypertension r/t I am at risk for pain Further review of the electronic medical record indicated that Resident #111 had a previous CP that was individualized and comprehensive but that it had been completed (not active or current) on 11/4/24. Resident #111's active current CP did not include all of the previous focus areas or interventions that were implemented. On 2/11/25 at 12:46 PM, the surveyor interviewed the first floor Unit Manager (UM) regarding CP. The first floor UM stated that upon admission a baseline CP was done and that the CP was later updated by the supervisor, UM, Assistant Director of Nursing (ADON) or Director of Nursing (DON). The first floor UM stated that the CP did not have to be closed (completed) if went to hospital and came back a couple days later but that he would have to ask MDS. On 2/11/25 at 1:10 PM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) regarding CP. The MDSC/RN stated that she may open the CP but that usually other departments completed them and reviewed them. The MDSC/RN further stated that the CP was closed (completed) when the resident was discharged home or to the hospital and that when they returned a new CP was opened. The surveyor asked that if the information in the completed CP should be continued in the new CP if still relevant. The MDSC stated most probably The MDSC/RN added that the interventions should be in place but that she was not sure if the CP had to be closed out. On 2/12/25 at 1:43 PM, the surveyor notified the LNHA and DON the concern that Resident #111 did not have an individualized complete active CP that included all relevant focus areas that were individualized and were implemented prior to the resident's hospitalization . On 2/13/25 at 2:14 PM, in the presence of the LNHA and DON, the Regional Director of Clinical Services (RDCS) stated when Resident #111 went to the hospital the MDSC/RN had canceled the CP instead of resolving it and that a new CP had to be initiated. On 2/14/25 at 9:59 AM, the MDSC/RN stated that apparently the CP was not supposed to have been canceled (completed) when the resident went to the hospital unless they are there for 30 days. She added that if there was a bedhold then it does not get canceled (completed). The MDSC/RN stated that for Resident #111, someone canceled the CP by accident and that now it was updated. The LNHA did not provide any additional information. 46049 2. On 2/7/25 at 11:00 AM, the surveyor observed Resident #172 resting in their bed with their eyes closed. The resident did not respond to the surveyor's greeting. On 2/11/25 at 9:05 AM, the surveyor reviewed the medical records of Resident #172. The AR revealed that Resident #172 had diagnoses that included, but were not limited to, cerebral infarction (stroke), dementia, dysphagia (difficulty swallowing foods or liquids), and type 2 diabetes mellitus. chronic kidney disease, muscle weakness, bipolar disorder and depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the comprehensive MDS with an assessment reference date (ARD) of 1/2/25, indicated the facility assessed the resident's cognition and Resident #172 was coded as being rarely/never understood. The resident was coded for impairments to both sides of their upper and lower extremities. Additionally, the resident was dependent on staff assistance with all activities of daily living (ADLs). A review of the resident's CP for ADLs revealed it was not complete and individualized for Resident #172. The CP had an initiation date of 1/15/25 and a last revised date of 2/9/25. The focus and interventions of the CP included areas that had been left documented Specify and not individualized for the resident. On 2/14/25 at 1:07 PM, the surveyor notified the LNHA, and the DON of the above concern for Resident #172's ADL CP. On 2/18/25 at 11:32 AM, the LNHA, the DON, and the RDCS met with the survey team. The DON stated Resident #172's CP was incomplete and was updated by the staff. The DON also stated that re-education would be provided to their staff to ensure CPs were completed. 38327 3. On 2/7/25 at 11:35 AM, the surveyor observed Resident #180 lying on the bed, awake, and stated that they were at the facility for rehabilitation and had to go back to the doctor to remove the metal in their left arm. The surveyor observed the resident with a splint in use on their left arm. A review of Resident #180's medical records revealed: A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; unspecified intracranial injury with loss of consciousness status unknown, subsequent encounter, undifferentiated schizophrenia (is a mental disorder characterized variously by hallucinations (typically, hearing voices), delusions, disorganized thinking and behavior, and flat or inappropriate affect), unspecified protein-calorie malnutrition, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and bipolar disorder (is a mental health condition characterized by significant mood swings) unspecified. A review of the personalized CP revealed that there was no documented evidence that the left arm splint was identified and there were no interventions for care of the splint. On 2/10/25 at 8:28 AM, the surveyor observed the resident in the presence of LPN#2 during medication pass administration with a left arm splint. LPN#2 informed the surveyor that the resident would be going to the surgeon on Wednesday to remove the metal in the resident's left arm. LPN#2 stated that the resident should be always using the splint. She further stated that the resident sustained a fall incident at home which was why the splint was in use. On 2/12/25 at 1:29 PM, the survey team met with the LNHA and the DON, and the surveyor notified them of the above findings and concerns regarding the splint. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 1:07 PM, the survey team met with the LNHA and DON. The DON stated that the order and CP for the splint of Resident #180 were entered into the medical record after the surveyor's inquiry. 4. According to the AR of Resident #442, the resident was admitted to the facility with diagnoses which included but not limited to bipolar disorder, unspecified; altered mental status, unspecified; type 2 diabetes mellitus (DM) without complications; chronic obstructive pulmonary disease, unspecified; end stage renal disease; and dependence on hemodialysis. A review of the most recent MDS, with a brief interview for mental status (BIMS) of 6 of 15, which indicated that the resident was severely cognitively impaired. Further review of the resident's MDS revealed that Resident #442 had frequent urinary incontinence and frequent bowel incontinence. A review of Resident #442's CP initiated on 4/8/2024, and revised on 7/8/2024, revealed a focus, which indicated that Resident #442 was at risk for skin breakdown related to incontinence and dementia. The resident's CP revealed no Interventions/Tasks r/t the resident's risk for skin breakdown. Further review of Resident #442's CP initiated on 4/8/2024, and revised on 7/8/2024, revealed a Focus, which indicated that Resident #442 had DM. The resident's CP revealed no Interventions/Tasks related to the resident's diagnosis of DM. During an interview on 2/14/2025 at 1:35 PM, the DON confirmed the absence of interventions on Resident #442's CP. The DON stated that the CPs purpose was to inform staff of how to care for the resident. The DON stated that when CPs were not complete staff would need to rely on their basic nursing knowledge to care for a resident. A review of the facility's Care Plans, Comprehensive Person-Centered Policy, revised March 2022, revealed under Policy Interpretation and Implementation, that the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. This policy section further revealed that the CP should indicate which professional services were responsible for each element of care. Further review of this section of the facility policy revealed that CP interventions should be chosen after data gathering, sequencing of events, consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 11. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 7. The comprehensive, person-centered CP: a. includes measurable objectives and timeframes . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 9. CP interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . 12. The interdisciplinary team reviews and updates the CP .at least quarterly The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desire outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. On 2/18/25 at 1:47 PM, the survey team met with the LNHA, DON, RDCS, Regional Nurse, and Licensed Practical Nurse/Unit Manager at an exit conference, the LNHA did not provide additional information NJAC 8:39-11.2 (d)(e), 27.1 (a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38327 Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to ensure that a.) the monthly Psychoactive Review (behavior monitoring) was done routinely and accurately and b.) identified behaviors were discussed with the interdisciplinary team for 1 of 5 residents, (Resident #175), reviewed for unnecessary medications, according to the standard of clinical practice and facility policy. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 2/7/25 at 11:33 AM, the surveyor did not observe Resident #175 inside their room. On that same date and time, the 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. The surveyor reviewed the medical records of Resident #175 and revealed: A review of the Admission Record (or face sheet, an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; 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 Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 11/20/24, revealed in Section C Cognitive Patterns, a brief interview for mental status (BIMS) score of 3 of 15, which reflected that the resident's cognitive status was severely impaired. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the December 2024, January 2025, and February 2025 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) 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 1/2 (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 1/2 tab by mouth two times a day for psychosis. -A review of the December 2024 behavior monitoring for psychotropics revealed that 1 of 60 shifts was documented for the behavior of impulsiveness, 3 of 60 shifts were blanks, and 56 of 60 were documented no behaviors. For dates 12/12/24 to 12/17/24 were documented in the eMAR and for dates 12/18/24 to 12/31/24 were documented in the eTAR. -A review of January 2025 eTAR behavior monitoring for psychotropics revealed that 1 of 93 shifts was blank, 2 of 93 shifts behaviors were documented (1/17/25 restlessness and 1/18/25 poor sleep, anxiety, and restlessness), and 90 of 93 shifts no behaviors were documented. A review of the Psychoactive Review (PR) dated 2/1/25, which was electronically signed by the Licensed Practical Nurse/Unit Manager (LPN/UM) for the reason of evaluation was a monthly review for a target behavior of depression, anxiety, and sleep for medication (med) trazodone 25 mg. The PR reflected that no behavior or mood was identified for the period of review. Further review of the above PR dated 2/1/25 revealed that there were no other medications (meds) listed that were reviewed except for trazodone. The PR did not reflect the documented behaviors in December 2024 and January 2025 to reflect what behaviors were monitored in the eMAR and eTAR. Further review of the medical records revealed that there was no evidence that PR was done routinely and there was no other PR documented except 2/1/25. A review of the Psychiatric Consult follow-up dated 1/28/25, revealed that the Nurse Practitioner (NP) documented that there were no recent behaviors had been reported by the nursing. 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 Director of Nursing (DON). The surveyor notified the above concerns with Resident#175's behavior monitoring, PR (monthly) not done routinely with incomplete information, and the NP psychiatric follow-up consult note did not reflect what were documented in the January 2025 PR identified behaviors. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 2:14 PM, the survey team met with the LNHA, RDCS, and DON. The RDCS acknowledged that there was only one PR summary that was done, which was the 2/1/25. The RDCS stated that the reason why there was only one PR done for the resident was because the psychoactive med was started on 12/12/24, which was midway the month of December 2024, and the med was d/c. She further stated that it was not normal practice, and the best practice was that PR should be done monthly, for example, the PR for 2/1/25 was for the January 2025 psychoactive meds review, and if January 2025 PR was done, it should be for December 2024 psychoactive med. A review of the facility's Psychotropic Med Use Policy, with a revision date of July 2022, was provided by LPN/UM revealed: Policy Interpretation and Implementation: 2. Drugs in the following categories are considered psychotropic meds and are subject to prescribing, monitoring, and review requirements specific to psychotropic meds: a. Anti-psychotics; b. Anti-depressants . 8. Consideration of the use of any psychotropic med is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. On 2/18/25 at 1:47 PM, the survey team met with the LNHA, DON, RDCS, Regional Nurse (Registered Nurse), and LPN/UM for an exit conference, the LNHA did not provide additional information. NJAC 8:39-11.2(b)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39885 Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to ensure a) the resident's current active care plan (CP) contained the interventions that were implemented after each resident's fall, in order to prevent any additional falls; and b) ensure a fall risk assessment was done quarterly in accordance with their facility policy for 1 of 2 residents reviewed for accidents/falls (Resident #111). The deficient practice was evidenced by the following: On 2/7/25 at 11:26 AM, the surveyor interviewed Resident #111 who was seated in a wheelchair. Resident #111 stated that they had just returned from a physical therapy session. Resident #111 stated that they had several falls and that they banged up knee and it was still bruised maybe because of diabetes. The surveyor observed a Fall Risk wrist band on Resident #111's wrist and that the resident's bed was low to the ground. On 2/11/25 at 9:58 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) to provide any incidents or investigations for the last six months for Resident #111. On 2/11/25 at 10:37 AM, the surveyor interviewed Resident #111's Licensed Practical Nurse (LPN) regarding the process for fall risk assessment and falls. The LPN stated that a fall risk assessment was done on admission and that it may be done by the unit manager quarterly but was not sure. She added that physical therapy saw the resident within 24 hours to determine if the resident was a fall risk. The LPN stated that most residents had a CP that included risk for fall with interventions that included frequent checks and floor mats. The LPN stated that if a resident had a fall then a risk management/incident report was done which included statements from staff. She added that an investigation for the cause was done and that the unit manager would update the CP with a new intervention. A review of Resident #111's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; autistic disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave), type 2 diabetes mellitus (a chronic condition that affects how the body uses sugar (glucose) for energy) and hypertension (high blood pressure). A review of Resident #111's most recent discharge return anticipated Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for decision making were moderately impaired. Further review of the MDS indicated the resident had one fall with no injury since admission or prior assessment. A review of Resident #111's Progress Notes (PN) indicated that in October 2024, the resident was found sitting on the floor and had an unwitnessed fall. Further review of the PN indicated that in November 2024 the resident was transferred to the hospital for abnormal vital signs and elevated blood sugar. