STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alps at Wayne Rehab & Care Center	1120 Alps Road Wayne, NJ 07470

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42440 Based on record review, staff interview, and facility policy review, the facility failed to complete a discharge Minimum Data Set (MDS) tracking form within 14 days of a resident's discharge and submit it to the Centers for Medicare and Medicaid Services (CMS) system for one resident out of 37 sampled residents (Resident (R) 7) reviewed for MDS completion. This failure prevented the transmission and compilation of resident-specific information for payment and quality measure purposes. Findings include: Review of R7's undated Admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including clostridium difficile, pressure ulcers of the right and left buttocks, chronic kidney disease, and diabetes. Review of R7's Census tab of the EMR revealed the resident discharged on [DATE]. Review of a Social Service note, dated 09/03/24 and located in the Prog Note tab of the EMR revealed, [R7] requesting discharge home tomorrow 9/4 . Referral made to [home health company]. Review of R7's MDS tab of the EMR revealed the most recent assessments that had been completed and transmitted were admission and Medicare - 5 Day MDSs with an Assessment Reference Date (ARD) of 08/26/24. During an interview on 02/21/25 at 2:44 PM, the MDS Coordinator (MDSC) stated a discharge tracking MDS should be opened and completed within 14 days of the resident discharging. During an interview on 02/21/25 at 3:41 PM, the Director of Nursing stated she expected MDSs to be completed timely. Review of the facility's policy titled RAI Process-MDS Completion, reviewed July 2024, revealed, The MDSs will be filled out accurately, after proper collection of data, in a timely manner according to the RAI manual standards and Periodic checks will be performed to ensure the MDS is being opened, filled out and transmitted timely and accurately, according to the RAI requirements. Review of the RAI Manual, dated 10/01/24, revealed a Discharge Assessment-Return Not Anticipated must be completed within 14 days after the discharge date . (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-11.2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 42440 Based on observation, interview, record review, facility policy, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure five residents (Resident (R) 89, 138, 293, 295, and R299) out of 37 sampled residents had an accurate Minimum Data Set (MDS) assessment. This had the potential to cause the residents to have unmet care needs. Findings include: 1. Review of R138's Admission Record, located in the resident's electronic medical record (EMR) section titled Profile, revealed the resident was admitted to the facility on [DATE] and had diagnoses that included aftercare following explanation of hip joint prosthesis. Review of R138's Prog Note tab in the EMR revealed a Physician Note dated 12/05/24, which stated [discharge] in [morning] . [follow up] with [primary medical doctor] as [outpatient] for regular screening and checkup . [discharge] to home. A Nurses Notes, dated 12/06/24 stated Patient picked up by family member via private care. Review of the R138's discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/06/24 and located in the resident's EMR section titled MDS, documented R138 discharged to home, return anticipated. During an interview on 02/20/25 at 2:05 PM, Registered Nurse (RN) 6 stated R138 had discharge home and was not expected to return to the facility. During an interview on 02/21/25 at 2:44 PM, the MDS Coordinator (MDSC) stated if a resident returned home, their MDS should reflect discharge return not anticipated. 2. Review of R293's Admission Record, located in the resident's EMR section titled Profile, revealed the resident was admitted to the facility on [DATE] and had diagnoses that included chronic respiratory failure with hypoxia and tracheostomy status. Review of R293's Orders tab in the EMR revealed no orders for a ventilator. Review of the R293's admission MDS, with an ARD of 01/23/25 and located in the resident's EMR section titled MDS, revealed he scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. It further documented the resident used invasive mechanical ventilator while a resident or within the last 14 days. During an observation and interview on 02/18/25 at 10:12 AM, R293 had a tracheostomy tube in place with oxygen flowing at 4 liters per minutes via a tracheostomy mask. No ventilator was used, and R293 reported not utilizing a ventilator since admission or during the 14 days prior to admission. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/20/25 at 2:00 PM, Licensed Practical Nurse (LPN) 6 stated R293 did not use a ventilator, and the facility admitted no residents on ventilators. Review of the Facility assessment dated [DATE] revealed the facility did not admit residents on ventilators or respirators. During an interview on 02/21/25 at 2:44 PM, the MDSC stated unless a resident was on a ventilator, invasive mechanical ventilator should not be coded on the MDS. The MDSC was unaware of anyone in the facility who used a ventilator. 