STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315438	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Post Acute Care at Park Ridge	120 Noyes Drive Park Ridge, NJ 07656

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Complaint #2611374Based on interview, record review, and review of other pertinent facility provided documentation, the facility failed to follow appropriate tuberculosis (TB) testing and documentation for 3 of 3 residents, Residents #1, #2, and #3 according to the standard of clinical practice and facility's 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 and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 10/23/25 at 10:49 AM, Surveyor #1 (S #1) reviewed the paper and electronic medical record (eMR) of Resident #2. A review of the admission Record or face sheet (AR; an admission summary) documented that the resident had diagnoses that included but were not limited to, lesion of the lumbar spinal cord, secondary malignant neoplasm (cancer) of the bone, cord compression, morbid obesity, chronic kidney disease, and type 2 diabetes. A review of the comprehensive Minimum Data Set (cMDS), an assessment tool, with an assessment reference date (ARD) of 7/31/25, revealed a brief interview for mental status (BIMS) score of 14 out of 15, which indicated Resident #2's cognition was intact. A review of the physician's order (PO) dated 8/27/25, tuberculin PPD (Purified Protein Derivative, which is a key component used in the TB skin test to determine if a person has been infected with TB bacteria) Solution 5 UNIT/0.1milliliter (ml), inject 0.1 ml intradermally (ID) one time only for house protocol (HP) until 8/27/25, PPD Step (1) administration. Repeat in 14 days if results of 1st PPD is negative. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the August 2025 eMAR (electronic Medication Administration Record) of the above PPD order entry dated 8/27/25, revealed the entry was not signed by a nurse to indicate if the PPD solution was administered to Resident #2. The entry was left blank. A review of August 2025 progress notes (PN) revealed there was no documentation to indicate if the PPD solution was administered or not administered to Resident #2 on 8/27/25. On 10/23/25 at 1:39 PM, S #1 interviewed the Director of Nursing (DON), regarding PPD solution administration. The DON stated there was a HP for PPD administration upon a resident's admission, according to a PO. The DON further explained the PPD administration would be documented in the eMAR, and the order entry would be signed to indicate that the PPD was administered or not administered. The DON stated it was expected that eMAR order entries were signed and not left blank. On 10/23/25 at 4:09 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA), the DON, the Assistant DON (ADON), and the Regional DON (RDON) of the above concern that Resident #2's order entry for the PPD testing which was scheduled to be administered 8/27/25 was unsigned and left blank. There was no verbal response from the facility management at this time. On 10/23/25 at 4:59 PM, the LNHA, DON, ADON and the RDON met with the survey team. There was no additional information provided by the LNHA. A review of the facility's Tuberculosis, Screening Residents for Policy, last reviewed date of January 2025, under the Policy statement revealed, this facility shall screen all residents for tuberculosis infection and disease (TB). Further review of the above policy did not address documentation for PPD administration. 2. On 10/23/25 at 10:00 AM, Surveyor #2 (S #2) reviewed the paper and eMR of Resident #1. A review of the AR revealed Resident #1 with diagnoses that included but not limited of urinary tract infection, sepsis, cerebral infarction, hemiplegia and hemiparesis following a cerebral infarction affecting right dominant side, aphasia, and chronic combined systolic and diastolic congested heart failure. A review of the cMDS, with an ARD of 9/11/25, revealed a BIMS score of 9 out of 15 indicating moderate cognitive impairment. A review of the PO dated 9/4/25, tuberculin PPD Solution 5 Unit/0.1 ml, inject 0.1 ml ID one time only for HP until 9/4/25, PPD Step (1) administration. Repeat in 14 days if results of 1st PPD is negative. A review of the September 2025 eMAR of the above PPD order entry dated 9/4/25, revealed the entry was signed and administered by Registered Nurse #1 (RN #1) (3-11 shift). An additional entry on the September eMAR of the above PPD order entry dated 9/5/25, revealed RN #1 signed with a chart code of (9) indicating Other/See PN Ineffective. A review of the nursing PN at 11:00 AM, revealed PPD Double Entry. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:20 PM, S #2 interviewed the LNHA who stated, that when the ADON was completing an audit for immunizations, the next day after admission, she saw the immunization tab in the Resident #1's eMR was blank, so she asked the nurse to give the PPD, not knowing that it was already given the previous day. The LNHA stated that this was a self-identified medication (med) error, investigation, report, statements, and education were completed. At 3:22PM, S #2 interviewed RN #2, who stated that he admitted the Resident#1, he forgot to put an order for PPD and to administer it. He further stated that the ADON asked him the next day if a PPD was given because according to the admission checklist, the PPD was not checked off that it was given. He was then asked to administer the PPD, and he confirmed he administered the PPD the next day. At that same time, RN #2 stated that the Personal Aide (PA) was in the room when he administered the PPD. The PA called the Resident's Representative (RR), and the RR called the facility to say that Resident#1 received the PPD the previous day. RN #2 stated he was not aware that the Supervisor from the day before (3-11 shift) put an order in for the PPD and administered it. RN #2 further stated that there was no negative reaction to the resident, the Physician was made aware, and he received education. At 4:15 PM, the survey team met with the LNHA, DON, RDON, and the ADON, and S #2 notified them of the concern with the two PPD administrations. The LNHA provided a copy of the med error report and in-services. The LNHA stated they self-identified the PPD med error and included it in their Quality Assurance and Performance Improvement program. 