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #111's current active CP, with an initiated date of 11/19/24, indicated a focus area of at risk for falls r/t (related to); a goal of my risk for falling will be reduced with my current interventions; and one intervention of maintain clutter-free environment. A review of the facility provided incident report of Resident #111's October 2024 fall included a printout of a CP with the focus area of at risk for falls and related injuries secondary to history of multiple fall from the community, impaired mobility requiring ADL (activities of daily living) assistance, episodes of being impulsive and diagnosis of hypotension anemia, DM (diabetes mellitus), syncope, CKD (chronic kidney disease), and HTN (hypertension) which was initiated 5/24/2022, and revised on 10/18/20224. Further review of the printout indicated that the resident had a fall in June 2024 and October 2024. The following interventions were added after the resident's falls: resident educated on safety, calling for staff assistance as well as wheelchair safety.; clothes hamper relocated to resident room to free up space in bathroom.; Smaller trash bin placed in bathroom to ensure clear path for resident when transferring self. These interventions were not included in Resident #111's current active CP. Further review of the electronic medical record indicated that Resident #111 had a previous CP that included the falls and interventions but that it had been completed (not active or current) on 11/4/24. Resident #111's active current CP did not have any of the previous implemented interventions listed to attempt to prevent any further falls. A review of Resident #111's fall risk assessments included the following: January 2024 which was included in the NSG (nursing): Quarterly/Annual/SignificantChange Evaluation which reflected the evaluation was in progress, not completed. June 2024 was listed as other not quarterly and was dated the same day as the resident's fall. October 2024 was listed as other not quarterly and was dated the same day as the resident's fall. November 2024 which was included in the NSG: Admission/Readmission Evaluation and listed as a readmission There were no quarterly fall risk assessments for April 2024, July 2024 and January 2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 12:46 PM, the surveyor interviewed the first floor Unit Manager (UM) regarding the process for fall risk assessment and CP related to fall and fall risk. The first floor UM stated that upon admission a fall risk assessment and a baseline CP was done and that the CP was later updated by the supervisor, UM, Assistant Director of Nursing (ADON) or Director of Nursing (DON). The first floor UM stated that the fall risk assessment was done on admission then repeated quarterly and if something happened. The first floor UM stated that when a fall occurred an incident report risk management was done and that the CP would be updated with a new intervention to prevent a future fall. The surveyor asked if a CP was completed when a resident went to the hospital. The first floor UM stated that the CP did not have to be closed (completed) if went to hospital and came back a couple days later but that he would have to ask MDS. The surveyor then asked the first floor UM to view Resident #111's active CP for fall risk. The first floor UM confirmed that Resident #111's current active CP had only one intervention for a fall risk and did not mention the falls at the facility. The first floor UM then confirmed that Resident #111 had a completed CP that had the falls and multiple interventions to prevent a fall. The surveyor asked if Resident #111's active current CP should have the completed CP for falls with interventions and he stated it should be in the current CP. On 2/11/25 at 01:10 PM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) regarding CP and fall risk assessment. The MDSC/RN stated that she may open the CP but that usually other departments completed them and reviewed them. The MDSC/RN stated that the CP was closed (completed) when the resident was discharged home or to the hospital and that when they returned a new CP was opened. The surveyor asked that if the information in the completed CP should be continued in the new CP if still relevant. The MDSC/RN stated most probably. She added that the interventions should be in place but that she was not sure if the CP had to be closed out. The MDSC/RN stated that she did not do anything with the fall risk assessment. On 2/12/25 at 11:42 AM, the first floor UM stated that the quarterly nursing assessment usually contained the fall risk. On 2/12/25 at 1:43 PM, the surveyor notified the LNHA and DON the concern that Resident #111 did not have a current active CP that included the interventions implemented prior to the resident's hospitalization and that the resident did not have quarterly fall risk assessments done. On 2/13/25 at 2:14 PM, in the presence of the LNHA and DON, the Regional Director of Clinical Services (RDCS) stated that in regards to the quarterly risk assessment that because of the different changes of positions that it was unclear with MDS and nursing who was initiating the quarterly assessment (fall, pain, braden, elopement, siderail) and that now the MDSC/RN would be providing assessment dates and nursing would follow the risk assessment based on the dates provided. The RDCS stated that when Resident #111 went to the hospital the MDSC/RN had canceled the CP instead of resolving it and that a new CP had to be initiated. On 2/14/25 at 9:59 AM, the MDSC/RN stated that apparently the CP was not supposed to have been canceled (completed) when the resident went to the hospital unless they are there for 30 days. She added that if there was a bedhold then it does not get canceled (completed). The MDSC stated that for Resident #111, someone canceled the CP by accident and that now it was updated. The MDSC stated that nursing was supposed to do the quarterly nursing assessment. The LNHA did not provide any additional information. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided policy titled, Fall Prevention Program with a reviewed/revised date of 10/16/24, included the following: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls . Policy Explanation and Compliance Guidelines: 1. The facility utilizes a standardized risk assessment for determining a resident's fall risk 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate on the (specify location) the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk 5. Low/Moderate Risk Possible Protocols: . g. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes . 9. When any resident experiences a fall, the facility will: . e. Review the resident's care plan and update as indicated . A review of the facility provide policy titled, Care Plans, Comprehensive Person-Centered with a revision date of March 2022, included the following: 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 11. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desire outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. N.J.A.C. 8:39-27.1 (a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46049 Based on observation, interview, and record review, it was determined that the facility failed to monitor enteral tube feeding administration to assure the total volume (TV) administered was in accordance with physician's orders. This deficient practice was identified for 1 of 1 resident, (Residents #172), reviewed for enteral tube feeding. This deficient practice was evidenced by the following: On 2/7/25 at 10:45 AM, the surveyor observed Resident #172 lying in bed with the head of the bed elevated and their eyes were closed. The resident had enteral feeding equipment and supplies at the bedside. On 2/11/25 at 9:05 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #172. A review of the Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, cerebral infarction (stroke), dementia, type 2 diabetes mellitus, and gastrostomy (tube that is inserted through the abdominal wall into the stomach to provide nutrition, fluids, and medication). A review of the quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/2/25, indicated that resident's cognitive status was severely impaired. In Section K (Swallowing/Nutritional Status), Resident #172 was coded as receiving nutrition through a feeding tube while a resident. A review of the physician's order (PO) dated 10/2/24, indicated the resident was NPO [nothing by mouth]. A review of the PO dated 1/3/24, indicated every day (7AM to 3PM) shift to document the TV infused once the enteral feeding was completed. A review of the PO dated 1/28/25, indicated to provide Diabetisource 1.2 via feeding tube at 55 milliliter/hour (ml/hr) to be started at 4 PM and turned off once a TV of 1100 ml was infused. A review of the resident's care plan (CP) included a CP with a focus on enteral feeding. An intervention of the CP indicated the resident needed to be provided enteral feedings and to view the PO. A review of the February 2025 Medication Administration Record (MAR) revealed for 6 of 11 days the documented TV infused was less than order TV of 1100 ml to be administered. The entries revealed the following: On 2/1/25, the nurse documented the TV infused as 500 ml. On 2/2/25, the nurse documented the TV infused as 450 ml. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25, the nurse documented the TV infused as 500 ml. On 2/4/25, the nurse documented the TV infused as 500 ml. On 2/5/25, the nurse documented the TV infused as 500 ml. On 2/6/25, the nurse documented the TV infused as 500 ml. A review of the progress notes revealed there was no documentation that indicated why the TV documented was less than 1100 ml, which was the ordered TV to be infused to the resident. On 2/13/25 at 11:57 AM, the surveyor interviewed a Licensed Practical Nurse (LPN) about enteral feeding and nursing documentation. The LPN stated an enteral feeding for a resident was administered according to the PO and the total volume infused depended on the PO. The LPN further explained the administration and TV infused was documented in the MAR. On 2/13/25 at 1:24 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) about tube feeding administration and TV documentation. The RN/UM stated PO were entered in the EMR and there was a set of orders for enteral feeding. The RN/UM further explained a resident's enteral feeding was administered per PO and the nurses documented the TV of the enteral feeding to be infused in the MAR. The surveyor reviewed with the RN/UM the documented TV infused in the February 2025 MAR. The RN/UM could not speak to why the nurses documented 500 or 450 for the TV infused and would follow up with the nurses to provide additional information. On 2/13/25 at 2:18 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Director of Clinical Services of the above concern for the documented TV infused which differed from the prescribed total volume to be administered to the resident. On 2/14/25 at 1:07 PM, the LNHA and the DON met with the survey team. The DON stated some of the nurses were confused about the volume to document and were documenting the total infused on their shift. The DON added that in-service education was initiated. There was no additional information provided by the facility. A review of the facility's Enteral Tube Feeding via Continuous Pump Policy, with a last revised date of November 2018. Under Preparation it specified, 1. Verify that there is a PO for this procedure . Under Documentation indicated the person performing the procedure should record information in the resident's medical record which included, 3. Amount and type of enteral feeding .5. All assessment data obtained during the procedure . NJAC 8:39-25.2(c)2; 27.1 (a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48781 REPEAT DEFICIENCY Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to, a.) maintain the necessary respiratory care and services of residents and b.) develop an individualized care plan in accordance with professional standards of practice for one 1 of 4 residents, (Resident #187), reviewed for respiratory care. This deficient practice was evidenced by the following: On 2/7/25 at 11:00 AM, the surveyor observed the Resident #187 sitting on the bed, nebulizer (neb) machine on top of the bedside table, mask in the drawer and not in the bag. The resident stated they placed the neb in the drawer and did not put it back in the plastic bag. The plastic bag was dated 2/1/25. The resident stated, I had an infection before, not now. I use that for breathing. A review of the Admission Record (an admission summary) revealed diagnoses which included but not limited to; encounter for surgical aftercare following surgery on the circulatory system, presence of aortocoronary bypass graft, and pneumonia unspecified organism. A review of the Order Summary Report (OSR) revealed: Ciprofloxacin HCl (hydrochoride) Oral Tablet (tab) 750 mg (milligram), give one tab by mouth every 12 hours for pneumonia. Do not crush, ordered on 1/8/25, completed on 1/13/25; Budesonide Suspension 0.5 mg/2 ml (milliliters) one vial inhale orally via neb two times a day for shortness of breath. Further review of the OSR revealed that there was no order for neb change of mask or tubing. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/14/25, revealed Brief Interview of Mental Status (BIMS) score of 12 out of 15 indicating intact cognition. A review of the Care Plans (CP) reflected that the resident was on antibiotics for pneumonia and with altered respiratory status/difficulty breathing, date initiated 1/8/25. Further review of the CP revealed that there were no goals or interventions for respiratory care and no individual CP for neb. On 2/14/25 at 10:00 AM, the surveyor interviewed the 3rd Floor Unit Manager (UM), License Practical Nurse (LPN), and the UM stated, Everyone's tubing and neb mask, the nurses change every week on Wednesday night and dated. Everyone has their own individual bag, and is dated, and changed every week. The UM confirmed that the Resident #187 should have an order to change neb weekly and a CP in place. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 10:15 AM, the UM confirmed with the surveyor by looking in the Electronic Health Record, I don't see the order for neb to be changed weekly, there should be an order to change them every week. The UM further stated that there was no CP, it was started but it did not have goals, interventions or anything about the neb. The UM also stated that the CP was initiated by the admitting nurse and I'm supposed to go back and ensure everything was in place. The UM further stated I don't have an explanation for this one. On 2/14/25 at 1:39 PM, the surveyor notified the Director of Nursing (DON) and the License Nursing Home Administrator (LNHA) regarding concerns with the care of the neb mask/tubing and CP. A review of the facility's Nebulizer Therapy Policy, dated 4/16/24, revealed, Care of the equipment change neb tubing as ordered and a policy on CP, Comprehensive Person-Centered revealed, .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being NJAC 8:39-25.2(c)3