3. Review of R295's Admission Record, located in the resident's EMR section titled Profile, revealed the resident was admitted to the facility on [DATE] and had diagnoses that included metabolic encephalopathy. Review of R295's Care Plan located in the Care Plan section of the EMR revealed the resident required a foley catheter and had a colostomy. Review of the R295's admission MDS, with an ARD of 01/18/25 and located in the resident's EMR section titled MDS, revealed she scored 15 out of 15 on the BIMS, indicating intact cognition. It further documented the resident had an indwelling catheter and an ostomy and was frequently incontinent of bowel and bladder. During an observation and interview on 02/18/25 at 3:42 PM, R295 had a drainage bag from her foley catheter hanging from the bed. R295 reported the catheter was placed in the hospital prior to her admission to the facility. R295 also reported she had a colostomy. During an interview on 02/21/25 at 2:44 PM, the MDSC stated when a resident had a urinary catheter and colostomy, bowel and bladder continence needed coded as not rated. 4. Review of R299's Admission Record, located in the resident's EMR section titled Profile, revealed the resident was admitted to the facility on [DATE] and had diagnoses that included pneumonia, respiratory failure, and tracheostomy status. Review of R299's Orders tab in the EMR revealed no orders for a ventilator. Review of the R293's admission MDS, with an ARD of 01/22/25 and located in the resident's EMR section titled MDS, revealed he scored zero out of 15 on the BIMS, indicating severe cognitive impairment. It documented the resident used invasive mechanical ventilator while a resident or within the last 14 days. During an observation on 02/18/25 at 12:30 PM, R299 had a tracheostomy tube in place with oxygen flowing at 8 liters per minutes via a tracheostomy mask. No ventilator was in use. During an interview on 02/20/25 at 2:00 PM, LPN6 stated the facility admitted no residents on ventilators. Review of the Facility assessment dated [DATE] revealed the facility did not admit residents on ventilators or respirators. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/21/25 at 2:44 PM, the MDSC stated unless a resident was on a ventilator, invasive mechanical ventilator should not be coded on the MDS. The MDSC was unaware of anyone in the facility who used a ventilator. During an interview on 02/21/25 at 3:41 PM, the Director of Nursing (DON) stated she expected MDSs to be coded accurately. The facility's RAI Process - MDS Completion policy, last reviewed 07-2024, stated The MDSs will be filled out accurately, after proper collection of date, in a timely manner according to the RAI manual standards. Review of the RAI Manual, dated 10/01/24, indicated, . It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. 5. Review of R89's Admission Record face sheet located in the EMR under the Admission Record tab revealed she was admitted to the facility on [DATE] with diagnoses of urinary tract infection, anxiety, dysphagia, malnutrition, acidosis, neuropathy, peripheral vascular disease, and osteoarthritis. Review of R89's annual MDS assessment located in the MDS tab of the EMR with an ARD of 05/04/24, revealed R89 had a BIMS of 15 out 15 which indicated R89 was cognitively intact. Review further revealed R89 had not received Hospice treatment. Review of R89's quarterly MDS assessment located in the MDS tab of the EMR with an ARD of 11/04/24 revealed R89 received Hospice treatment. Review of R89's quarterly MDS assessment located in the MDS tab of the EMR with an ARD of 02/04/25 revealed R89 had not received Hospice treatment. During an interview on 02/21/25 at 3:49 PM with the MDS Coordinator revealed R89 had never been with Hospice and the quarterly MDS was inaccurate. During an interview on 02/21/25 at 4:00 PM with the DON revealed the MDS coding should be accurate and timely. Review of the facility's policy titled, RAI Process-MDS Completion, revealed it was their policy to follow the requirements and standards of the latest published RAI manual. The policy further revealed all disciplines would assess all aspects of the resident's care and needs accurately. The policy revealed the MDS would be filled out accurately. NJAC 8:39-33.2(d)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to ensure one out of two resident (Resident (R)4) had an accurate Pre-Admission Screening and Resident Review (PASRR) done out of the 37 sampled residents. This failure put R4 at risk of not receiving the services needed. Findings include: Review of R4's Admission Record face sheet located under the Admission Record tab of the electronic medical record (EMR) revealed he was readmitted to the facility on [DATE], from an acute care hospital with diagnoses of Parkinson's, hemiplegia, diabetes mellitus, nephropathy, angina pectoris, schizoaffective disorder, hypertension, atherosclerosis of coronary artery bypass, bipolar, depression, anxiety, convulsions, and spinal stenosis. Review of R4's annual Minimum Data Set (MDS) assessment located in the MDS tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 05/10/24, revealed R4 had a Brief Interview for Mental Status (BIMS) 15 out of 15 which indicated intact cognition. Review of the comprehensive care plan, located in the EMR under the Care Plan tab with a review date of 12/08/24 revealed a problem for behaviors and an intervention for psych consults. Review of the PASRR Level I screen assessment, dated 05/15/23, revealed a bipolar diagnosis had been marked no instead of yes for the mental illness screen. The screening further revealed R4 did not qualify for a Level II screening. During an interview on 02/21/25 at 11:42 AM with the Social Services Director (SSD) revealed the PASRR came with the admission packet from the hospital. The SSD revealed she did not review the PASRR for accuracy. During an interview on 02/21/25 at 11:51 AM with the Admission Coordinator revealed she did not review the Level I for accuracy. The Admission Coordinator revealed she only uploaded the PASRR into the computer system. The Admission Coordinator further revealed the Liaison Person would review the PASRR level II. During an interview on 02/21/25 at 12:01 PM with the Director of Nursing (DON) revealed she reviewed the clinical chart on admissions and she would check the PASARR if it was included in the packet. The DON confirmed the PASARR was inaccurate because R4 had a diagnosis of bipolar and it was marked no on the screening. The DON revealed a PASARR Level II would indicate if a resident needed special services that the facility would be able to offer. The DON revealed she did not know who was responsible for ensuring the PASARR Level I and II were accurate. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Preadmission Screening and Annual Resident Review (PASRR) created on 08/14 and reviewed on 08/24, revealed the PASARR process consisted of a Level I screen and a review and implementation of the Level II recommendations upon admission to the facility. The policy further revealed the PASRR process required that all applicants to the Medicaid certified Nursing Facilities be given a preliminary assessment to determine whether they might have a pertinent diagnosis which was called a Level I screen. The policy revealed those individuals who test positive at Level I will be evaluated in depth, which was called a PASRR Level II and a determination would be made of the need for an appropriate setting and a set of recommendations for services. NJAC 8:39-5.1(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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure comprehensive care plans were initiated for two out of three residents (Resident (R) 63 and R128) of the 37 sampled residents. Specifically, R63 was on Intravenous (IV) medication and fluids, and R128 had religious and cultural preferences that were not addressed in the care plan. Findings include: 1. Review of R63's Admission Record face sheet located in the Admission Record tab of the electronic medical record (EMR), revealed R63 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus, peripheral vascular disease, pleural effusion, cardiomyopathy, hypertension, benign prostatic hyperplasia, hypothyroidism, chronic kidney disease stage 2, atrial fibrillation, and acute respiratory failure. Review of R63's admission MDS under the MDS tab in the EMR, with an ARD of 06/25/24 revealed a BIMS of 15 out of 15 which indicated his cognition was intact. Review of the comprehensive care plan located under the Care Plan tab in the EMR, with a review date of 12/20/24 revealed there was not any problem for hydration or interventions for IV fluid and IV medication usage. Review of the physician orders, dated 02/17/25 for Sodium Chloride 0.45% use one liter intravenously one time only for 60 cubic centimeters (cc) at one hour for one day for IV hydration. Review of the physician orders revealed an order for a sodium chloride flush 0.9% to use ten cc IV every shift for IV hydration for one day before and after medication administration. Another physician order was for Venofer (which was iron sucrose) IV solution 200 milligram (mg) IV one time a day for low hemoglobin for five days. The physician orders included Piperacillin 3.375 grams IV every six hours for infection for seven days. A physician order was obtained on 02/18/25 for a midline insertion. During an observation on 02/18/25 at 10:03 AM R63 was lying in bed in his room and normal saline was infusing per IV. During an interview on 02/21/25 at 2:40 PM with LPN1 revealed there should be a care plan due to a change