STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Rehabilitation and Healthcare at Maywood	100 West Magnolia Avenue Maywood, NJ 07607

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain kitchen sanitation practices as well as store, and label in a manner intended to prevent the spread of food borne illness. This deficient practice was evidenced by the following:On 8/5/25 at 9:29 AM, the surveyor in the presence of the Food Service Director (FSD) observed the following during the initial kitchen tour:1. Two rectangular pans wet nesting on the racks. The surveyor asked when the pans were washed and the Main [NAME] (MC) responded, They were washed last night. The FSD confirmed the wet nesting on the pans and stated, I'm obviously upset right now and will talk to pot washer.2. In the dry storage room: two cans of stewed tomatoes each dented half an inch on the side; and one can of creamed corn observed with lip dented. The FSD stated that the expectation was if anything was dented, it shoul be on the dented can area and that the [NAME] would be spoken to about the incident. The FSD further stated that he and the [NAME] were responsible for checking the cans every Tuesday and Wednesday, and the cook would check it when grabbing something off the shelves every day.On 8/7/25 at 11:11 AM, the surveyor toured the 3rd floor nursing unit nourishment room in presence of the License Practical Nurse/Unit Manager (LPN/UM). Both the surveyor and LPN/UM observed a posted signage on the door of the refrigerator (ref), All food must be dated and have resident's name. Dated food will be discarded after 3 days. Any undated item will be thrown away. Employees must use employee lounge ref. The surveyor and the LPN/UM also observed the following:The freezer temperature (temp) at minus 10 F (fahrenheit) degrees with thick ice accumulation on the entire bottom of the freezer.American beef patty inside a plastic not labeled with a resident name or dated.Four mini apple pie not labeled with resident name or dated.An open mustard bottle labeled with name of Resident #64, no date when bottle was opened. The mustard bottle had a best used by date of 7/2025. At that same time, the surveyor asked the LPN/UM what the process was for storing food in the freezer and ref and how the freezer should be maintained. The LPN/UM confirmed that there should be no freezer ice build up, the beef patty and pie should be labeled with resident's name and dated. The LPN/UM further stated that the mustard should not be in there because it was expired. The surveyor asked the LPN/UM whose responsibility was to keep the freezer/ref cleaned and to check that food were labeled and not expired, and she responded, The kitchen is in charge of keeping the ref cleaned and making sure nothing is expired and everything is labeled.On 8/7/25 at 12:34 PM, the surveyor interviewed the FSD on who was responsible for the nourishment rooms in the units. The FSD responded, My staff goes up in the morning, check the temp and is responsible for cleaning ref and freezer. In the past it's always been maintenance who unplugs and defrost the freezer. The FSD further stated that it was the responsibility of nursing department to ensure food were labeled and dated. The FSD also stated that their department was in charge of the bottles expiration dates. The FSD confirmed that there should be no ice build up in the ref or freezer. At that same time, the surveyor showed the picture of the ice buildup in the freezer. The FSD responded, It does not seem it happened overnight.On 8/7/25 at 1:36 PM, the survey team met with the License Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	findings and concerns. The LNHA provided in service and education and the LNHA confirmed it was done after surveyor's inquiry.A review of the facility's Sanitization Policy, under Policy Statement: The food service area is maintained in a clean and sanitary manner . Policy Interpretation and Implementation .#7. Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical .A review of the facility's Food Receiving and Storage-Dry Food Storage Policy, goods are handled and stored in a matter that maintains the integrity of the packaging until they are ready to use .A review of the facility's Use and Storage of Food Brought in by Family or Visitors Policy, under Policy Explanation and Compliance Guidelines . #2. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated .NJAC 8:39-17.2(g)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and review of facility documentation, it was determined that the facility failed to; a.) follow the facility's policy and procedure with regard to overseeing the grievance process, receiving, and tracking grievances through their conclusions; leading any investigations by the facility, b.) issue a written grievance decisions to the resident, and c.) ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. This deficient practice was identified for 3 of 3 resident council meetings (April, May, and June 2025). This deficient practice was evidenced by the following: On 8/6/25 at 3:11 PM, the surveyor reviewed the last three months resident council minutes that were provided by the Licensed Nursing Home Administrator (LNHA), included but not limited to: -On 4/24/25 meeting, the maintenance concerns were two residents asked to have their beds checked and one resident asked to have their wheelchair (w/c) looked at. -On 5/29/25 meeting, one resident would like to be out of bed (OOB) more often and reported that not all staff were confident with using a sliding board to get the resident OOB. Nursing to follow up. Another resident reported that they felt that meal were being picked up late and would like their urinal to be emptied. There were other two residents asked to have their w/c brakes looked at. -On 6/24/25 meeting, residents reported day room doors had no handles on the inside, and that Maintenance would address it. There was one resident asked to have their w/c brake checked. Further review of the above resident council meeting minutes revealed that there were no documented evidence who were the identified residents who had concerns and issues. There were no documented evidence that the concerns were filed to grievance and resolution were notified, agreed by the residents. There were no documented evidence that the previous voiced concerns of the residents in the resident council meeting were discussed in the next meeting if resolution was reached and was rectified. On 8/7/25 at 8:38 AM, the surveyor asked again the LNHA the names of the resident identified in the resident council minutes for nursing and other concerns, and she stated that she would get back to the surveyor. On 8/7/25 at 8:42 AM, the surveyor reviewed the Grievance binder for 2025, and revealed:-there was no documented evidence for 4/24/25 voiced concerns of the residents to reflect they were resolved or followed up.-there was no documented evidence for the 5/29/25 voiced concerns of a resident with regard to their urinal and other residents' with w/c concerns were followed through, and resolution were accepted by the residents. -there was no documented evidence for 6/24/25 voiced concerns of residents with regard to day room door handles and w/c to reflect they were resolved or followed up. On 8/7/25 at 9:00 AM, the LNHA informed the surveyor that Resident #4 and Resident #64 were the residents who voiced out concerns on 5/29/25 resident council meeting. She added that Resident #4 was about the sliding board and OOB concerns while Resident #64 was about their urinal. The surveyor followed up the other residents' names for dates 4/24/25 and 6/24/25 who voiced out concerns in the resident council meetings, and the LNHA responded that she would get back to the surveyor. The LNHA was unable to provide further information and did not provide documentation as previously requested. On 8/7/25 at 9:02 AM, the Director of Maintenance (DoM) informed the surveyor that he attended resident council meetings, and it was the Director of Activities (DoA) who was responsible for documenting residents' concerns during the meeting. The DoM stated that if there were an issue on the said meeting, the DOA would send him a note in writing that resident council concerns pertaining to his department (Maintenance department). He further stated that the concerns of the residents during resident council were official if a note was given. On that same date and time, the surveyor asked the DoM how the resident knew (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if the concerns with regard to maintenance issues were resolved and if it was documented. The DoM stated that he relied on the maintenance book of each unit and if it was brought to the resident council, it was considered a problem to solve, and not an issue anymore. The DoM acknowledged that there should be documentation for resolving grievance. The surveyor notified the above findings and concerns that there were no documented evidence that the concerns on resident council meetings concerning maintenance department was resolved and followed up. On 8/7/25 at 9:19 AM, the surveyor interviewed the DoA, who informed the surveyor that she had been working in the facility for years. The DOA stated that as facility's practice and process, during resident council meeting, she was responsible for documenting and emailing to all department heads the minutes of the meeting. She further stated that she utilized a form where to document the voiced concerns of the residents during the meeting and handed them to each department heads if the concerns were according to their department. The DOA also stated that after the department head followed up and took action for the voiced concerns, the department head will fill up and sign that form that she provided, will return to the DOA the filled up form, and I will acknowledge, review, and signed off as well. She added that she have a binder for all of them as she was the gate keeper. She also stated that she was responsible for tracking and record keeping of all resident council meeting concerns of residents. On that same date and time, the DOA went to her office and showed to the surveyor the binder for the Resident Council Response Form (RCRF) and revealed:-for April 2025, there were RCRF for 4/24/25, that included Maintenance Department with Department Response: all issues resolved. Further review of the RCRF dated 4/24/25, revealed, there were no names to identify residents and what was fixed. The surveyor asked the DOA who was the resident identified in the resolved issues, and the DOA responded that it was Resident #96. Upon review of the provided 4/24/25 resident council meeting attendees, Resident #96 did not attend the meeting. The surveyor asked the DOA if it was resolved for Resident #96, and why the resident was not even present in the meeting. The DOA then responded that she think it was Resident #117, and not Resident #96.-for May 2025, the Resident Council Response Form Checklist for the Maintenance department was blank. There was no RCRF to address the 5/29/25 maintenance and care issue for meals and urinal concerns of the residents who voiced out their concerns. The surveyor asked the DOA why there was no 5/29/25 RCRF for the concerns of two residents with regard to their w/c and resident who had concern with their meals and urinal, and the DOA responded that even there was no form, it did not mean that it was not rectified. The surveyor asked the DOA who were the residents for the w/c concerns, and she stated that it was Resident #119, and I believe the other one was Resident #28. The surveyor asked the DOA as to why there was no documented evidence or RCRF initiated for the 5/29/25 concerns if that was the facility's practice and process, and the DOA stated, I have no answer for that. On 8/7/25 at 9:46 AM, the surveyor interviewed the LNHA, who stated that the facility's process for the resident council was that meeting done once a month. The LNHA further stated that residents verbalized either positive and negative comments, and it was the DoA's responsibility to give the response form to each department, if immediate like the maintenance issues, it would be addressed the same day. At that same time, the surveyor notified the LNHA of the above findings and concerns about Resident#64's concerns with urinal had no documented evidence that grievance was done, followed up, resolution was reached, and resident agreed according to the facility's process and practice. The LNHA did not provide additional information. On 8/7/25 at 10:30 AM, the surveyor met with the four residents for resident council meeting. Resident #32 stated that on 6/24/25 council meeting, it was the day rooms in 2nd and 3rd floor handles were fixed within a week by DoM. Resident #32 further stated that they knew it was fixed within a week from their report because there were handles in the day room doors already. The resident acknowledged that there was no formal report