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 38327 Based on observation, interview, and record review, it was determined that the facility failed to, a.) ensure a resident's medication, blood sugar check, and times were adjusted to accommodate their dialysis (a clinical purification of blood as a substitute for the normal function of the kidneys) schedule for 2 of 3 residents (Residents #77 and #121) and b.) clarify duplicate orders for 1 of 3 residents, (Resident #77), reviewed for dialysis, according to facility's policy and standard of clinical practice. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 2/7/25 at 10:29 AM, Surveyor #1 (S#1) observed Resident#77 seated in a wheelchair in the day room in a group activity. Surveyor #2 (S#2) reviewed the medical records of Resident #77. A review of the Admission Record (AR, admission summary) reflected that Resident #77 was admitted to the facility with a diagnosis that included but was not limited to diabetes mellitus, end-stage renal disease (ESRD, a condition in which the kidneys lose the ability to remove waste and balance fluids), and dependence on renal dialysis. A review of the most recent comprehensive Minimum Data Set (cMDS), an assessment tool, with an assessment reference date (ARD) of 10/31/24 revealed in Section C Cognitive Status with a BIMS (Brief Interview for Mental Status) score of 10 of 15, which reflected that the resident's cognition was moderately impaired. The cMDS revealed that the resident was on dialysis. A review of the February 2025 electronic Medication Administration Record (eMAR) revealed: Start date of 1/29/25 for Blood sugar (BS) without overage before meals and at HS (bedtime) for monitoring. Start date 1/31/25 Finger stick one time a day for monitoring (plotted at 5:30 AM). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the above February 2025 eMAR revealed that on 2/1/25 at 11:30 AM was coded X, on 2/4/25 at 11:30 AM was coded NA, on 2/6/25 at 11:30 AM was coded X, and 2/8/25 at 11:30 AM was coded X. On 2/11/25 at 11:56 AM, S#2 interviewed the Registered Nurse (RN), who informed the surveyor that she was the nurse of Resident # 77 who was currently not at the facility and was at the dialysis center. The RN stated that the resident was picked up today at around 10:00 AM, usually, picked up at around 9-9:30 AM and comes back around 3-3:30 PM. The RN also stated that the resident was cognitively impaired, and required minimal to maximal assistance depending on days when the resident had dialysis required more help. At that same time, S#2 asked the RN regarding the resident's February 2025 eMAR. S#2 asked the RN why there were duplicate orders for BS, one early morning and the other one before meals and at HS without coverage for both. S#2 also asked what was the code X on 2/1/25 and 2/6/25 at 11:30 AM for BS, and the RN had no response. The RN confirmed that the NA was not applicable. On 2/11/25 at 12:02 PM, the Registered Nurse/Unit Manager (RN/UM) informed S#2 that she was aware of the concerns of the surveyor about duplicate orders and the Accu check (BS) coding that was not according to the resident's dialysis timing and that she corrected it after the surveyor's inquiry. She further stated that the nurse should have picked it up when the resident came back from hospitalization and followed the correct order and plotting of orders according to dialysis time and days. On 2/12/25 at 1:29 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). S#2 notified the above concerns with Resident#77's orders not according to dialysis days and times and duplicate orders for Accu-Chek. On 2/18/25 at 1:47 PM, the survey team met with the LNHA, DON, Regional Director of Clinical Services (RDCS), Regional Nurse, and Licensed Practical Nurse/Unit Manager for an exit conference, the LNHA did not provide additional information. 46049 2. On 2/7/25 at 10:21 AM, S#1 observed Resident #121 resting in bed with their bed. The resident did not respond to the surveyor's greeting. On 2/13/25 at 9:04 AM, S#1 reviewed the medical records of Resident #121. A review of the AR documented the resident had diagnoses that included but were not limited to, ESRD and dependence on renal [kidney] dialysis. A review of the quarterly MDS, with an ARD of 12/24/24, indicated a BIMS score of 10 out of 15, which indicated the resident had moderate cognitive impairment. A review of the physician's order (PO) dated 9/24/24, indicated change medications and treatment timing from facility's medication (med) and treatment administration time to accommodate hemodialysis treatment. (continued on next page)