in condition and IV use for R63. LPN1 revealed, after she reviewed the care plan, there was not any care plan for the IV hydration and IV medication use and there should be. LPN1 stated a care plan informed the staff of R63's needs. During an interview on 02/21/25 at 3:30 PM with the MDSC revealed R63 should have a care plan for IV medication and IV fluids and after she reviewed the care plan state R63 did not have a care plan for IV medication and IV fluids. LPN1 revealed the purpose of the care plan was to guide the staff on R63's care. LPN1 revealed the staff that took the order should have put it on the care plan. During an interview on 02/21/25 at 12:30 PM with the DON revealed IV fluids and IV medications should be included in R63's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Care Plan Process, with a last reviewed and revised date of 09/24, revealed a care plan should be developed that was appropriate for each resident's needs. The policy further revealed a care plan should incorporate identified problems with appropriate interventions. The care plan policy further revealed the plan of care must describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and social well-being. 2. Review of R128's Admission Record, located in the resident's electronic medical record (EMR) section titled Profile, revealed the resident was admitted to the facility on [DATE] and had diagnoses that included unspecified fracture of unspecified femur. R128's religion was listed as Muslim. Review of the Orders tab of the EMR revealed R128 had an order on admission, 08/30/24 for no pork or chicken. Review of a Dietary Assessment, dated 09/03/24 and located in the resident's EMR section titled Assmnts revealed no response to the Ethnic/Religious/Cultural area and none; per nurse via phone as the response for Diet Preferences/Dislikes. Review of the R128's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/07/24 and located in the resident's EMR section titled MDS, revealed she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of R128's Care Plan, located in the resident's EMR section titled Care Plan, revealed [R128] is at risk for malnutrition r/t [related to] varied intakes, revised on 12/09/24. Interventions included to monitor intakes, provide diet as ordered, and obtain food preferences as needed. The Care Plan did not address R128's religion/culture and corresponding dietary restrictions or the need for a female caregiver. During an interview on 02/18/25 at 1:59 PM, R128 stated due to her religion and culture she could not eat chicken or pork and needed female staff to provide cares. She stated she had to order other foods on days there was chicken or pork on the menu, and so she often ate cereal. During an interview on 02/19/25 at 3:55 PM, Certified Nurse Aide (CNA) 10 stated only females could assist R128 with cares. If a male CNA was assigned to R128's room, a female CNA switched out a resident and provided cares. During an interview on 02/20/25 at 4:00 PM, the Registered Dietician stated she had worked at the facility for one month and could not state what alternatives were offered to R128 for chicken and pork. The facility had an always available menu. During an interview on 02/21/25 at 11:48 AM, the Dietary Manager (DM) stated she was aware of R128's dietary restrictions and that R128 frequently requested yogurt, cereal, and milk, sometimes twice for one meal. The DM said she was not involved in care planning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/21/25 at 2:32 PM, Registered Nurse/Unit Manager (RN) 5 stated she or the Assistant Director of Nursing initiated care plans for the floor. Care plans were then updated as needed through report at morning meetings and as changes occurred. Updates were completed by whoever got to them first. RN5 expected cultural/religious needs and preferences to be included in the care plan. During an interview on 02/21/25 at 2:44 PM, the MDS Coordinator (MDSC) stated nursing management initiated the care plans. The care plans were then updated quarterly with MDS assessments and as needed. The MDSC stated it was a team effort to maintain the accuracy of the care plans. Preferences, such as religious/cultural, should be on the care plan. During an interview on 02/21/25 at 3:41 PM, the Director of Nursing (DON) said she expected cultural and religious preferences to be care planned and verified that R128's were not. Review of the facility's Care Plan Process policy, reviewed 09/2024, stated, The plan of care must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and social well-being. NJAC 8:39-11.2(e)thru(i) NJAC 8:39-27.1(a) 42440