or resolution provided to the resident about it. On 8/7/25 at 1:35 PM, the survey team met with the LNHA and Director of Nursing (DON), and the surveyor asked the LNHA and DON if they consider the resident's concerns mentioned in the resident council meetings were a form of a grievance, and both the LNHA and DON had no answer. At that (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	same time, the surveyor notified the concerns about resident council meetings, that the facility did not follow the facility's procedure with regard to overseeing the grievance process, receiving, and tracking grievances through their conclusions as per interview with the DoA, as a gatekeeper; leading any investigations by the facility, ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, and a summary of the pertinent findings or conclusions regarding the resident's concerns. The LNHA and DON did not provide additional information. On 8/8/25 at 10:52 AM, the surveyor interviewed Resident #64 inside their room while seated on the bed with oxygen in use at that time, with left leg dressing, and wheelchair at the bedside. The resident claimed that they attended the resident council meeting on 5/29/25, and voiced out concern that the staff were not emptying their urinal timely, and had to wait at times even though they called for assistance. The resident also stated that no one had come to tell them what the resolution for the concern was, but they knew it was getting better, and staff had been coming to their room to empty the urinal promptly, which they noticed in the 1st week of July 2025. On 8/8/25 at 12:53 PM, the survey team met with the LNHA and DON, and the Regional Director of Clinical Services (RDoCS). The RDoCS stated that the DOA had been at the facility for seven years and that the DON and the DoM had their own follow up documentation for the resident council voiced residents' concerns. The RDoCS further stated that the handle for the doors in the day rooms were fixed as soon as possible and was in the maintenance log. The LNHA, DON, and RDoCS were unable to provide documented evidence was filed and done for w/c concerns. At that same time, the surveyor asked the LNHA and DON as to why there was no documented evidence that grievance was filed, followed up, and resolution was relayed to identified residents for the above mentioned concerns when the surveyor had asked for it, and the DON had no answer. Furthermore, the surveyor also notified the concerns with resident council that the facility did not issue a written grievance decisions to the resident as confirmed by Resident#64 and to other residents who had voiced out concerns with their w/c, and a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. Resident #64 also mentioned that the resident knew that it was getting better, that the staff had been prompt with going to resident's room to empty their urinal on 1st week of July 2025, for the 5/29/25 concerns that they voiced out. A review of the provided Service Requestor Log (SRL) from 5/21/25 to 6/6/25, that was provided by the DON revealed a highlighted information for the following dates:-5/29/25, requestor: Licensed Practical Nurse/Unit Manager (LPN/UM), location of need: rooms 329A and 310B, correction request of need: w/c broke needs to be fixed, correction date: 5/29, and correction by: DoM.-6/24/25, requestor: unidentified staff, location of need: dayrooms, correction request of need: missing door handles on inside of doors, correction date: 6/26, and correction by: DoM. Further review of the above provided SRL revealed that there was no documented evidence that the resident's concern on 6/24/25 for w/c was identified in the log. The DON did not provide a copy of SRL for April 2025. A review of the provided Grievance/Concern Form (G/CF) dated 5/29/25 (typewritten) that was signed by the DON was incomplete. The attached Summary of Investigation that was signed by the LNHA was incomplete. The attached Summary of Investigation and the G/CF were not in the 2025 Grievance binder that was previously provided on 8/7/25. The attached Summary of Investigation Summary and the G/CF were not provided on 8/6/25 at 3:11 PM when the surveyor asked for the resident council minutes for the last three months not until 8/8/25 at 12:55 PM. On 8/11/25 at 8:45 AM, the surveyor interviewed the DON regarding the facility's process with resident council meeting and grievances. The DON stated that it would be each department's responsibility to follow up with resident's concerns in the resident council meeting. The DON stated that the concerns voiced out in the resident council meeting was considered form of grievance and should be filed and resolved. The DON also stated that if the resident's concerns were about care issues like resident's urinal or continence care, care plan should be updated or revised to reflect the resolution in the grievance and acknowledge the (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's care preferences. At that same time, the surveyor notified the DON of the above findings and concerns that Resident #64's urinal concerns were not followed through in timely manner and the resolution was notified to the resident. The surveyor also notified the DON of the concerns that there were discrepancy on the facility's IDT (interdisciplinary team) process to follow on how the grievance was filed and handled. The DON stated that moving forward we will put our process more united. A review of the facility's Grievances/Complaints, Filing Policy that was provided by the LNHA, with a revision date of April 2017, revealed, under Policy Statement: residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. Under Policy Interpretation and Implementation: 3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response On 8/11/25 at 1:00 PM, the survey team met with the LNHA, DON, RDoCS, and the Regional Director of Operations for an exit conference. The LNHA and DON did not provide additional information and did not refute the findings. NJAC 8:39-4.1(a)5, 12; 13.2(c)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on the interview and record review, it was determined that the facility failed to complete the comprehensive Minimum Data Set (MDS) assessment in accordance with the Resident Assessment Instrument (RAI) manual and facility policy for 6 of 6 (Residents #15, #17, #61, #74, #92, and #105) residents reviewed for comprehensive resident assessments. This deficient practice was evidenced by the following:Reference: Centers For Medicare and Medicaid Services (CMS), RAI manual, Version 3.0, last revised in October 2024 indicated in Chapter 2, pages 2-8 to 2-9 revealed: .admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 AM (12 AM) and ends at 11:59 PM. Regardless of whether admission occurs at 12 AM or 11:59 PM, this date is considered the 1st day of admission. Completion of an OBRA.Under Chapter 2, Section 2.6-Required OBRA [Omnibus Budget Reconciliation Act] Assessments for the MDS revealed:.MDS Completion Date (Item Z0500B) No Later Than. 14th calendar day of the resident's admission (admission date + 13 calendar days) .The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1if.this is the resident's first time in this facility, OR.the resident has been admitted to this facility and was discharged return not anticipated, or.the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the admission comprehensive assessment at any time prior to the end of day 14 .The surveyor reviewed the system selected resident assessments which revealed the following: A review of Resident #15's comprehensive MDS (cMDS) with assessment reference date (ARD) of 7/15/25, revealed that the MDS was dated and signed as complete on 7/31/25. The MDS assessment was completed more than 14 days after the admission date. A review of Resident #17's cMDS with an ARD of 7/19/25, revealed that the MDS was dated and signed as complete on 7/29/25. The MDS was completed more than 14 days after the admission date. A review of Resident #61's cMDS with an ARD of 7/22/25, revealed that the MDS was dated and signed as complete on 8/6/25. The MDS was completed more than 14 days after the admission date. A review of Resident #74's cMDS with an ARD of 7/20/25, revealed that the MDS was dated and signed as complete on 7/31/25. The MDS was completed more than 14 days after the admission date. A review of Resident #92's cMDS with an ARD of 7/17/25, revealed that the MDS was dated and signed as complete on 7/29/25. The MDS was completed more than 14 days after the admission date. On 8/6/25 at 9:55 AM, the surveyor interviewed the Registered Nurse MDS coordinator (RN/MDSC), who stated that the cMDS assessment should be completed one to two weeks after creating it and it should be submitted one to two weeks after the MDS assessment was completed. The RN/MDSC stated she was responsible for ensuring completion and accuracy of the MDS assessments. The surveyor requested the final validation report for Resident #15, #18, #61, #74, and #92 as there were concerns with their MDS assessments. On 8/6/25 at 11:25 AM, the RN/MDSC provided the MDS final validation report which was dated 8/6/25. The RN/MDSC acknowledged late completion of the MDS assessments. On 8/6/25 at 11:34 AM, the RN/MDSC informed the surveyor the cMDS should be completed by 14 days after the resident's admission. The RN/MDSC further explained if there was anything pending or needed to be looked into for the resident's assessment, the MDS might be late. On 8/7/25 at 1:41 PM the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding the concern of late MDS completion for Residents' # 15, #17, #61, #74, and #92. On 8/8/25 at 12:53 PM, the LNHA, DON, and Regional Director of Clinical Services (RDoCS) met with the survey team. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The LNHA acknowledged the MDS assessments were completed late and that they had no additional information to provide the surveyor. On 8/11/25 at 8:40 AM, an additional review for Resident #105's cMDS with an ARD of 7/20/25, revealed that the MDS was dated and signed as complete on 7/30/25. The MDS was completed more than 14 days after the admission date.On 8/11/25 at 11:43 AM, the surveyor notified the LNHA, DON, and RDoCS of the concern for late completion of Resident #105's admission assessment. The facility did not provide any additional information. A review of the facility's Comprehensive Assessments Policy with a revised date of March 2022, under Policy Interpretation and Implementation revealed: 1. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the RAI User Manual. 2. admission Assessment- The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: a. this is the resident's first time in this facility, b. the resident had been admitted to this facility and was discharged return not anticipated, c. the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.A review of the facility's Electronic Transmission of the MDS Policy with a revised date of October 2023, under Policy Statement revealed:.All MDS assessments.and discharge and reentry records are completed and electronically encoded into the facility's MDS information system and transmitted to the CMS' Internet Quality Improvement and Evaluation System (IQIES) system in accordance with current OBRA regulations governing the transmission of MDS data.Under Policy Interpretation and Implementation revealed:.1. All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the Resident Assessment Instrument (RAI) User's Manual, before being permitted to use the MDS information system.NJAC 8:39-11.1, 11.2(e)(h)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to provide a copy of the resident and the resident's representative's written notification of the reason for transfer to the hospital to a representative of the Office of the State Long-Term Care Ombudsman (LTCO) for 1 of 2 resident's (Resident #130) reviewed for hospitalization. This deficient practice was evidenced by the following:A review of Resident #130's closed electronic medical record included the following:Resident #130's discharge return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, reflected that the resident was transferred to the hospital. A review of the medical record did not include a written notification of the reason for transfer to the resident or resident representative and a copy to the LTCO for the transfer to the hospital uploaded into the electronic medical record.On 8/7/25 at 10:24 AM, the surveyor interviewed the Director of Social Services (DoSS) regarding the process for written notification for transfer to the hospital and notification to the LTCO. The DoSS stated when she gets the update from nursing that a resident was transferred to the hospital she will fill out the Notice of Transfer or Discharge form. The DoSS stated that the form was mailed out to the family and that they kept a copy in a binder. The DoSS stated that in the front of the binder there was a log for each month that they updated with the resident transfer information and that the log was emailed to the ombudsman once a month. On 8/7/25 at 1:00 PM, the surveyor reviewed the facility provided emergency transfer binder and Resident #130's Notice of Transfer or Discharge form was not in the binder and Resident #130 was not listed on the February 2025 log that was sent to the LTCO.On 8/7/25 at 2:18 PM, the DoSS confirmed that Resident #130 was not listed on the log that went to the ombudsman and that a copy of Resident #130's Notice of Transfer or Discharge that was sent to the family was also not in the binder. The DoSS stated that she remember a backstory and that she would let the surveyor know the next day the reason the form was not in the binder. On 8/8/25 at 9:16 AM, the DoSS stated that she believed that they were looking at the form for some reason and that she found the form in a soft file. The DoSS stated that she mailed out the notice to the family but that the LTCO was not notified because Resident #130 was not written on the log.On 8/8/25 at 1:54 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Regional Director of Clinical Services (RDoCS) the concern that a copy of Resident #130's Notice of Transfer or Discharge was not provided to the LTCO. On 8/11/25 at 11:43 AM, in the presence of the DON and RDoCS, the LNHA stated that they performed an audit for notification to the ombudsman and that there were no further resident's transfers that were not sent to the LTCO. The LNHA did not provide any additional information.A review of the facility's Transfer or Discharge Notices with a revised date of March 2025, included the following:Policy StatementResidents (or resident representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understand. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman.Policy Interpretation and ImplementationNotice of Transfer or Discharge (Emergency)1. When a resident is sent emergently to an acute care setting, this is considered a transfer, not discharge, because the resident's return is generally expected.2. Notice of Transfer is provided to the resident and or representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements).N.J.A.C. 8:39-4.1(a)31,32

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	315386	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Rehabilitation and Healthcare at Maywood	100 West Magnolia Avenue Maywood, NJ 07607

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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. Based on interview, record review and review of pertinent facility documentation, it was determined that the facility failed to submit the Minimum Data Set (MDS) assessments in a timely manner for 1 of 2 residents reviewed for hospitalization (Resident #11). The deficient practice was evidenced by the following:On 8/7/25 at 11:42 AM, the surveyor reviewed the closed medical record of Resident #11. A review of the admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; critical illness myopathy (a severe muscle weakness condition that occurs in critically ill patients, often associated with prolonged stays in intensive care units), acute respiratory failure with hypoxia (impairment of gas exchange between the lungs and the blood causing low levels of oxygen in your body tissues) and gastrointestinal hemorrhage (or GI bleeding, is a serious condition that can occur anywhere in the digestive tract, from the mouth to the anus, and can range from mild to life-threatening). A review of Resident #11's Universal Transfer Form (UTF), a communication form used when a resident is transferred, indicated that the resident was transferred to the hospital on 5/20/25. A review of Resident #11's Progress Note indicated that the resident was transferred to the hospital on 5/20/25. There was no additional note that the resident had returned to the facility. A review of Resident #11's last MDS, an assessment tool used to facilitate the management of care, indicated that the MDS was an interim payment with an ARD of 5/14/25. There was no Discharge Return Anticipated MDS (DRAMDS) with an ARD of 5/20/25 in the electronic medical record for the resident's transfer to the hospital. On 8/7/25 at 11:54 AM, the surveyor interviewed the MDS Coordinator (MDSC) regarding the MDS process when a resident was transferred to the hospital. The MDSC stated that if a resident is transferred to the hospital she would review the progress notes and go into the MDS portal put in a discharge MDS and the type depended on insurance whether it was a DRA Discharge Return Anticipation or a Discharge Return Not Anticipation. The MDSC stated that there is a timeframe for when it was due for completion and submission but that she would have to check on the specifics. On 8/7/25 at 1:07 PM, MDSC stated that a Discharge MDS would be opened the next day after a hospitalization. She added that it would be completed within 14 days of opening and submitted within 14 days of completion. On 8/7/25 at 1:11 PM, the MDSC confirmed that Resident #11 did not have a DRAMDS done and that it should have been. On 8/7/25 at 1:42 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Regional Director of Clinical Services (RDoCS) the concern that Resident #11 did not have a DRAMDS. On 8/8/25 at 1:00 PM, in the presence of the DON and RDoCS, the LNHA stated that the MDSC completed Resident #11's DRAMDS after surveyor inquiry. The RDoCS stated that the MDSC was new and that she had started a QAPI (quality assurance performance improvement) on late completion. The LNHA did not provide any additional information. A review of the facility's Electronic Transmission of the MDS Policy with a revised date of October 2023, included the following:All MDS assessments.and discharge and reentry records are completed and electronically encoded into the facility's MDS information system and transmitted to the CMS' Internet Quality Improvement and Evaluation System (IQIES) system in accordance with current OBRA (Omnibus Budget Reconciliation Act (OBRA), also known as the Nursing Home Reform Act of 1987, has dramatically improved the quality of care in the nursing facility) regulations governing the transmission of MDS data. N.J.A.C. 8:39-11.2

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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. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to consistently document resident refusal for daily weights and notify the physician regarding the resident's refusal for 1 of 26 residents (Resident #77) reviewed. This deficient practice was evidenced by the following:On 8/5/25 at 10:26 AM, the surveyor observed Resident #77, lying in bed, alert and verbally responsive. The resident was being attended to by a Certified Nurse's Aide (CNA). On 8/6/25 at 10:25 AM, the surveyor reviewed the paper chart and the Electronic Medical Record (EMR) of Resident #77. A review of the admission Record (an admission summary) documented Resident #77 had diagnoses that included but were not limited to; heart failure, adjustment disorder with depressed mood, visual loss, atrial fibrillation, and vertebra fracture. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/8/25, reflected a Brief Interview Mental Status (BIMS) score of 12 out of 15, which indicated the resident had moderate cognitive impairment. A review of the physician's order dated 7/16/25, daily weights for CHF [congestive heart failure] in the morning, document weights. A review of the documented weights for Resident #77 revealed the following: - 7/17/25: 208.5 pounds (lbs.)- 8/4/25: 206 lbs.A review of the July 2025 electronic Treatment Administration Record (eTAR) revealed the nurses signed on 7/19/25, 7/21/25, 7/22/25, 7/27/25, 7/28/25, 7/29/25, 7/30/25, and 7/31/25 for the daily weights being completed. On 7/17/25 and 7/26/25 the entries were blank. A review of the August 2025 eTAR revealed the nurses signed on 8/1/25 to 8/5/25 for the daily weights being completed. There were no documented weights within the entry. A review of July and August 2025 progress notes revealed the nurses documented the resident refused daily weights on the following dates: 7/18/25, 7/20/25, 7/23/25, 7/24/25, 7/25/25, and 8/6/25. There was no documentation of a weight or refusal for the dates of the resident's daily weight being signed as completed. There was no documentation indicating the physician was notified about the resident refusing daily weights to be done. On 8/6/25 at 11:57 AM, the surveyor interviewed the Certified Nurse Aide (CNA) about weights. CNA stated CNAs would obtain residents' weights and assigned which weights for residents to obtain. The CNA further explained that after obtaining the weight, the CNA would notify the nurse who would document the weight. The surveyor asked the CNA what would happen if the resident refused to be weighed. The CNA replied that the nurse would be notified, and the nurse would document the refusal. On 8/6/2025 at 12:16 PM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN#1) about obtaining residents' weights. LPN#1 stated the CNAs obtained residents' weights who informed the nurses about the result of weights obtained. LPN#1 explained the nurses would document the results in the weight/vitals section of the EMR and there was a weight binder at the nurses' station. LPN#1 further stated that resident refusal would be documented in the EMR. On 8/6/25 at 12:20 PM, the surveyor interviewed LPN#2 about obtaining weights. LPN#2 confirmed there was a weight binder that listed monthly and weekly weights that needed to be obtained. LPN#2 further explained weights were completed according to the list in the binder; nurses documented in the EMR the results and the registered dietician reviewed the weights obtained. The surveyor asked LPN#2 about daily weights. LPN#2 stated daily weights were ordered by the physician and was found under physician's orders and the eMAR (electronic Medication Administration Record). LPN#2 explained the nurse would document the weight directly into the eMAR. On that same date and time, the surveyor asked LPN#2 what was done if a resident refused to be weighed. LPN#2 replied that it would be documented in the EMR that the resident refused to be weighed. LPN#2 added that she would attempt multiple times, encourage and educate the resident on the benefits of obtaining daily weights. On 8/6/25 at 12:26 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) about obtaining daily weights. The RN/UM stated daily weights were ordered and found in the eMAR. The RN/UM explained the nurses documented the weight in the EMR and if the resident refused the nurses would document (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's refusal and notify the physician. The surveyor asked the RN/UM how soon was if expected for the nurse to notify the physician that a resident was refusing daily weights. The RN/UM replied that once a resident refused the first time the nurse should notify the physician. The surveyor discussed with the RN/UM the concern regarding the above concerns for Resident #77's daily weight documentation and there was no documentation to indicate the nurse notified the physician of the resident having episodes of refusing daily weights. On 8/7/25 at 9:50 AM, the RN/UM informed the surveyor that she followed up regarding Resident #77's daily weights and provided education to staff about documentation of weights and weight refusals. The RN/UM stated the nurses were to code in the eMAR when the resident refused, instead of signing that it was completed. Additionally, the RN/UM explained the physician was to be notified and the resident's family was to be notified about weight refusal. The RN/UM stated she followed up with the nurses who signed that the daily weight was completed and had no weight results entered. The RN/UM continued that the nurses stated the resident had refused to be weighed and they did not document the refusal or notify the physician. On 8/7/25 at 11:04 AM, the surveyor interviewed the Director of Nursing (DON) who stated daily weights were ordered by the physician for residents who needed closer monitoring such as CHF residents. The DON stated that the physicians were to be notified if resident refused, there was weight gain as per facility protocol.At that same time, the surveyor asked the DON where daily weights were documented, and the DON replied weights were documented in the weights/vitals section of the EMR and there was a daily weights order in the eMAR which the nurse would sign off. The DON further stated if a resident refused to be weighed, upon the first refusal, the nurse was to notify the physician and the resident's representative to keep them up to date and involved in the plan of care. The DON explained if the resident continued to refuse it would be expected for staff to notify the physician every so often and document it in the EMR. Furthermore, the surveyor discussed the concern regarding Resident #77's daily weight documentation, refusal