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of PO dated 11/18/24, indicated the resident had dialysis every Monday, Wednesday, and Friday at a dialysis center with a pickup time of 3:00 PM. A review of progress notes revealed the nurses documented that the resident returned to the facility from dialysis at 7:45 PM on 1/13/25, 7:35 PM on 1/15/25, 8:25 PM on 1/22/25, 8:00 PM on 1/29/25, 8:30 PM on 2/5/25, and 8:10 PM on 2/12/25. A med administration note dated 2/4/25 at 5:57 PM, indicated that the Brimonidine Tartrate eye drops were not given as Pt[Patient] at dialysis appointment. A review of January 2025 and February 2025 eMAR revealed the following: An entry with a start date of 10/24/24 for Brimonidine Tartrate 0.2% eye drops, instill one drop to both eyes two times a day which was scheduled to be administered to the resident at 9:05 AM and 6:05 PM. The Brimonidine Tartrate eye drops were signed as administered at 6:05 PM by the nurses on 1/13/25, 1/15/25, 1/22/25, 1/29/25, 2/5/25, and 2/12/25. On 2/4/25, was signed 9 which indicated Other/See Nurses Note. On 2/13/25 at 11:42 AM, S#1 asked the Licensed Practical Nurse (LPN) about care for dialysis residents. The LPN stated that a resident's med should be scheduled around their dialysis sessions. The LPN further explained that if there was a med scheduled for when the resident was not in the facility, the nurse should call the physician to clarify the order. On 2/13/25 at 2:18 PM, S#1 notified the LNHA, the DON, and the RDCS about the concern of Resident #121's Brimonidine Tartrate 0.2% eye drops med scheduled time not being adjusted to accommodate when the resident was out of the facility to dialysis. On 2/14/25 at 1:07 PM, the LNHA and the DON met with S#1. The DON acknowledged the eye drop med should have been clarified by the nurses. The DON stated the eye drop order was clarified and education would be provided to the nursing staff. A review of the facility's Hemodialysis Policy that was provided by the LNHA on 2/7/25 at 2:49 PM, revealed that the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental and psychosocial needs of residents receiving hemodialysis. NJAC 8:39-11.2(b), 27.1(a)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 38327 Based on interviews and review of other facility documentation, it was determined that the facility failed to ensure that the physicians must review the residents' total program of care including medications and treatments, and write, sign, and date progress notes at each visit. This deficient practice was identified for 14 of 35 residents, (Residents#10, #13, #16, #18, #50, #60, #68, #102, #103, #121, #131, #149, #175, and #180), reviewed for physician services. This deficient practice was evidenced by the following: 1. On 2/7/25 at 11:49 AM, Surveyor #1 (S#1) observed Resident #18 in the activity room behind the 1 East nursing station seated in a wheelchair with other residents. The surveyor reviewed the medical record of Resident #18 and revealed: A review of the Admission Record (AR, an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; effusion of left knee (swollen joint), essential hypertension (elevated blood pressure), and lymphedema (most common manifestation of lymphedema is soft tissue swelling). A review of the Progress Notes (PN) and Assessment tabs in the electronic medical records (EMR) revealed that there was no evidence that Physician #1 (P#1) wrote, signed, and dated PN and documented in the assessment tab from July 2024 through February 11, 2025 his visit notes. Further review of the EMR revealed that Nurse Practitioner #1 (NP#1) documented on 1/23/25, that the reason for a visit was due to an acute cough and that the SNF (Skilled Nursing Facility) H & P (history and physical) not yet on file. A review of the monthly physician orders (MPO) revealed that on 7/9/2024, the orders were 225 days overdue for P#1 to sign. 2. On 2/7/25 at 11:28 AM, S#1 interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who informed the surveyor that Resident # 175 was on contact precaution for 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) in urine with a foley catheter and required to use PPE (personal protective equipment) gown, gloves when providing direct care. S#1 reviewed the medical records of Resident #175 and revealed: A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; urinary tract infection site not specified, ESBL 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). (continued on next page)