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure comprehensive care plans were revised for one out of three residents (Resident (R91) of the 37 sampled residents. Specifically, R91 had a contracture to the left hand and it was not addressed in the care plan. Findings include: Review of the Admission Record face sheet located in the Admission Record tab of the electronic medical record (EMR), revealed R91 was admitted to the facility on [DATE] with diagnoses of contracture of the left hand, diabetes mellitus, Alzheimer's disease, dementia, heart failure, hypertension, dysphagia. Review of R91's annual Minimum Data Set (MDS) assessment located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/30/24 revealed R91 had a Brief Interview for Mental Status (BIMS) of zero out of 15 which indicated R91 was severely cognitively impaired. R91 had a functional limitation of the range of motion on the left upper extremity. Review of the comprehensive care plan, located in the EMR under the Care Plan tab with an initiated date of 12/09/22 and revised on 04/10/24 revealed a problem for limited physical mobility. Interventions included ambulation with the assistance of one, wheelchair, bed mobility was to have the assist of one, and a mechanical lift was to be used for transfers. The contracture of the left hand was not addressed. Record review of the physician orders, dated 02/14/25 located under the Orders tab of the EMR revealed R91 had an order for Restorative Nursing Program (RNP) to use a left carrot hand splint for four hours on and four hours off daily for flexion contracture management. During an interview on 02/21/25 at 2:33 PM with LPN1 revealed the initial care plan was initiated by the Social Worker and the MDS Coordinator, nurses, dietary, rehab, and activities update the care plan. LPN1 further revealed the contracture of the left hand should be addressed on the care plan and it was not addressed. During an interview on 02/21/2025 at 2:48 PM, MDS Coordinator (MDSC) revealed the managers on the unit initiated the care plan, and social services, dietary, and activities all initiated and updated care plans. The MDSC revealed the team all oversaw that the care plan was accurate. The MDS further revealed R91 should be care planned for contractures and she reviewed the care plan, which included a problem for limited physical mobility and an intervention was for a left hand carrot, but was added to the care plan on 02/19/25. The MDSC stated the nurse that took the order for RNP, which included a left hand carrot, should have updated the care plan. NJAC 8:39-11.2(e)(h)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure one out of the 37 sampled residents (Resident (R)91) who had a contracture to the left hand was provided restorative services. This failure put R91 at risk for worsened contracture. Findings include: Review of the Admission Record face sheet located in the Admission Record tab of the electronic medical record (EMR), revealed R91 was admitted to the facility on [DATE] with diagnoses of contracture of the left hand, diabetes mellitus, Alzheimer's disease, dementia, heart failure, hypertension, and dysphagia. Review of R91's annual Minimum Data Set (MDS) assessment located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/30/24 revealed R91 had a Brief Interview for Mental Status (BIMS) of zero out of 15 which indicated R91 was severely cognitively impaired. R91 had a functional limitation of the range of motion on the left upper extremity. Review further revealed R91 had received occupational therapy that started on 08/16/24. Review revealed R91 had not received any restorative therapy for splint or brace assistance. Review of the comprehensive care plan, located in the EMR under the Care Plan tab with an initiated date of 12/09/22 and revised on 04/10/24 revealed a problem for limited physical mobility. Interventions included ambulation with the assistance of one, wheelchair, bed mobility was to have the assist of one, and a mechanical lift was to be used for transfers. The contracture of the left hand was not addressed. Record review of the physician orders, dated 02/14/2025 located under the Orders tab of the EMR revealed R91 had an order for Restorative Nursing Program (RNP) to use a left carrot hand splint for four hours on and four hours off daily for flexion contracture management. During an observation on 02/19/2025 at 8:38 AM, R91 was lying in bed in her room and did not have any carrot or splint in her left hand which the fingers were partially closed. Observation further revealed a carrot splint was not laying around in the room. During an observation on 02/19/25 at 2:50 PM R91 was up in her modified wheelchair at the nurses station and did not have a carrot hand splint on her left hand. During an observation on 02/20/25 at 10:25 AM, R91 was lying in her bed in her room and the left hand did not have a carrot hand splint on the left hand. During an observation on 02/20/25 at 3:57 PM, R91 was sitting in her modified wheelchair up at the nurse's station and she did not have a carrot hand splint on the left hand. (continued on next page)

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	315335	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alps at Wayne Rehab & Care Center	1120 Alps Road Wayne, NJ 07470