documentation and there being no documentation that the physician was made aware of the resident refusing daily weights. The DON stated she was made aware of the issue by the RN/UM, after surveyor inquiry. The DON acknowledged the concern and that it would be expected for nurses to document if a resident refused and to put in a weight result if the eMAR entry was signed as completed by nurse. On 8/7/25 at 1:41 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) about the above concerns for Resident #77's daily weights. On 8/8/25 at 12:53 PM, the LNHA, the DON, and the Regional Director of Clinical Services met with the survey team. The DON stated the staff were in-serviced about the expectation for daily weights including the importance of documenting refusals, notifying the physician and resident's representative. There was no additional information provided by the facility. A review of the facility's Weight Assessment and Intervention Policy, last revised in March 2022, revealed under Policy Statement, Resident weights are monitored for undesirable or unintended weight loss or gain .Under Policy Interpretation and Implementation revealed:.2. Weights are recorded in each unit's weight record chart and in the individual's medical record.NJAC 8:39-27.1(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to provide appropriate Activities of Daily Living (ADLs) care, for residents who were dependent on staff assistance for care, by failing to provide incontinence care. This deficient practice was identified for 1 of 2 residents reviewed for ADL care (Resident #14). This deficient practice was evidenced by the following: On 8/5/25 at 11:07 AM, the surveyor asked the Licensed Practical Nurse/Unit Manager (LPN/UM) to accompany the surveyor inside Resident #14's room. Both the surveyor and the LPN/UM observed the resident lying on bed with one clean diaper and clothing on top of the bed near resident's right side of the head. The resident was wearing a night gown and was covered by a blanket. The LPN/UM donned (put on) gloves and check the resident for incontinence, both the surveyor and the LPN/UM observed the resident's incontinence brief was soaked and wet with urine, and there was a strong smell of urine. The LPN/UM changed the resident's incontinence brief without wiping or performing incontinence care. The LPN/UM went to the resident's toilet room and performed handwashing. At that same time, the surveyor asked the LPN/UM what time the resident should be done for ADLs, checked or changed for incontinence care, and what was that smell. The LPN/UM confirmed and stated, that was a strong smell of urine, and the resident should have been changed. The LPN/UM also confirmed that the incontinence brief was soaked with urine. On 8/5/25 at 11:30 AM, the surveyor interviewed Certified Nursing Aide #1 (CNA#1), who informed the surveyor that the CNA assigned to the resident was probably with other resident, and unavailable for an interview at that time. On 8/5/25 at 11:38 AM, the surveyor interviewed the assigned CNA of the resident, CNA#2, who informed the surveyor that she was unable to state how many residents she had today in her assignment because the LPN/UM took her paper that included her assignments. CNA#2 confirmed that Resident #14 was assigned to her. CNA#2 also stated that she came in today at 7:00 AM (7 AM) and she provided breakfast of Resident #14. She further stated that she was unable to check resident if the resident was wet and was unable to provide incontinence and morning care since 7 AM. On that same date and time, CNA#2 stated that she was unable to provide morning and incontinence care to Resident #14 at this time due to the LPN/UM took her linen cart and she did not know as to why. CNA#2 confirmed that since 7 AM, this was the 1st time she would provide incontinence and morning care to the resident for 7:00 AM-3:00 PM shift. On 8/6/25 at 12:05 PM, the surveyor interviewed the Registered Nurse (RN), the assigned nurse of the resident, who stated that the resident was cognitively impaired. The RN further stated that the resident was compliant with care including incontinence care, and there were no reports from the aides that the resident had refused care. On 8/6/25 at 12:15 PM, the surveyor interviewed the LPN/UM, and the surveyor notified the LPN/UM of the concern that the tasks tab of the CNA for bladder continence accountability from 7/24/25 to 8/6/25, there were days that only one entry and two entries versus three entries of documentation on other days. The LPN/UM stated that there should be three entries to show that bladder continence was provided each shift by the CNAs. She acknowledged the printed bladder continence task had one entry on 7/28/25, two entries for: 7/29/25, 7/31/25, 8/1/25, and 8/3/25. The LPN/UM had no answer as to why there were days with no three entries for bladder continence to reflect that the continence care was provided by three shifts (7-3, 3-11, and 11-7 shifts). On 8/6/25 at 12:40 PM, the surveyor interviewed CNA#1 regarding the tasks tab for CNAs accountability log for ADLs. CNA#1 informed the surveyor that as a CNA she document in the computer at the end of their shift or on times that they remember to document, including bladder continence that was provided to the resident. She further stated that each shift, the expectation was for them to document the care provided in the tasks tab of computer. She also stated that there should be three entries in each category in the tasks of the CNAs. The surveyor reviewed the medical records of Resident #14. A review of the admission Record (an admission summary) or face sheet, revealed, Resident #14 had been admitted with diagnoses which included but were not (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limited to; Alzheimer's disease unspecified, schizoaffective disorder, depressive type, peripheral vascular disease (is a chronic disease that blocks blood flow in your blood vessels) unspecified, and vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate care, with an assessment reference (ARD) date of 6/18/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 indicating severely impaired cognition. The cMDS further documented that Resident #14 was always incontinent of both bowel and bladder elimination. A review of the electronic medical records, under tasks of the CNA, revealed, toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment) was coded for dependent from 7/30/25 to 8/7/25. A review of the Annual Evaluation dated 6/16/25, that was electronically signed by the LPN/UM on 7/17/25, revealed that the resident was coded as dependent for toileting hygiene. A review of the personalized care plan (CP) included a focus area, ADL self-care performance deficit related to activity intolerance, confusion, dementia, impaired balance, and limited mobility that was created on 8/14/24, by the LPN/UM, with an intervention that included but not limited to toilet use I am totally dependent on staff for toilet use. On 8/7/25 at 1:35 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 observation and findings of Resident #14's incontinence care. A review of the provided incontinence list that was provided by the LNHA revealed that Resident #14 was included in the list. A review of the facility's Urinary Incontinence-Clinical Protocol Policy that was provided by the LNHA, with a revision date of April 2018, did not include information about toileting process for incontinent residents and the CNA responsibilities with ADLs/incontinence care. On 8/11/25 at 1:00 PM, the survey team met with the LNHA and DON, Regional Director of Operations, and the RDoCS for an exit conference. The LNHA and DON did not provide additional information. NJAC 8:39-11.2 (e), 27.1(a), 27.2 (d)(h)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, by failing to; a.) follow the physician's order, document, and notify the physician if medications were not administered for 1 of 26 residents (Resident #4) reviewed and b.) ensure accurate documentation of wound assessment and description of skin impairment for 1 of 23 residents (Resident #8) reviewed, in accordance to facility's protocol and policies.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 or 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 well-being, and executing medical regimes 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 8/5/25 at 10:58 AM, Surveyor #1 (S#1) interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) in the 3rd floor nursing station, who informed S#1 that Resident #4 was a dialysis resident. On 8/5/25 at 11:40 AM, S#1 asked Licensed Practical Nurse #1 (LPN#1) about the whereabouts of the resident, and she stated that the resident was in therapy. LPN#1 stated that the resident's dialysis days were every Tuesday, Thursday, and Saturday. S#1 reviewed the medical records of Resident #4, 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; type 2 diabetes mellitus with stable proliferative diabetic retinopathy (an advanced stage of diabetic retinopathy characterized by the growth of abnormal new blood vessels in the retina, which can lead to severe vision loss if untreated) right eye, acquired absence of left leg above knee, acquired absence of right leg above knee, other seizures, and end stage renal disease (ESRD). A review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool, with an assessment reference date (ARD) of 6/24/25, under Section C Cognitive Patterns revealed a brief interview for mental status (BIMS) score of 15 of 15, which reflected that the resident had intact cognition. A review of Resident #4's Order Summary Report (OSR) included the following physician orders (PO): -Ordered date 5/8/25, nifedipine ER (extended release) 60 mg (milligram) tablet (tab), give 1 tab by mouth one time a day (OD) for HTN (hypertension). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ordered date 5/8/25, hydralazine 50 mg tab, give 1 tab by mouth two times a day (2x/day) for HTN. -Ordered date 5/9/25, isosorbide mononitrate ER oral tab 60 mg, give 1 tab by mouth OD for stable angina pectoris (a type of chest pain caused by reduced blood flow to the heart), do not give if HR (heart rate) below 60. -Ordered date 5/9/25, apixaban 2.5 mg tab, give 1 tab by mouth 2x/day for atrial fibrillation (an irregular and often very rapid heart rhythm). -Ordered date 5/9/25, ticagrelor 90 mg tab, give 1 tab by mouth 2x/day for acute coronary syndrome (a term that describes a range of conditions related to sudden reduced blood flow to the heart). The above PO were transcribed to the August 2025 electronic Medication Administration Record (eMAR) and revealed that on 8/2/25, the above medications (meds) were coded as 3 during the morning of day shift, which indicated that the meds were not administered because the resident was absent from home. Further review of the medical records revealed that there was no documented evidence that the physician was notified of the meds that were not administered. A review of the most recent Progress Notes (PN) with an effective date of 7/22/25, that was electronically signed by the physician, revealed the following meds and corresponding diagnosis: -nifedipine ER oral tab for coronary artery disease with atrial fibrillation. -eliquis (apixaban) 2.5 mg tab for PVD (peripheral vascular disease) with recent multiple stents. -ticagrelor 90 mg tab for GERD (a chronic digestive disorder where stomach acid flows back into the esophagus, causing symptoms like heartburn and regurgitation) with ESRD and history of anemia. On 8/6/25 at 11:55 AM, S#1 observed the resident seated in a wheelchair with cushion in the dining room of 3rd floor with bilateral above the knee amputation. On 8/6/25 at 11:56 AM, S#1 interviewed the Registered Nurse (RN) regarding resident's meds. The RN stated that if the resident's meds were not administered for any reason, the nurse should notify the Unit Manager (UM) and the physician. He further stated that the information about missed meds and notification of the UM and the physician should be documented in the PN, that included what was the plan or order of the physician for missed meds. On that same date and time, S#1 notified the RN of the above findings and concerns about the 8/2/25 eMAR that meds were not administered and was coded 3. On 8/7/25 at 1:35 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). S#1 notified the concerns above for Resident #4. On 8/8/25 at 10:02 AM, S#1 asked LPN#2 for an interview while at the nursing station of 2nd floor and she stated that she was in the middle of discharging another resident at this time and was unavailable. LPN#2 was the nurse who did not administer the above meds on 8/2/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Rehabilitation and Healthcare at Maywood	100 West Magnolia Avenue Maywood, NJ 07607