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F 0711

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A review of the PN and Assessment tabs in the EMR revealed that there was no evidence that Physician #2 (P#2) wrote, signed, and dated PN and documented it in the assessment tab from November 2024 through February 11, 2025 his visit notes.

Further review of the EMR revealed that Nurse Practitioner #2 (NP#2) documented on 2/10/25, that the reason for a visit was due to a UTI (urinary tract infection)/ESBL.

A review of the MPO revealed that on 12/14/2024, the orders were 60 days overdue for P#2 to sign.

3. On 2/7/25 at 11:35 AM, S#1 observed Resident #180 lying on the bed, awake, and stated that they were at the facility for rehabilitation and had to go back to the doctor to remove the metal in their left arm. The surveyor observed the resident with a splint in use on their left arm.

S#1 reviewed the medical records of Resident #180 and revealed:

A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; unspecified intracranial injury with loss of consciousness status unknown, subsequent encounter, undifferentiated schizophrenia (is a mental disorder characterized variously by hallucinations (typically, hearing voices), delusions, disorganized thinking and behavior, and flat or inappropriate affect), unspecified protein-calorie malnutrition, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and bipolar disorder (is a mental health condition characterized by significant mood swings) unspecified.

A review of the PN and Assessment tabs in the EMR revealed that there was no evidence that P#2 wrote, signed, and dated PN in a timely manner from December 2024 through January 11, 2025. The PN dated 12/6, 12/9, 12/12, 12/15, 12/18, 12/21, 12/24, 12/27, 12/30, and 1/11/25 were all created on 1/13/25. There was no documented evidence that P#2 wrote his visit notes in the assessment tab of EMR December 2024 through from February 11, 2025.

Further review of the EMR revealed that there was NP wrote and signed the PN and the Assessment tab.

A review of the MPO revealed that on 12/5/2024, the orders were 69 days overdue for P#2 to sign.

On 2/12/25 at 1:29 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and S#1 notified them of the above findings and concerns regarding physician services for Residents #18, #175, and #180.

On 2/13/25 at 2:14 PM, the survey team met with the LNHA, Regional Director for Clinical Services (RDCS), and DON. The RDCS stated that as far as physician services with no physician notes, we did reach out to the physicians and had been periodically reaching out. The RDCS acknowledged it was an ongoing problem with regard to physician services signing orders and writing their visit notes.