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/21/25 at 8:46 AM with the Restorative Aide revealed he did not do splint or carrot application to the left hand of R91 because it was the nurse's responsibility to apply them. The Restorative Aide revealed he did restorative for range of motion for R91 but since occupational therapy had picked her up, he would not be performing range of motion to her. The Restorative Aide revealed the nursing staff knew they were supposed to apply the carrot hand splint to the left hand of R91. During an interview on 02/21/25 at 8:46 AM with the Assistant Director of Therapy revealed an occupational therapy evaluation had been done on 02/20/25 and they would be working on the left hand contracture. The Assistant Director of Therapy revealed the carrot hand splints should have been applied to R91's left hand, by the nurses, up until the occupational therapy evaluation was completed. The Assistant Director of Therapy revealed R91 was at risk of not maintaining her previous level of range of motion. During an interview on 02/21/25 at 9:18 AM with Certified Nursing Assistant (CNA)9 revealed he had not applied any carrots to R91's left hand and it was not on the Kardex to apply any. Review of the Kardex as of 02/19/25 indicated the carrot hand splints were not listed on the document. During an interview on 02/21/25 at 9:25 AM with Licensed Practical Nurse (LPN)2 revealed R91 should have had carrots on to the left hand but the carrot hand splint was supposed to be applied by therapy. During an interview on 02/21/25 at 10:31 AM RN4 revealed restorative was not done until rehab therapy educated the staff on how to apply the carrots and splints to the left hand of R91 even though the physician ordered the restorative nursing program on 02/14/25 and initially on 12/27/24. RN4 revealed R91 was on a trial program right now with occupational therapy and would not be receiving any restorative. RN4 revealed an occupational therapy evaluation was done on 02/20/25. During an interview on 02/21/25 at 12:30 PM with the Director of Nursing (DON) revealed when the physician ordered the carrot hand splint on 02/14/25 it should have been applied on that day to prevent any further contracture. During an interview on 02/21/25 at 2:48 PM, MDS Coordinator (MDSC) revealed R91 should have been care planned for contractures and she reviewed the care plan, which included a problem for limited physical mobility and an intervention was for a left hand carrot but was added to the care plan on 02/19/25. Review of the undated Policy and Procedure Manual for Functional Maintenance/Restorative Nursing Program, revealed the restorative nursing program was developed to assist in the delivery of interventions that promote a resident's ability to function at their highest level. The policy further revealed a resident's ability to perform active or passive range of motion exercises would not diminish unless the clinical condition demonstrated that diminution was unavoidable. NJAC 8:39-27.1(a)

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on observation, record review and staff interview, the facility failed to ensure the facility received licensure and certification approval prior to changing the name of the facility on the facility sign located outside the facility. Failure to get approval prior to changing the name of the facility on the sign had the potential to result in confusion among visitors, employees, and residents. This had the potential to affect 144 of 144 residents in the facility. Findings include: Review of the facility State license titled New Jersey Department of Health Division of Certification of Need and Licensing License stated the facility was licensed to operate as Atrium Post Acute Care of [NAME] consisting of 209 Long-Term Care Beds. Observations upon the facility at 8:15 AM on 02/18/25, 02/29/25, 02/20/25, and 02/21/25, revealed the sign located at the driveway to the facility read Alps at [NAME]. The sign was a banner that completely covered the facility's original sign. Interview with the Administrator on 02/19/24 at 1:04 PM, revealed they were in the application process and were unable to provide approval for the name change. When asked if she had a CMS-855B form she stated they had not completed one because that gets completed further in the approval process. When asked about the name change and the Administrator stated the name change was not official, and they were in the process of getting the name changed. Further interview on 02/19/25 at 1:34 PM the Administrator provided the following documents: A letter from an attorney, dated 01/03/25, titled Change of Information referring to exhibits that were not attached to the letter. Review of a letter from an attorney. dated 01/29/25, with the Application for a Long-Term Care Facility License with attachments. The attachments include an Application for a Long-Term Care Facility License, a certificate of a Merger, and an Interim Management Agreement. A letter from an attorney, dated 02/18/25, revealed the transfer of ownership application again referred to attachments that were not attached or provided with the information she gave me. Review of an undated document titled, CHOW [Change of Ownership] application from the New Jersey Department of Health thanking them for submitting their application. The facility did not provide CMS 855B or any documentation showing the name change was approved. On 02/20/25 at 2:00 PM, the Administrator verified they did not have an approval letter from the State Licensure agency approving the name change. (continued on next page)