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/25 at 12:53 PM, the survey team met with the LNHA, DON, and Regional Director of Clinical Services (RDoCS). The RDoCS stated that the nurse who did not administer the above meds was provided education, did a late entry note, and the facility initiated a medication error incident report after surveyor's inquiry. She further stated that we did order a stat (immediate) keppra laboratory request order last night to check the level. The RDoCS informed S#1 that there was no seizure activity since 8/2/25, vital signs were monitored every shift, and there was no negative outcome. On 8/11/25 at 1:00 PM, the survey team met with the LNHA and DON, Regional Director of Operations, and the RDoCS for an exit conference. The LNHA and DON did not provide additional information. 2. On 8/5/25 at 10:18 AM, Surveyor #2 (S#2) observed Resident #8 lying in their bed, alert and verbally responsive. The resident was wearing protective heel boots. Resident #8 stated they had a wound to their buttock and had heel wound. The resident confirmed they received wound treatment and their wound was healing. On 8/7/25 at 9:20 AM, S#2 reviewed the electronic medical record (EMR) of Resident #8. A review of the AR documented the resident had diagnoses that included but were not limited to; multiple sclerosis (MS; a chronic autoimmune disease that affects the brain and spine), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), hypertension (high blood pressure), type 2 diabetes mellitus, and osteoarthritis. A review of the qMDS, with an ARD of 6/6/25, reflected a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. In Section M (Skin Conditions) of the MDS, Resident #8 was coded as having one unhealed stage 3 pressure ulcer, and one venous/arterial ulcer. A review of the PO dated 6/25/25, documented to apply medihoney gel to sacrum topically one time a day for pressure (stage 3) wound; clean with normal saline, apply with collagen cover with silicone bordered gauze. On 8/7/25 at 10:15 AM, S#2 observed LPN#3 complete a wound care treatment for Resident #8. LPN#3 disinfected the treatment cart for preparing her wound care supplies using wipes from the container labeled hand sanitizing wipes. When preparing the wound care supplies onto a drape on the treatment cart. LPN#3 stated she would clean the re-usable scissors for the wound treatment to place on the drape. LPN#3 disinfected the scissors using wipes from the container labeled hand sanitizing wipes. After preparing the supplies for the wound care treatment LPN#3 went to wash her hands at the resident's bathroom sink. The surveyor observed LPN#3 turn on the water faucet, apply soap, then wet her hands with the running water. The LPN lathered her hands for 20 seconds outside the water prior to rinsing, dried her hands with a paper towel then used the same paper towel to turn off the faucet. After washing her hands, LPN#3 applied gloves and using the wipes from the container labeled hand sanitizing wipes disinfected the resident's bedside table. The LPN placed a drape on the bedside table place wound care supplies. On 8/7/25 at 10:35 AM, after completion of the wound treatment, LPN#3 went to wash her hands at the resident's bathroom sink. S#2 observed LPN#3 turn on the water faucet, apply soap, then wet her hands with the running water. The LPN lathered her hands for 20 seconds outside the water prior to rinsing, dried her hands with a paper towel then used the same paper towel to turn off the faucet. Outside of the resident's room, S#2 observed LPN#3 disinfect the scissors, and the top of the treatment cart using wipes from the container labeled hand sanitizing wipes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/25 10:45 AM, S#2 interviewed LPN#3 after completion of the wound care treatment about what to use when disinfecting equipment. LPN#3 showed the bleach wipes (blue top) found in the medication (med) cart and the hand sanitizing wipes (white top) on the top of the treatment cart could be used to disinfect equipment. S#2 discussed their observation of the use of hand sanitizing wipes to disinfect equipment and asked if it was part of the facility's protocol. LPN#3 stated that she believed it was ok to use to disinfect equipment. At that same time, S#2 asked LPN#3 about the steps in the hand hygiene process. LPN#3 stated she would open the faucet, apply soap, lather for at least 20 seconds, rinse her hands, dry hands with a paper towel and turn off faucet with the paper towel. S#2 asked if the same paper towel to dry hands would be used to turn off the faucet. LPN#3 stated the same paper towel could be used to turn off the faucet. S#2 discussed the observed concern with hand hygiene of applying soap first prior to wetting hands; and using the same paper towel instead of using another paper towel to turn off faucet. LPN#3 provided no additional verbal response. On 8/7/25 at 10:49 AM, S#2 interviewed a Registered Nurse Unit Manager (RN/UM), about what could be used to disinfect equipment including treatment carts. The RN/UM replied bleach wipes were available to be used to disinfect equipment and surfaces. S#2 asked the RN/UM if it was okay to use hand sanitizing wipes to disinfect equipment and surfaces, and the RN/UM stated she would like to verify before providing the surveyor with an answer. On that same date and time, S#2 asked the RN/UM about the hand hygiene process. The RN/UM stated to turn on the faucet, wet hands, apply soap, lather hands for at least 15-20 seconds, rinse hands, dry with paper towel and take another paper towel to turn off faucet. S#2 discussed the concerns observed during wound treatment. The RN/UM acknowledged the concerns and stated she will follow up with LPN#3 to provide in-service education. On 8/7/25 at 11:01 AM, S#2 interviewed the Infection Preventionist (IP) about disinfecting equipment and surfaces. The IP stated bleach wipes were used in the facility. S#2 asked the IP if hand sanitizing wipes could be used, and the IP replied that the hand wipes were for hand use only. S#2 asked the IP about the hand hygiene process. The IP stated to turn on the faucet, wet hands, apply soap, lather hand for at least 20 seconds, dry hands with paper towel and grab another paper towel to turn off faucet. S#2 discussed the observed concerns during wound treatment. The IP acknowledged the concerns, and no further verbal response was provided. On 8/7/25 at 11:04 AM, S#2 interviewed the DON about what to use when disinfecting equipment and surfaces. The DON stated staff were to use bleach wipes. S#2 asked the DON if hand sanitizing wipes could be used. The DON replied those wipes were for hand use only. S#2 discussed the concern observed during the wound treatment, The DON acknowledged the concern and stated she would follow up. At that same time, S#2 asked the DON about the hand hygiene process. The DON stated the process was to turn on the faucet, wet hands, apply soap, lather hands for at least 20 seconds, dry hands with a paper towel and then grab another paper towel to turn off the faucet. S#2 discussed the observed concerns during wound treatment. The DON acknowledged the concerns, and stated she would follow up with the LPN. On 8/7/25 at 1:41 PM, S#2 notified the DON, the LNHA of the concerns observed during the wound treatment related to the use of hand sanitizing wipes used to disinfect equipment and surfaces and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hand hygiene technique by the LPN#3. On 8/8/25 at 8:50 AM, S#2 conducted additional review of Resident #8's EMR which revealed the following: A care plan (CP) with a focus area, I am at risk of skin breakdown r/t [related to] impaired mobility, MS had an initiated date of 4/17/25. Interventions included to assess for changed in skin condition each shift; elevate legs as needed; keep skin clean and dry; turning and repositioning. A CP with a focus area, I have an ADL self care performance deficit r/t impaired balance, limited mobility had an initiated date of 4/23/25. Interventions included but were not limited to monitor skin integrity and observe for redness, open areas, scratches, cuts, bruises, and report changes to nurse. A CP with a focus area, I have PVD r/t diabetes, heart disease had an initiated date of 7/4/25. Interventions included but were not limited to monitor the extremities for signs and symptoms of injury, infection, or ulcers. A review of the wound consultant (WC) note dated 6/5/25, by the wound consultant physician (WC-P) revealed the resident was being initially evaluated for a right heel wound, present upon admission. The right heel wound was evaluated and classified as an arterial ulcer. The measurements were 1.0-centimeter (cm) x 1.0 cm x 0.2 cm. A review of the IDCP meeting note dated 6/12/25, revealed the resident's new heel wound was discussed with the resident's representative (RR). A review of the readmission evaluation dated 4/17/25, revealed no documentation of a right heel wound. A review of the PN and assessments for 4/17/25 to 6/5/25, revealed no additional documentation regarding the right heel wound to indicate when the wound was identified. Additional review of weekly skin checks completed by nurses after the WC-P's evaluation of the right heel wound on 6/5/25, revealed no documentation of the presence of a right heel wound on 6/13/25, 6/16/25, 6/20/25, 6/23/25, and 6/27/25. On 8/8/25 at 9:09 AM, S#2 interviewed the IP about skin assessments and wound evaluation by nursing staff. The IP stated that at times he would conduct rounds with the WC or with nurses to see residents' wounds. The IP stated upon admission the nurse would complete a head-to-toe assessment. The admission assessment nurse would document any findings such as open wounds and bruising. The IP continued to explain hospital records would be reviewed to determine if a wound identified was a pre-existing wound or a new one. Whether the wound was pre-existing or new, the IP stated the nurse would notify the physician for treatment orders; notify the RR; and notify the WC to evaluate the resident. On 8/8/25 at 9:32 AM, S#2 interviewed the WC-P over the phone. S#2 asked the WC-P about Resident #8's right heel wound. The WC-P reviewed her documentation and notes for Resident #8. The WC-P stated she evaluated Resident #8 for a newly opened right heel wound on 6/5/25. The WC-P further explained the wound was arterial in nature and recommended medi-honey treatment which was effective, and the resident's wound healed on 7/3/25. S#2 asked about the WC-P's note dated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/5/25, which indicated wound was present on admission. The WC-P reviewed her notes, stated it was a newly opened wound, that she believed it was an old wound site prior to admission and had newly re-opened. The WC-P believed that's why she indicated present upon admission in her notes. The WC-P stated the wound was superficial and new wound. The WC-P further explained that she had been seeing Resident #8 prior for their sacral wound and did not have a right heel wound. On 8/8/25 at 11:26 AM, S#2 interviewed LPN#4 about skin assessments for residents. LPN#4 stated nurses would complete skin assessments upon resident admissions and document in their notes a detailed explanation of what was identified. LPN#4 stated there was a second day skin assessment to complete a skin check and then weekly skin checks were ordered to be continued. LPN#4 further explained it was expected for nursing staff if any skin changes noted during care to inform the nurse, and they will notify the physician. At that time, S#2 asked LPN#4 if a new wound was identified by the nurse what is the protocol. LPN#4 stated the nurse would notify the physician, describe the wound, obtain treatment orders, and follow up with the wound consultant, who visited weekly. LPN#4 acknowledged all findings should be documented in the EMR. On 8/8/25 at 12:53 PM, the LNHA, the DON, and the Regional Director of Clinical Services (RDoCS) met with the survey team. The DON stated competency, and in-service education was completed with LPN#3. On 8/8/25 at 1:40 PM, S#2 notified the LNHA, the DON, and the RDoCS of the concern there was no documentation by the nurses regarding Resident #8's right heel wound as identified above. The DON stated she was working on the wound timeline and provide additional information to S#2. On 8/11/25 at 11:43 AM, the LNHA, the DON, and the RDoCS met with survey team. The DON stated Resident #8 was re-admitted to the facility with no right heel wound and the right heel wound was identified newly opened on 7/4/25. The DON further explained an incident report was completed. S#2 asked if would be expected for the nurses to document their findings of a new wound in the EMR. The DON acknowledged that it would be expected for the nurses to document a note in the resident's EMR. There was no additional information provided by the facility. A review of the facility's Wound Care Policy with a last revised dated of October 2010, under Steps in the Procedure.21. Wipe reusable supplies with alcohol as indicated. The policy did not further address disinfecting of equipment and surfaces. A review of the facility's Handwashing/Hand Hygiene Policy with a last revised date of October 2023, under Washing Hands revealed:.1. Wet hands first with warm water, then apply an amount of product recommended by the manufacturer to hands.3. Rinse hands with water and dry thoroughly with a disposable towel.4. Use towel to turn off the faucet. A review of the facility's Pressure Ulcers/Skin Breakdown- Clinical Protocol Policy with a last revised date of April 2018. The policy did not address the protocol for new wound identified or the expectation for documentation by nurses regarding a wound. N.J.A.C. 8:39-3.2 (a), (b); 19.4; 27.1 (a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that the facility failed to provide care and services consistent with professional standards of practice for a resident with pressure ulcers. This deficient practice was identified in 1 of 2 residents (Resident #113), reviewed for pressure ulcer care and prevention.The deficient practice was evidenced by the following:On 8/5/25 at 10:24 AM, the surveyor observed Resident #113 lying in the bed in their room. Resident #113 was alert and verbally responsive. The resident had no concerns with their care.On 8/8/25 at 8:50 AM, the surveyor reviewed the hybrid (paper and electronic) medical records of Resident #113.A review of the admission Record (an admission summary) reflected that the resident had diagnoses that included but were not limited to; type 2 diabetes, left above the knee amputation (LAKA), hypertension (high blood pressure), and muscle weakness. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/8/25, with a Brief Interview Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Under Section M (Skin Conditions), Resident #113 was coded for having one stage 2 (characterized by partial thickness loss of skin affecting the epidermis and dermis and presenting as a shallow, open sore) and one stage 3 (characterized by full thickness loss of skin where subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed) pressure ulcer. The resident had a care plan (CP) with a focus that read, I have actual skin breakdown r/t [related to] . sacral. LAKA-surgical.Right heel. had an initiated date of 7/1/25. Interventions of the CP included, but were not limited to: Observe for signs and symptoms of wound infection and intervene accordingly; treatments as ordered; wound evaluation weekly to determine progress or deterioration of wound. A wound consultant (WC) note, written by the wound consultant physician (WC-P) dated 7/17/25, indicated the resident was evaluated for a right heel wound. The WC-P classified the wound as a diabetic right heel wound and recommended an x-ray to rule out osteomyelitis as bone exposed in wound. Additionally, the WC-P recommended vascular consult, and wound treatment orders to cleanse the wound with Vashe, apply santyl, cover with silicone bordered gauze, and cover with an abdominal (ABD) pad and kling dressing. An admission assessment dated [DATE], revealed there was no documentation of a right heel wound.An admission second day skin evaluation dated 6/30/25, revealed the resident had a right heel pressure ulcer and sacral pressure ulcer. The right toe was indicated as a site and had no description documented. The June 2025 electronic Treatment Administration Record (eTAR) revealed no treatment orders for the right heel wound. A review of the physician's orders (PO) revealed there was no wound treatment order for the right heel from 6/28/25 to 7/1/25.A PO dated 7/1/25, indicated to cleanse and apply Vashe soaked gauze and cover with abd pad and wrap with kerlix dressing daily/prn. Monitor for changes. Offload heel. A review of the July 2025 eTAR revealed for the Vashe treatment order, the 7/2/25 and 7/21/25 entry were left blank and unsigned. A review of progress notes (PN) revealed there was no documentation by nurses to indicate treatment for Resident #113's right heel wound, follow up with the physician between 6/28/25 to 7/1/25. A podiatry PN dated 7/1/25, did not indicate any recommendation for right heel wound treatment orders. There was no documentation found to indicate that the resident was seen outpatient by vascular or podiatry consultant. On 8/8/25 at 9:09 AM, the surveyor interviewed the Infection Preventionist (IP) who created the second day skin assessment. The IP confirmed that was his username. The IP stated that at times he would conduct rounds with the WC or with nurses to see residents' wounds. The IP stated upon admission the nurse would complete a head-to-toe assessment. The admission assessment nurse would document any findings such as open wounds and bruising. The IP continued to explain hospital records would be reviewed to determine if a wound identified was a pre-existing wound or a new one. Whether the wound was pre-existing or new, the IP stated the nurse would notify the physician for treatment orders; notify the resident's representative; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and notify the WC to evaluate the resident.The surveyor asked the IP if he recalled Resident #113. The IP replied the resident was not familiar to him. The surveyor reviewed with the IP the second skin assessment in the EMR (electronic medical record). The IP confirmed it was his documentation. The IP stated he does recall Resident #113 but could not remember anything from the time about the resident's right heel wound. On 8/8/25 at 9:32 AM, the surveyor interviewed the WC-P about Resident #113. The WC-P stated her first evaluation of the resident was on 7/17/25, for the right heel wound and that it had been present upon admission. The WC-P further explained that she worried about osteomyelitis due to bone being exposed and it had been ruled out by x-ray. The surveyor asked WC-P if she had seen the resident prior to 7/17/25. The WC-P replied she did not and stated that she believed the staff were following up to determine if the resident could be seen by a wound consultant since they previously had podiatry and vascular on the case. The WC-P could not speak to the treatment orders for Resident #113 prior to 7/17/25. On 8/8/25 at 11:15 AM, the surveyor interviewed the podiatrist over the phone who visited the resident on 7/1/25. The podiatrist confirmed he had assessed and visited Resident #113 on 7/1/25. The podiatrist stated the resident had a LAKA and a right heel wound. The podiatrist stated the resident had the right heel wound prior to admission and he recommended for heel boots. The surveyor asked if the podiatrist took care of the resident prior to 7/1/25. The podiatrist stated the resident was new to him and he did not know the resident prior.The surveyor asked the podiatrist about the wound treatment at the time of the visit and previously from the resident's admission. The podiatrist stated the wound care team was always following the resident and he could not speak to the resident's previous treatment orders. The surveyor asked the podiatrist if he made any treatment recommendations for the right heel wound. The podiatrist replied he did not and recommended for staff to continue with the wound care team's recommendations. The podiatrist added the wound care team were the primary on the case and on 7/1/25 was the only time he saw the resident. On 8/8/25 at 1:40 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Director of Clinical Services (RDoCS) of the concern of there being no documentation of wound treatment to Resident #113's right heel, which was present on admission from 6/28/25 to 7/1/25. There was no verbal response from the LNHA, DON, and the RDoCS at this time. On 8/11/25 at 9:32 AM, the DON informed surveyor after interviewing staff that upon admission the right heel wound was assessed by the nurse supervisor and the admitting nurse. The DON stated they applied a dry dressing to the wound and did not document it. The DON further stated that the hospital record did not indicate wound treatment orders. The surveyor asked the DON if anyone followed up with the physician for treatment orders. The DON replied that a wound consultant order was entered and no treatment order was obtained. The DON could speak to why no treatment order was obtained for the right heel wound assessed upon admission. The surveyor asked the DON who entered the PO on 7/1/25, and the DON replied the IP did. The surveyor asked if anyone followed up with the wound consultant prior to their 7/17/25 as the order was placed on 6/28/25, and the DON replied no one followed up. On 8/11/25 at 11:43 AM, the LNHA, the DON, and the RDoCS met with the survey team. There was no additional information provided to the surveyor regarding Resident #113. A review of the facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol Policy, with a revised date of April 2018, under Assessment and Recognition revealed,.1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s).2. In addition, the nurse shall describe and document/report the following:a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue.d. Current treatments, including support surfaces.3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions.The policy did not further address nursing assessment, documentation of resident wounds and care planning. NJAC 8:39-27.1 (a)(e)

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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. Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to ensure that staff provided adequate routine monitoring for a resident after returning from receiving offsite hemodialysis and provided care and services in accordance with professional standards clinical practice for 1 of 2 residents (Resident #4), reviewed for dialysis services. 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. On 8/5/25 at 10:58 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) in the 3rd floor nursing station, who informed the surveyor that Resident #4 was a dialysis resident. On 8/5/25 at 11:40 AM, the surveyor asked the Licensed Practical Nurse (LPN) about the whereabouts of the resident, and she stated that the resident was in therapy. The LPN stated that the resident's dialysis days were every Tuesday, Thursday, and Saturday. The surveyor asked for the resident's dialysis communication records, and she stated that she would get back to the surveyor. On 8/5/25 at 11:50 AM, the Registered Nurse (RN) provided the resident's dialysis binder. The surveyor reviewed the binder and the following dates from the Dialysis Communication Record (DCR) were missing documentation from the hemodialysis (HD) center nurse, and the bottom part of the form was blank with no information from the facility's receiving nurse after HD for dates 8/5/25, 8/2/25, 7/24/25, 7/22/25, 7/12/25, and 7/10/25. The surveyor reviewed the medical records of Resident #4, and revealed the following: The admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; type 2 diabetes mellitus with stable proliferative diabetic retinopathy (an advanced stage of diabetic retinopathy characterized by the growth of abnormal new blood vessels in the retina, which can lead to severe vision loss if untreated) right eye, acquired absence of left leg above knee, acquired absence of right leg above knee, other seizures, and end stage renal disease (ESRD). A review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool, with an assessment reference date (ARD) of 6/24/25, under Section C Cognitive Patterns revealed a brief interview for mental status (BIMS) score of 15 of 15, which reflected that the resident had intact cognition. The qMDS reflected that the resident was on HD. A review of Resident #4's Order Summary Report (OSR) included a physician orders (PO) with an ordered date of 8/5/25 for HD on Tuesday, Thursday, and Saturday with chair time of 5:00 AM and pick up time of 4:15 AM. On 8/5/25 at 11:53 AM, the surveyor notified the LPN/UM of the above concerns with missing information from the HD nurse and blanks documentation from the facility receiving nurse in the DCR. The LPN/UM stated that the top and bottom parts of the DCR should be filled out by the facility nurse and the middle part for the dialysis center, if the middle part was blank, the nurse from facility should call the dialysis center. On 8/6/25 at 11:55 AM, the surveyor observed the resident seated in a wheelchair with cushion, in the dining room of 3rd floor with bilateral above the knee amputation. On 8/6/25 at 11:56 AM, the surveyor interviewed the RN regarding the DCR of the resident. The surveyor also notified the RN of the above concerns with missing/incomplete documentation in DCR. The RN stated that he was unaware prior to surveyor's (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Rehabilitation and Healthcare at Maywood	100 West Magnolia Avenue Maywood, NJ 07607