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

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48781 4. A review of the medical record for Resident #10, revealed the resident's physician had not hand signed or electronically signed the MPO for October 2024, November 2024, and January 2025. 5. A review of the medical record for Resident #13, revealed the resident's physician had not hand signed or electronically signed the MPO for July 2024, August 2024, September 2024, October 2024, November 2024, December 2024, and January 2025. A review of the Physician PN (PPN) for Resident #13, revealed that the physician did not conduct face to face visits and did not write PN for the month of July 2024, August 2024, September 2024, October 2024, November 2024, December 2024, and January 2025. 6. A review of the medical record for Resident #50, revealed the resident's physician had not hand signed or electronically signed the MPO for July 2024, August 2024, September 2024, October 2024, November 2024, December 2024 and January 2025. A review of the PPN for Resident #50, revealed that the physician did not conduct face to face visits and did not write PN for the month of June 2024, July 2024, August 2024, October 2024, and January 2025. 7. A review of the medical record for Resident #60, revealed the resident's physician had not hand signed or electronically signed the MPO for January 2025. 8. A review of the medical record for Resident #68, revealed the resident's physician had not hand signed or electronically signed the MPO for January 2025. A review of the PPN for Resident #68, revealed that the physician did not conduct face to face visits and did not write PN for the month of January 2025, a late entry was created on 2/12/25, and back dated for January 15, 2025. 9. A review of the medical record for Resident #102, revealed the resident's physician had not hand signed or electronically signed the MPO for July 2024, September 2024, November 2024, and January 2025. A review of the PPN for Resident #102, revealed that the physician did not conduct face to face visits and did not write PN for the month of July 2024, August 2024, September 2024, January 2025, a late entry was created on 2/13/25, and back dated for December 28, 2024. 10. A review of the medical record for Resident #103, revealed the resident's physician had not hand signed or electronically signed the MPO for December 2024 and January 2025. A review of the PPN for Resident #103, revealed that the physician did not conduct face to face visits and did not write PN for the month of November 2024, December 2024, and January 2025, a late entry was created on 2/12/25, and back dated for November 2024, December 2024 and January 2025. (continued on next page)

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F 0711

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 2/14/25 at 10:00 AM, Surveyor #2 (S#2) interviewed the 3rd Floor LPN/UM who stated, I know they're supposed to come in once a month, I have to review the policy. After they see the patient, they usually write a PN in Electronic Health Record (EHR). I'm not sure about signing orders, I have to review it, but I believe it's once a month. They document under the PPN.

46049

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

The AR documented that Resident #121 had diagnoses that included but were not limited, type 2 diabetes mellitus, end stage renal disease, kidney transplant, dependence on renal [kidney] dialysis, and anemia.

A review of the PN revealed a PN written by P#2, the resident's primary physician, with effective dates of 10/18/24, 11/13/24, 12/17/24, and 1/15/25, were written on 2/12/25, after the surveyor's inquiry.

A review of the order review history revealed P#2 last signed orders for the resident on 11/2/24.

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

The AR documented that Resident #16 had diagnoses that included but were not limited, left bundle branch block (condition where electrical impulse that causes your heart to beat is disrupted or blocked), heart disease, osteoarthritis, major depressive disorder, and hypertension (high blood pressure).

A review of the PN revealed the following:

NP #2 wrote a PN on 9/18/24.

NP #1 wrote PN on 11/5/24, 11/7/24, 11/14/24, and 2/6/25.

There were no PN written by P#3, the resident's primary physician, from June 2024 to February 2025.

A review of the order review history revealed the last signed orders for the resident was on 6/27/24 by P#3.

13. On 2/13/25 at 9:36 AM, S#3 reviewed Resident #149's medical records.

The AR documented that Resident #149 had diagnoses that included but were not limited, Alzheimer's disease, type 2 diabetes mellitus, anxiety disorder, and anemia.

A review of the PN revealed P#3, the resident's primary physician, wrote PN with effective dates of 6/27/24, 7/29/24, and 11/17/24. There were no PN written by P#3 in August 2024, September 2024, October 2024, December 2024, January 2025, and February 2025.

A review of the order review history revealed the last signed orders for the resident was on 6/27/24 by P#3.

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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

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. On 2/13/25 at 9:36 AM, S#3 reviewed Resident #131's medical records. The AR documented that Resident #131 had diagnoses that included but were not limited, anemia and thrombocytopenia (blood has lower than normal number of platelets. A review of the PN revealed there were no PN written by P#3, the resident's primary physician, from June 2024 to February 2025. A review of the order review history revealed the last signed orders for the resident was on 6/27/24 by P#3. On 2/13/25 at 2:18 PM, S#3 notified the LNHA, the DON, and the RDCS of the concerns with PPN, review, and signing of orders for residents. A review of the facility's Physician Visits Policy, with a revision date of April 2013, that was provided by the Regional Nurse revealed that the attending physician must make visits in accordance with applicable state and federal regulations. Policy Interpretation and Implementation: 1. The attending physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone. 2. The attending physician must visit his/her patients at least once every 30 days for the 1st 90 days following the resident's admission, and then at least every 60 days thereafter. 3. Non-physician practitioners (physician assistant, NP) may perform required visits (initial and follow-up), sign orders, and sign certifications/re-certifications as permitted by state and federal regulations . NJAC 8:39-11.2(1); 23.2(b)(d)

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

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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 0732

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Post nurse staffing information every day.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48781

Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the accurate Nursing Home Resident Care Staffing Report daily for 2 of 7 days in a prominent place within the facility readily accessible and visible to the residents and the visitors.

This deficient practice was evidenced by the following:

1. On 2/7/25 at 8:47 AM, upon entry to the facility, Surveyor #1 (S#1) observed the Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the main lobby. The NHRCSR posted was dated 2/6/25 for the [7:00 AM to 3:00 PM] day shift. There was no NHRCSR for 2/7/25 posted.

On 2/7/25 at 9:20 AM, S#1 interviewed the receptionist by the main lobby, who stated, I am responsible for posting the staffing. I know it's the wrong date, I was waiting on the Staffing Coordinator (SC) to come in, she's running late. She will usually give me the numbers and I will correct it on the paper. I am the one printing out the staffing.

On 2/11/25 at 1:15 PM, S#1 interviewed the SC in the presence of the Regional Director of Recruitment and Labor Management. The SC stated, [Name Redacted] or whoever is on the front desk is responsible for posting the staffing. I am the one who gives the numbers, the number of nurses, Certified Nursing Assistants (CNAs), and the census. I will email or text the census, for it to be corrected on the form. The person on the front desk prints the NHRCSR. The corrected one was printed out after you guys arrived. The SC confirmed that [Name Redacted] did not print out the NHRCSR correctly for 2/7//25. The Regional Director of Recruitment confirmed, Usually it gets posted at the beginning of the shift, 7AM, 3PM, and 11PM.

On 2/11/25 at 1:46 PM, the Unit Manager (UM) for the 4th floor provided the facility Policy and Procedure titled, Nurse Staffing Posting Information dated 2/5/25, which revealed, The facility will post the Nurse Staffing Sheet at the beginning of each shift.

On 2/13/25 at 2:17 PM, S#1 notified the License Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Director of Clinical Services (RDCS) regarding incorrect posting of the NHRCSR. The LNHA stated, The expectation is, it's due on the receptionist desk when he comes in the beginning of the shift.