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	NJAC 8:39-2.1 thru2.7

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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 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** 15879 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure infection control procedures were followed while lunch trays were being passed on one of the three floors. This failure puts residents at risk for infections. Findings include: Review of the facility's policy titled, Infection Control Transmission Precautions-Enhanced Barrier Precautions dated 05-2024, revealed the policy was to provide guidance on when to implement enhanced barrier precautions. The policy further revealed the facility was committed to providing a safe and healthy environment for residents to minimize or prevent the spread of disease. The policy revealed clear signage should be on the door or wall by the resident's room indicating the type of precautions. During an observation on 02/18/25 at 12:26 PM on the third-floor unit revealed lunch trays were being passed by staff. Certified Nursing Assistant (CNA)2 passed a tray to room [ROOM NUMBER] which had signage on the wall that said Enhanced Barrier Precautions (EBP) and to sanitize your hands upon entry and exit to the room. CNA2 did not sanitize his hands before going into the room and leaving the room. CNA2 continued to pass tray to room [ROOM NUMBER] which did not have EBP, and he did not sanitize his hands. CNA2 continued to pass trays to room [ROOM NUMBER], which did not have any signage, and moved the bedside table, and did not sanitize his hands. CNA2 continued to pass trays to room [ROOM NUMBER] which had EBP signage, and he did not sanitize his hands going into the room or exiting the room. CNA2 continued passing trays to room [ROOM NUMBER] and did not sanitize his hands going into the room but did us the sanitizer when he exited the room. Interview on 02/18/25 at 2:10 PM with CNA2 revealed he had never heard of enhanced barrier precautions, but he did sanitize his hands before he went into a room to pass trays and after he came out. CNA2 revealed he used the sanitizers on the wall, and he kept one in his pocket, however he checked, and he did not have any in his pocket. During an interview on 02/20/25 at 8:38 AM with the Infection Preventionist (IP) revealed if a resident was on EBP then staff should sanitize their hands before going into the room to pass a tray and then sanitize their hands when they exit, but if the resident needed assistance, then staff would have to put a gown on and gloves. The IP further revealed if staff did not follow proper precautions, it would put the residents and staff at risk to spread an infection. The IP further revealed the residents were already at risk for infection due to their conditions and if improper precautions were used it increased the risk. The IP revealed staff were educated on proper personal protective equipment (PPE). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/20/25 at 3:00 PM with the Director of Nursing (DON) revealed EBP protected the residents. The DON revealed before you went into a room with EBP signage you should sanitize your hands, take the tray in, and sanitize your hands when you exit the room. The DON further revealed when a resident was on contact precautions anytime you cross that barrier your hands should be sanitized, gloves, and gown should be worn even passing trays. The DON revealed improper precautions put the residents at risk for the spread of infection. The DON revealed she had been monitoring correct isolation application of PPE Review of the Handwashing, PPE in-service done on 12/23/23 revealed CNA 2 had attended the in-service. Review of the signage for EBP on the walls revealed EBP everyone must clean their hands including before entering the room and when leaving the room. Review of the contact precautions signage revealed everyone must clean their hand, including before entering the room and when leaving the room. The signage further revealed providers and staff must also put on gloves before room entry and discard gloves before room exit, put on gown before room entry. Discard gown before room exit. NJAC 8:39-19.4