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inquiry that the DCR had to be filled out completely. He further stated that at times no one notified him that the resident had returned from the HD and that was why there were missing documentation from the communication records on the days he worked. On 8/7/25 at 1:35 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyor notified the LNHA and the DON of the concerns above for Resident #4's DCR. On 8/8/25 at 12:53 PM, the survey team met with the LNHA, DON, and Regional Director of Clinical Services (RDoCS). The RDoCS stated that the facility spoke to the nurses who did not fill out the DCR, two of the nurses said that they did assess the resident upon return to the facility from HD but did not fill up the form. The RDoCS further stated that a late entry notes were entered after surveyor's inquiry. A review of the facility's Hemodialysis Policy that was provided by the LNHA, with a reviewed/revised date of 12/2/24, revealed a policy 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 HD. The purpose.the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.ongoing assessment and oversight of the resident before, during, and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices; and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.#8. The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications. On 8/11/25 at 1:00 PM, the survey team met with the LNHA and DON, Regional Director of Operations, and the RDoCS for an exit conference. The LNHA and DON did not provide additional information. NJAC: 8:39-11.2(b), 27.1(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interviews, record review, and a review of pertinent facility documents, it was determined that the facility failed to act on the Consultant Pharmacist (CP) Medication Regimen Review (MRR) in a timely manner for 1 of 23 residents, (Resident #134), reviewed. This deficient practice was evidenced by the following:The surveyor reviewed the hybrid medical record (electronic and paper) for resident #134, and revealed the following:A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility on with diagnoses of, but not limited to, essential hypertension (high blood pressure) and malignant carcinoma of the lung (lung cancer). A review of the Social Services Assessment (SSA) dated 8/1/25, reflected that the resident had a Brief Interview for Mental Status (BIMS), a tool used to screen and identify cognitive condition, score of 15 out of 15, which indicated that Resident #134 was cognitively intact. A review of the resident's electronic Medication Administration Record (eMAR) for August 2025, up to and including 8/7/25, revealed the following: -A physician order (PO) for midodrine 10 mg (milligrams), give 1 tablet (tab) by mouth every 8 hours for orthostatic hypotension (also called orthostasis or postural hypotension, is a form of low blood pressure that happens when standing after sitting or lying down and can cause dizziness or lightheadedness and possibly fainting). The above PO for midodrine did not reflect any additional instructions to take or monitor blood pressures (BP) or to not give the medication (med) if the BP was above or below a certain level, also known as a parameter. The order was plotted to be given at 7:00 AM (7 AM), 3:00 PM (3 PM), and 11:00 PM (11 PM). -A PO for metoprolol succinate ER (extended release) (Toprol) oral tab 100 mg, give 1 tab two times a day (2x/day) for HTN (hypertension), hold for systolic BP (SBP) lower than 100 mmhg (millimeters mercury) or HR (heart rate) lower than 60. The above PO order for metoprolol was plotted to be given at 9:00 AM (9 AM) and 9:00 PM (9 PM). -A PO for losartan potassium (losartan) oral Tab 25 mg, give 1 tab by mouth one time a day (OD) for HTN hold for SBP lower than 100 mmhg.The eMAR also revealed entries for toprol on 8/3/25 at 9 AM that was not given when the BP was 103 and should have been, was given on 8/3/25 at 9 PM when the BP was 94 and should have been held, and not given on 8/5/25 at 9 PM when the BP was 107 and should have been given.The eMAR also revealed an entry for losartan on 8/3/25 at 9 AM that was not given when the BP was 103 and should have been.A review of the resident's progress notes (PN), up to and including 8/7/25, documentation including but not limited to physicians, and other professional staff. The PN did not reveal any documentation referencing a MRR, in person or remotely, by a pharmacist, nor any irregularities in medications (meds) or med changes.Further review of the PN, revealed a nursing note dated 8/7/25, that reflected on 8/7/25 at 7:23 PM, a nurses notes that the resident was seen by the cardiologist today, with new recommendations for ekg (electrocardiogram (ECG or EKG) is a quick test to check the heartbeat), to change metoprolol succinate 100 mg 2x/day to metoprolol tartrate 100 mg 2x/day, d/c (discontinue) losartan, and that the physician was made aware and was in agreement.The surveyor reviewed the electronic MRR (eMRR) for Resident #134, dated 8/4/25, that was provided by the Unit Manager (UM) of the unit where Resident #134 resided. The UM stated that the eMRRs were kept in a binder in their office. The eMRR revealed several recommendations for nursing and at least one for the attending physician.The recommendations listed for nursing to address were as follows:4. Metoprolol succinate was recommended to be scheduled and given with or immediately following a meal. Please review current administration times.5. Med error(s) noted. Metoprolol succinate was not always held as required by the physicians hold order (hold for SBP less than 100). Please review 9 PM administration on 8/3/2025.6. Do not administer midodrine after the evening meal or within four hours of bedtime to reduce the potential for supine HTN during sleep. (a type of high BP that occurs specifically when a person is lying down).Further review of the resident's paper chart revealed that the facility's CP reviewed the resident's record in person on 8/7/25, and documented that an eMRR was done on (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/4/25.The recommendation listed for the attending physician to address was to review the concurrent use of losartan and metoprolol succinate for HTN with midodrine for hypotension, due to opposing effects. Please clarify losartan and metoprolol succinate indications and continued use of all three meds.On 8/7/25 at 12:30 PM, the surveyor interviewed the CP, who stated if the eMRR had not yet been completed, they will do a complete review. If the eMRR had been done completely, the record will be considered as reviewed for the month.On 8/8/25 at 9:52 AM, the surveyor interviewed the UM for Resident #134. The surveyor asked the UM how the eMRR recommendations were addressed. The UM stated that she did them as soon as she could get to them. The UM stated that on admission, the request for an eMRR was sent to the wrong company, so it came back late. The surveyor asked the UM if it was common for midodrine to have a hold parameter. The UM stated yes, they usually do, but did not know why the order for Resident #134 did not have one. The UM also stated that the resident was seen the previous evening (8/7/25) by the cardiologist who made med changes, but no parameter to midodrine.The surveyor later reviewed the resident's PN which revealed a note by the cardiologist dated 8/8/24 at 3:28 PM, after surveyor inquiry, that addresses the resident's meds in question.On 8/8/25 at 12:53 PM, the survey team met with Regional Director of Clinical Services (RDoCS), Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON). The surveyor asked what the expectation or procedure for how admission/eMRR reviews were handled, including but not limited to what were the expected outgoing/incoming time frames, were they kept in the medical record, how were they addressed. The DON stated that they were send out to the CP office, then sent back, usually all within 24-72 hours of admission. They were kept in a binder on the floor and the nurse should follow up as soon as possible. The surveyor asked if four days to get the review and an additional three more days to act on, a total of seven days from admission would be an acceptable expectation. The DON stated no it should be quicker. At that same time, the surveyor also asked if there was an expectation for the nursing staff to follow the med parameters as the physician ordered them, and the DON stated yes, they should follow the order and document any other holds outside of that order.The LNHA and DON did not provide any further pertinent information.A review of the facility's Medication Regimen Reviews Policy that was provided by the DON, with a revision date of February 2025, revealed under policy statement that a licensed pharmacist reviews the med regimen of each resident at least monthly. Under policy interpretation and implementation .#5. The MRR is conducted in collaboration with the resident, family members, and the interdisciplinary team (IDT) .Timeframe for reporting .#3. Copies of MRR, including physician responses, are maintained as part of the permanent medical record .NJAC 8:39-29.3(a)(1)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more during medication administration, two (2) nurses administered medications to four (4) residents. There were thirty (30) opportunities for error, three (3) errors were observed which calculated to a medication administration error rate of 10%. This deficient practice was identified for 2 of 4 residents, (Resident #73, Resident #81), that was administered medications by (one) 1 of two (2) nurses that were observed. 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.On 8/07/25 at 8:23 AM, the surveyor observed the Registered Nurse (RN) prepare meds for Resident #81.The meds included an active physician's order (PO) for multivitamin-minerals oral tablet (tab) (multiple vitamins with minerals), give 1 tab by mouth two times a day (2x/day) for multiple vitamin and mineral deficiencies/extra supplement. The surveyor observed the RN prepare and administer Resident #81's medications (meds) which included one multivitamin (MVI) tab. The surveyor then observed the RN administer the MVI, along with other due meds to the resident. Upon return to the medication cart (med-cart), the surveyor asked the RN to identify the bottle she took the MVI from. The RN showed the surveyor the bottle labeled MVI tablets (tabs). The surveyor asked the RN to compare the bottle label to the order on the resident's electronic medication administration record (eMAR). The RN stated that it should have been with minerals.On the same date, at 8:51 AM, the surveyor observed the same RN prepare to administer meds to Resident #73. The meds included active POs for the following: Colace oral capsule (cap) 100 mg (a stool softener), give 1 cap by mouth 2x/day for constipation.Glipizide oral tab 5 mg, give 1 tab by mouth in the morning for diabetes, give 30 minutes (mins) before meals.The surveyor observed the RN enter the resident's room and observe that the resident needed to be re-positioned before med administration. The RN then went to get assistance. The RN returned with a staff member to aid in re-positioning the resident a few minutes later. The surveyor observed that the resident had their morning meal tray on the over bed table. The surveyor observed the RN prepare the resident's meds. The surveyor observed the RN select and pour a med labeled docusate sodium 100 mg tab along with the resident's other due meds. The surveyor accompanied the RN to the resident's bedside for med administration. The surveyor observed the resident eating their morning meal. The nurse then administered the meds, including the glipizide and docusate tab.Upon return to the med-cart, the surveyor asked the RN to identify the bottle she took the docusate from. The RN showed the surveyor the bottle labeled docusate tabs. The surveyor asked the RN to compare the bottle label to the order on the resident's eMAR. The RN stated that it should have been the docusate cap. The surveyor asked the RN about the timing of the glipizide and the directions how to give regarding meals. The RN stated that it should be before meals, but she was a little late and the resident likes to eat now. The surveyor asked the RN if a diabetic med was late, what was the usual procedure. The RN stated to document it late.The surveyor concluded the med pass observation with the RN.On 8/7/25 at 1:36 PM, the survey team met with the Director of Nursing (DON) and Licensed Nursing Home Administrator (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(LNHA) to discuss the above concerns. The surveyor discussed the results of the med pass observation. The surveyor asked the DON if it was an expectation for the staff to administer meds on time and to follow the PO as they were in the medical record. The DON stated yes, it was expected that the meds should be given on time and as the PO.A review of the facility's Administering Medications Policy, with a revision date of April 2019, reflected, under line 4. Meds are administered in accordance with prescribed orders, including any required time frame. Line 