38327

2. On 2/10/25 at 6:30 AM, Surveyor #2 (S#2) entered the facility and met with the Certified Nursing Aide (CNA), who informed the surveyor that she was from 7:00 AM-3:00 PM shift CNA and assigned to check the staffing for nursing. The surveyor observed the posted sign for NHRCSR dated 2/9/25, Evening Shift 3:00 PM-11:00 PM with the census of 205.

On 2/10/25 at 8:02 AM, the SC provided the Nursing Daily Staffing Sheet for the date 2/9/25, with handwritten information on the side of the paper of the following:

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Friday 202 3 bed Saturday 203 2 bed [NAME] 203 3 bed At that same time, the surveyor asked the SC what those handwritten notes in blue ink pen were that the SC provided. The SC stated that on Friday, 2/7/25, the census was 202, with a 3-bed hold, on Saturday, 2/8/25, the census was 203, with a 2-bed hold, and on Sunday, 2/9/25, the census was 203, with a 3-bed hold. The SC stated that the posted staffing that the surveyor observed today for 2/9/25, was for Sunday, and the census was wrong. A review of the facility Policy and Procedure titled Nurse Staffing Posting Information dated 2/5/2025 revealed, The facility will post the Nurse Staffing Sheet at the beginning of each shift. N.J.A.C. 8:39-41.2 (a)(b)(c)(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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 46049 Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to ensure a resident's dietary preferences were honored for 1 of 1 resident, (Resident #48), reviewed for food concerns. This deficient practice was evidenced by the following: On 2/7/25 at 10:41 AM, the surveyor observed Resident #48 lying in their bed with the head of the bed elevated. The resident was alert, and verbally responsive. Resident #48 expressed concerns with their meals. The resident stated that they selected from a menu the food items they wanted and did not get what was requested most of the time. The resident further explained that if they received a food item they did not request, the staff would call the kitchen, and the resident would just get what's available .whatever they have left at the time. Resident #48 stated they did discuss with kitchen and registered dietician (RD) about not getting food items requested and the issue still occurs. On 2/11/25 at 9:35 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #48. A review of the Admission Record (admission summary) documented the resident had diagnoses that included but were not limited to hypertension and type 2 diabetes mellitus. A review of the comprehensive Minimum Data Set (MDS), an assessment a tool, with an assessment reference (ARD) of 12/18/24, indicated a Brief Interview Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. A review of the physician's order dated 1/29/25, revealed the resident had a no concentrated sweets, regular texture, and regular (thin) liquid diet. A review of the resident's care plan (CP) included a CP for nutrition with an initiation dated of 12/12/24, and a revision dated of 1/29/25. An intervention of the CP indicated Honor food/beverages preferences as available and offer alternatives with an initiation date of 12/12/24. On 2/11/25 at 1:10 PM, the surveyor observed Resident #48 sitting at a table in the dining area of their unit. The resident had a bowl of soup only and there was no meal ticket for the resident on the table. The surveyor asked Resident #48 about their meal. The resident replied that they had received turkey meatloaf instead of the roasted chicken that they had requested. The resident stated that they told staff in dining area who called the kitchen. Resident #48 further explained that the staff informed them that there was no more chicken left and Resident #48 asked for a salad which she was waiting to receive. The surveyor interviewed the Medical Record Staff (MRS) who had followed up with the kitchen for Resident #48. The MRS stated that Resident #48 wanted chicken instead of the turkey meatloaf, the kitchen was called, they did not have any more roast chicken, and the resident selected a salad. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 1:22 PM, the surveyor interviewed the Food Service Director (FSD). The FSD stated the menu schedule was available on the units for all the residents to review and for staff to inform residents of available options. The FSD further explained three-week cycle selective menus were provided to some of the residents so that they could choose their preference for each meal. The FSD acknowledged food preferences of residents should be honored. The FSD confirmed that Resident #48 was provided a menu to select their food items for each meal. The surveyor informed the FSD of the concern that the resident ordered a roast chicken for lunch and did not receive it on their lunch tray. The FSD stated that sometimes residents changed their mind and would want the alternative option that was being served to other residents. The surveyor requested the meal ticket for the resident's lunch today and the resident's selective menu. The FSD provided the selective menu and the meal ticket. The FSD reviewed with the surveyor the selective menu for Resident #48. For today's lunch meal the resident crossed out turkey meatloaf and the Chicken, Roast option remained. The FSD confirmed that the resident selected the roasted chicken option, and the crossed-out item indicated the resident did not want that food item. The surveyor reviewed with the FSD the resident's lunch meal ticket, which revealed listed food items of fruit cocktail, vegetable barley soup, turkey meatloaf/gravy, mashed potatoes with gravy, peas and carrots. The FSD could not speak to why the resident received turkey meatloaf when the resident had ordered the roast chicken on the selective menu. The FSD stated she would follow up to determine what happened. On 2/13/25 at 2:18 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Regional Director of Clinical Services (RDCS) of the above concern for Resident #48's food preferences not being honored. On 2/14/25 at 1:07 PM, the LNHA and the DON met with the survey team. The LNHA stated the facility investigated and that it was the unclear writing of white that confused the dietary staff. The surveyor showed the selective menu of Resident #48 where turkey meatloaf was crossed out in ink and chicken, roast in typed format remained. The LNHA and the DON stated they would in-service staff that moving forward staff were to clarify anything that was unclear. The surveyor reviewed the facility provided policy titled, Nutritional Management with a last review date of 4/9/24. Under CP Implementation indicated: The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care. Under Monitoring/revision of the policy indicated: .Interviewing the resident and/or resident representative to determine if their personal goals and preferences are being met . NJAC 8:39-17.4 (e); 27.1 (a)

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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.

38327

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.

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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.

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 1/2 (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 1/2 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. 46049 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. (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 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. 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. 50267 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. (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 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.