7. Meds are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).The LNHA did not provide any further pertinent information. N.J.A.C 8:39-29.2 (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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to, a.) cover the garbage container and b.) keep the garbage container area free of garbage and debris. This deficient practice was identified for 1 of 1 garbage containers.This was evidenced by:On 8/5/25 at 10:20 AM, in the presence of the Food Service Director (FSD), the surveyor toured the loading dock and dumpster area. Both the surveyor and the FSD observed the compactor was currently being dropped off. The Maintenance Director (MD), who stated that the compactor was being picked up every other week on Thursdays. On 8/6/25 at 12:58 PM, the surveyor and the FSD toured the refuse/dumpsters area and observed the following:1. The uncovered compactor filled with cardboard boxes and regular garbage.2. Gloves, water bottles, and loose trash inside the bottom floor of the compactor.3. Five spots of animal feces on the landing area of the facility near the opening part of the compactor.At that same time, the FSD stated, The garbage for cardboard and the regular garbage are not separated, all garbage of the facility goes all in one compactor. It's always been like that, not covered, cannot close it because of the metal part. It's always been an open dumpster, it should not be that way, housekeeping is in charge of keeping the area clean. The Housekeeping Director (HD) and MD confirmed the open compactor and garbage around the area. The MD stated that the compactor did not close and that was how it was designed. The MD also stated this is what we have. The surveyor asked, why was it important to keep it closed, and the MD replied, So animals cannot get in it. The FSD further stated that it was mentioned over the years and about two month ago to the Licensed Nursing Home Administrator (LNHA) about the dumpster. On 8/6/25 at 1:10 PM, the surveyor toured the refuse area with the LNHA and the FSD. The LNHA observed and confirmed the compactor area was open and confirmed animal feces on the landing. The surveyor asked, what was the expectation for this area as far as sanitation, and the LNHA responded, The expectation is to keep the dumpster closed to keep animals out. The surveyor requested for the facility policy for refuse/garbage area.On 8/7/25 at 1:00 PM, the LNHA and the Regional Director of Operations (RDO) toured the refuse area. The RDO stated, We sent the compactor back, they're going to put a lid on it, they gave us a temporary dumpster with a lid. We cleaned up the area and did some education with the staff. The surveyor observed the refuse area and found a new dumpster with a lid, observed the surrounding area with used disposal gloves and debris on the ground. The LNHA stated, They just took the compactor and still have to clean the grounds. The surveyor stated the concerns were the uncovered compactor, loose garbage and the animal feces on the landing. The surveyor asked the RDO if he saw those yesterday and he confirmed he saw those things yesterday, I understand the concern with the uncovered refuse and the animal feces.On 8/7/25 at 1:36 PM, the survey team met with the LNHA and the Director of Nursing (DON) to discuss the concerns above. A review of the facility's Disposal of Garbage and Refuse Policy which revealed: Garbage shall be disposed of in refuse containers with plastic liners and lids .Surrounding area shall be kept clean refuse shall be cleaned at a frequency necessary to prevent .becoming attractants for insects and rodents.A review of the facility's Sanitization Policy .Policy Statement: #14 Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered). On 8/8/25 at 12:36 PM, the Assistant DON (ADON), provided the facility responses in writing and revealed:Refuse: Upon administrator notification on 8/6/25, the loading dock was cleared of all items, and the floor was mopped, stripped, and waxed. [Name Redacted] was immediately contacted for immediate resolution. New, fully enclosed dumpster was delivered on 8/7/25 at 10:30 AM until the original compactor can be modified to allow for full enclosure housekeeping staff in-serviced to check loading dock 2x (times) daily to maintain cleanliness. Signs were hung inside the loading dock as a reminder to the housekeeping staff. Copy of in-service signage Loading dock and outside surrounding area dated 8/7/25 provided.On 8/8/25 at 12:54 PM, the survey team met with the (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regional Director of Clinical Services (RDoCS), LNHA and the DON, and the LNHA stated that we have temporary dumpster with a lid and the area was cleaned. The LNHA further stated that the dumpster would be maintained closed, housekeeping will be inspecting the loading dock area twice daily to clean. The LNHA added that the Housekeeping was responsible for cleaning the area. The RDoCS stated that would be included in their Quality Assurance Performance Improvement (QAPI). NJAC 8:39-19.3(a)(c),31.5(a)1,2

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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. Based on observation, interview, and review of facility documentation, the facility failed to maintain infection control practices to reduce the risk of infection, specifically by failing to ensure Alcohol Based Hand Rub (ABHR) was available to perform hand hygiene (HH) upon entering the facility and for use before and after signing in on the kiosk or provide disinfecting wipes to clean the kiosk after each use in between visitors. This deficient practice was observed for 2 of 5 days. This deficient practice was evidenced by the following:Reference: Centers for Disease Control (CDC) under the Healthcare-Associated Infections (HAIs) topic; Best Practices for Environmental Cleaning in Global Healthcare Facilities with Limited Resources with an updated date of March 19, 2024, at https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/introduction.html, included the following:As seen in Figure 1, colonized or infected patients can contaminate environmental surfaces and noncritical equipment. Microorganisms from these contaminated environmental surfaces and noncritical equipment can be transferred to a susceptible patient in two ways:If the susceptible patient makes contact with the contaminated surfaces directly (e.g., touches them).If healthcare personnel, a caretaker, or visitor makes contact with the contaminated surfaces and then transfers the microorganisms to the susceptible patient.Contaminated hands or gloves of healthcare personnel, caretakers, and visitors can also contaminate environmental surfaces in this way. Proper hand hygiene and environmental cleaning can prevent transfer of microorganisms to healthcare personnel, caretakers, and visitors and to susceptible patients.Evidence is increasing but remains limited that effective environmental cleaning strategies reduce the risk of transmission and contribute to outbreak control.Consequently, the use of multiple (i.e., a bundle) interventions as well as an overall multi-modal approach to IPC activities and programs is recommended, for both the outbreak and routine settings.On 8/5/25 at 9:00 AM, the survey team entered the facility. The survey team did not observe ABHR or disinfecting wipes in the front area of the facility or near the kiosk that was utilized for visitors to sign in on. On 8/6/25 at 9:00 AM, the surveyor entered the facility. The surveyor observed a kiosk that the Receptionist instructed the surveyor to sign in. The surveyor observed that there was not an ABHR dispenser in the area of the kiosk. The surveyor used their own ABHR prior to signing in on the kiosk and again used their own ABHR after signing in. The surveyor also observed that there were no disinfecting wipes located in the area to clean the kiosk after use. The Receptionist did not encourage the surveyor to perform HH. On 8/6/25 at 12:16 PM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) regarding the process for visitors entering the facility and the kiosk. The ADON/IP stated that when visitors entered the facility that they were encouraged to use ABHR. He added that there were ABHR stations throughout the facility. He added that there were hand washing signs in the elevator and the dayrooms. The ADON/IP stated that there was a ABHR station at the kiosk at the entrance. On 8/6/25 at 12:25 PM, the surveyor asked the ADON/IP to show the surveyor where the ABHR station was located at the entrance. The ADON/IP confirmed that the ABHR station was empty and did not contain ABHR and that there was no bottle of ABHR on the front desk near the kiosk or anywhere in the entrance area of the facility. The Receptionist also confirmed that there was no ABHR located on the front desk or in the area of the entrance. The ADON/IP then retrieved a bottle of ABHR from his office and placed it on the front desk. The ADON/IP stated that there should have been ABHR on the front desk. The surveyor asked for the facility's policy regarding visitors, hand hygiene and the kiosk. On 8/6/25 at 12:54 PM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor a policy regarding HH and stated that she did not have a specific policy related to the kiosk. On 8/7/25 at 10:57 AM, the surveyor interviewed the Receptionist regarding cleaning of the kiosk. The Receptionist stated that she did not do anything with the kiosk. She added that she just told the visitors to sign in. The Receptionist stated that she left at 4:30 PM and that she thought that housekeeping may clean it. On 8/7/25 at 10:59 AM, the surveyor interviewed the ADON/IP regarding (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Rehabilitation and Healthcare at Maywood	100 West Magnolia Avenue Maywood, NJ 07607

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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	cleaning the kiosk. The ADON/IP stated that it should be cleaned between uses and that he would place wipes there. On 8/7/25 at 11:35 AM, the surveyor interviewed the Director of Nursing (DON) regarding visitors, HH and kiosk. The DON stated that the Receptionist asked visitors to sign in on the kiosk and that visitors were encouraged to perform HH. The surveyor asked the DON if the kiosk was a high touch area and how it was cleaned. The DON confirmed that it was a high touch area and that she had to check regarding the cleaning. On 8/7/25 at 1:08 PM, the DON provided the surveyor a policy regarding routine cleaning and disinfection. The DON stated that the kiosk was part of the routine cleaning schedule of the front area. The kiosk was wiped down by the housekeeper daily and as needed. On 8/7/25 at 1:41 PM, the surveyor notified the LNHA, DON and Regional Director of Clinical Services (RDoCS) the concern that the entrance area did not have ABHR for visitors to use upon entrance and prior to using the kiosk to sign in and there were no disinfecting wipes to clean the kiosk screen between uses. The LNHA stated that there was usually a bottle of ABHR at the front desk.On 8/8/25 at 12:59 PM, in the presence of the DON and RDoCS, the LNHA stated that she interviewed the Receptionist and that she said the ABHR was there on Monday (8/4/25) and Tuesday (8/5/25). The LNHA stated that she had a whole box of bottles of ABHR delivered to the front desk and that kiosk was part of the housekeeping routine cleaning and that the kiosk was wiped at the beginning of the day. The LNHA did not provide any additional information. A review of the facility's Handwashing/Hand Hygiene Policy with a revised date of October 2023, included the following:Policy StatementThis facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and ImplementationAdministrative Practices to Promote Hand Hygiene1. All personnel are trained and regularly in-service on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. ABHR dispensers are placed in areas of high visibility and consistent with workflow throughout the facility.6. Residents, family members and/or visitors are encouraged to practice hand hygiene. Fact sheets, pamphlets and/or other written materials promoting hand hygiene practices are provided at the time of admission and/or posted throughout the facility.A review of the facility's Routine Cleaning and Disinfection Policy with a copyright date of 2023, included the following:Policy:It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Definitions: Disinfection refers to thermal or chemical destruction of pathogenic and other types of microorganisms. Hand Hygiene refers to a general term that applies to hand washing, antiseptic wash and ABHR. Standard Precautions refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Policy Explanation and Compliance Guidelines:1. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas.4. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to:.h. Monitor control panels, touch screens.N.J.A.C. 8:39-19.4