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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene, use of personal protective equipment (PPE) practices, and use of disinfecting wipes for 3 of 6 staff (1 Certified Nursing Aide and 2 Nurses) and b.) ensure that the COVID-19 infection precaution was posted and ensure the physician order for transmission based precautions (TBP) was followed for 1 of 1 resident, (Resident #292), and follow appropriate infection control practices, to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. On 2/10/25 at 6:54 AM, during the incontinence tour, the surveyor observed the Certified Nursing Aide (CNA) come out of the elevator with a surgical mask not covering the nose and mouth. The CNA informed the surveyor that she was one of the CNAs in the unit and confirmed that almost all residents in her assignments were incontinent of both bladder and bowel elimination. On that same date at 6:57 AM, both the surveyor and CNA went inside room [ROOM NUMBER]. The CNA stated that the resident in the room by the door, Resident # 93 was her resident and the resident was incontinent. Inside the resident's room, the CNA did not perform hand hygiene before and after touching her surgical mask. The surveyor observed the CNA adjusted her mask to cover her nose with the same surgical mask, took a pair of gloves inside her pocket sweater, and donned (put on) gloves. The CNA did not perform hand hygiene before donning gloves. After the CNA checked the resident's incontinence pad, the CNA immediately doffed (removed) off the used gloves and disposed of to the garbage receptacle inside the resident's room. The CNA did not perform hand hygiene after the removal of gloves and before exiting the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Outside the resident's room, the CNA pulled down her surgical mask below her nose and did not perform hand hygiene after touching her mask. The surveyor asked the CNA about her surgical mask not covering her nose and the doffing off gloves without performing hand hygiene. The CNA stated that at times the mask fell off because she could not breathe. After the surveyor notified the CNA of the concerns with hand hygiene and the use of gloves, the CNA went to wash her hands in another room. The surveyor observed the CNA open the faucet and take soap from the dispenser without wetting her hands first. The CNA performed handwashing (scrubbing) under the stream of water for 22 seconds. At that same time, the CNA acknowledged that she scrubbed her hands under the stream of water and stated that it was the appropriate way of washing hands. On 2/10/25 at 7:00 AM, the surveyor and the Registered Nurse/Unit Manager (RN/UM) went to room [ROOM NUMBER]. The surveyor observed the RN/UM donned gloves without performing hand hygiene and checked Resident #97's incontinence pad. The RN/UM did not perform hand hygiene after doffing gloves and before exiting the resident's room. Outside the room, the surveyor notified the RN/UM of the concern regarding the CNA's hand hygiene and use of gloves. The RN/UM stated that the CNA should have washed hands before and after the use of gloves and not stored gloves in the pocket. She further stated that the CNA should wear the mask properly which was to cover both mouth and nose. Afterward, the surveyor notified the RN/UM of the concerns that she did not perform hand hygiene before and after the use of gloves as well. 2. On 2/10/25 at 8:16 AM, during medication (med) administration pass, the surveyor observed the Licensed Practical Nurse (LPN) used the disinfecting wipes for cleaning the blood pressure (bp) apparatus (app) before and after use. The surveyor observed the LPN after the use of disinfecting wipes left the cover lid open and went to other resident without covering the disinfecting wipes container. On 2/10/25 at 8:40 AM, the surveyor interviewed the LPN after med administration pass observation of two residents and discussed the concern that from 8:16 AM to 8:40 AM, the disinfecting wipes container was left open. The LPN responded that because she was not finished with the med administration pass to all residents in her assignment that was why she did not close the cover of the disinfecting wipes. The LPN acknowledged that it was depicting the purpose of the disinfectant wipes if the container lid was left open for some time. On 2/10/25 at 11:37 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN) and notified of the concerns with the CNA, RN/UM, and the LPN. The IPN stated that CNA and RN/UM should have done hand hygiene before and after gloves use, and surgical masks should be worn properly to cover the mouth and nose. The IPN also stated that hand hygiene should not be under a stream of running water. She further stated that the LPN should have closed the container of disinfecting wipes to keep them wet. (continued on next page)

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 Atlas Healthcare at Daughters of Miriam		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 1:07 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns. The DON stated that the CNA should follow the facility's policy and protocol about the storage of PPE, proper use of masks, and hand hygiene, as well as the RN/UM. She further stated that the facility was taking seriously the concerns of the surveyor with regard to infection control and in-service ongoing. A review of the facility's Safety Data Sheet of [disinfecting wipes] revealed under Section 7. Handling and Storage: storage conditions: Keep the container closed when not in use . On 2/18/25 at 1:47 PM, the survey team met with the LNHA, DON, Regional Director of Clinical Services, Regional Nurse, and Licensed Practical Nurse/Unit Manager for an exit conference, the LNHA did not provide additional information. 39885 3. On 2/7/25 at 10:24 AM, the surveyor interviewed the first floor Unit Manager (UM) regarding if the unit had any residents that were on transmission based precautions (TBP). The first floor UM stated that Resident #292 was on TBP for COVID-19 (a highly contagious respiratory disease caused by the coronavirus SARS-CoV-2). On 2/7/25 at 10:54 AM, the surveyor observed Resident #292's room door closed. The surveyor observed that there was no signage outside the room to indicate the resident was on TBP and that in order to enter the room PPE including a N95 mask (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) was required to be donned. The surveyor observed a large cart near the resident's room that contained PPE which also included N95 masks and had instructions for donning and doffing PPE. The surveyor asked the first floor UM to observe Resident #292's room. The first floor UM confirmed that there was no signage outside the room to indicate that the resident was on TBP and what was required to don prior to entrance into the room. The first floor UM stated that he thought that the sign was on the inside of the door. The first floor UM confirmed that Resident #292 was transferred to the facility from the hospital and was COVID-19 positive and was on TBP. A review of Resident #292's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to COVID-19 and sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection). A review of Resident #292's care plan, included the following with an initiated date of 2/6/25: I am COVID-19+ /has had COVID-19 exposure and/or is exhibiting symptoms consistent with COVID-19 until 2/7/25 midnight. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 1:03 PM, the surveyor interviewed the IPN regarding TBP and Resident #292. The IPN stated that there should be signage on the door to indicate TBP. She added that if the resident was on a unit that was not the designated COVID-19 unit that the resident's door should remain closed. The surveyor notified the IPN of the observation of Resident #292's room. The IPN confirmed that the resident was not on the facility's designated COVID-19 unit and that there should have been signage on the outside of the door. She added that a staff probably put the sign on the inside of the door (when it was in the open position) before the resident came to the facility. The IPN stated that the sign should not be on the inside of the door and that for COVID-19, the door should be closed. On 2/12/25 at 1:40 PM, the surveyor notified the LNHA, DON, and RDCS of the concern that Resident #292 did not have TBP signage posted outside the room and that the UM stated that it was probably inside the door. The DON stated that she had placed the TBP sign herself. The surveyor asked the DON if a resident had COVID-19 should the TBP signage be on the inside of the door when the door should be closed. The DON stated that the TBP signage should not be on the inside of the door. A review of the Resident #292's February 2025 Medication Administration Record (MAR) included the following order: Strict Isolation Contact/Droplet precautions: All activities and services performed in room. every shift for COVID-19 until 2/7/2025 23:59. Further review indicated that the evening and night shift on 2/5/25 was not signed as administered (done). A review of Resident #292's Progress Notes (PN) for 2/5/25 did not indicate the resident was on TBP. On 2/13/25 at 2:14 PM, in the presence of the LNHA and DON, the RDCS stated that the TBP sign was posted on the inside of the door. On 2/14/25 at 1:22 PM, in the presence of the LNHA, the DON stated that she investigated the TBP sign for Resident #292 and that the door was opened when the TBP signage was posted and that she inserviced the staff. On 2/14/25 at 1:54 PM, the surveyor notified the LNHA and DON the concern that Resident #292's MAR was not signed for TBP for two shifts and that the PN did not indicate that the resident was on TBP for 2/5/25. On 2/18/25 at 11:42 AM, in the presence of the LNHA and RDCS, the DON stated that she reached out to the staff members and they stated that it was an omission but that they knew the resident was on TBP. The LNHA did not provide any additional information. A review of the facility provided policy titled Transmission-Based (Isolation) Precautions with a reviewed/revised date of 2/5/25 included the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Facility staff will apply TBP, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission . 9. e. Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room .Additionally, either the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne) or instructions to see the nurse before entering will be included in the signage . N.J.A.C. 8:39-19.4(a)(1,2),(l),(n)