3. On 10/23/25 at 9:46 AM, Surveyor #3 (S #3) reviewed the closed medical record of Resident #3, and revealed: A review of AR reflected that Resident #3 was admitted to the facility with medical diagnoses which included but not limited to; malignant neoplasm of colon (commonly known as colon cancer, is a type of cancer that begins in the large intestine and can develop from precancerous growths called polyps) unspecified, muscle weakness (generalized), and difficulty walking, not elsewhere classified. A review of the most recent (cMDS), with an ARD of 7/25/25, revealed a BIMS score of 15 out of 15, reflected that the resident's cognition was intact. A review of the July and August 2025 eMAR revealed the following PO: A PO with a start date (SD) of 7/18/25, tuberculin PPD 5 unit/0.1 ml, inject 0.1 ml ID one time only for HP for 1 day ppd step (1) administration. Repeat in 14 days if results of 1st ppd is negative. The order was administered and signed on 7/19/25 at 1257 (12:57 PM) by Licensed Practical Nurse #1 (LPN #1). A PO with a SD of 7/21/25, read ppd: 2 step one time only for HP for 1 day read 72 hours after step (1) administration and document in mm (millimeters). The order was coded 6 (six) in the eMAR on 7/21/25 by LPN #2 at 2:58 PM. The code six meant the resident was hospitalized (result was not read). A PO with a SD of 8/1/25, tuberculin ppd solution 5 unit/0.1 ml inject 0.1 ml ID one time only for HP for 1 day ppd step (2) administration 14 days after step 1 if results of 1st ppd is negative. The step 2 ppd was signed as administered by LPN #3 at 11:06 AM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A PO with a SD of 8/1/25, read PPD: 2 step one time only for HP for 1 day read 72 hours after step (2) administration and document in mm. The order was coded with a check mark in the eMAR, the mm was coded n on 8/1/25 by LPN #3 at 11:06 AM. The code check mark meant the step 2 ppd was read and the measurement (result) was n, which did not have a corresponding information in the custom prompt legend and chart codes. Further review of the medical record revealed that there was no documented evidence that the step 1 ppd was read and result was negative. On 10/23/25 at 12:25 PM, S #3 interviewed LPN #2, who informed S #3 that step 1 ppd should be administered on the day of admission, read within 48-72 hours, and step 2 ppd should be administered on the 14 day if step 1 ppd was negative. LPN #2 stated that the orders for ppd and the reading should be in the eMAR, other documentation should be in the PN and the electronic record immunization tab. On that same date and time, S #3 asked LPN #2 what the expectation for the nurse would be to do when the resident was hospitalized and returned the same day and the ppd was due to read. LPN #2 stated that he did not know the answer. LPN #2 was unable to remember Resident #3. On 10/23/25 at 12:55 PM, S #3 attempted to call LPN #3 twice for an interview. On 10/23/25 at 4:10 PM, the survey team met with the LNHA, DON, ADON, and the RDON, and S #3 notified them of the above findings and concerns with Resident #3's ppd. On 10/23/25 at 4:44 PM, the survey team met with the LNHA, DON, ADON, and RDON, and the DON acknowledged that ppd step 2 should be administered after step 1 ppd was negative, and step 1 and 2 ppd should be read within 48-72 hours of administration. On 10/23/25 at 5:00 PM, the survey team met with the LNHA, DON, ADON, and RDON for an exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-11.2(b)

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJ#2578488Based on interview, review of medical record, and other pertinent documentation, it was determined that the facility failed to; a.) ensure skin conditions and impairments were addressed appropriately, b.) obtain and follow physician order for skin impairments, c.) document reason as to why the order was not followed, and c.) ensure Certified Nursing Aide (CNA) documented provided care to the resident, for 1 of 3 residents, Resident #3 reviewed for quality of care.This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 10/23/25 at 9:46 AM, the surveyor reviewed the closed medical records (MR) of Resident #3, and revealed:A review of admission Record or face sheet (an admission summary) reflected that Resident #3 was admitted to the facility with medical diagnoses which included but not limited to; malignant neoplasm of colon (commonly known as colon cancer, is a type of cancer that begins in the large intestine and can develop from precancerous growths called polyps) unspecified, muscle weakness (generalized), and difficulty walking, not elsewhere classified. A review of the most recent comprehensive Minimum Data Set (cMDS), an assessment tool, with an assessment reference date (ARD) of 7/25/25, with a brief interview for mental status (BIMS) score of 15 out of 15, reflected that the resident's cognition was intact. Section H-Bladder and Bowel was coded 2 (frequently incontinent).A review of the 7/19/25 Skin Assessment/Observation revealed that Resident #3 had positive pitting edema to BLE (bilateral lower extremities) and JP drain (Jackson Pratt drain is a surgical suction drain that gently draws fluid from a wound to help you recover after surgery) to RUQ (right upper quadrant) of abdomen. There were no other documented skin impairment except for the BLE pitting edema and RUQ JP drain.A review of the progress notes (PN) dated 7/31/25 at 2:26 PM, that was electronically signed by Licensed Practical Nurse #1 (LPN#1), documented an alert note that Resident #3 was noted with a fluid filled blister to right hip, the site was cleaned with soap and warm water.Further review of the MR revealed that there was no documented evidence that the physician was notified of the right hip fluid filled blister to obtain an order and further assessment to determine the size and stage of the wound.A review of the PN dated 8/4/25 at 3:06 PM, that was electronically signed by LPN#2, documented a skilled note that Resident #3's findings: ruptured blister noted on left hip, the skin was open without serous drainage. The MD (medical doctor) was notified and a new order received to clean with NS (normal saline) and apply Xerofom (a sterile, non-adhering protective dressing consisting of absorbent, fine-mesh gauze impregnated with a petrolatum blend and provides bacteriostatic protection). Skin care was done as ordered, provided nursing care as tolerated and accepted by the resident.A review of the July and August 2025 electronic Treatment Administration Record (eTAR) revealed the following physician orders (PO):A PO with a start date (SD) of 7/25/25, skin assessment every day shift every Fri (Friday) for Skin Assessment I=Intact N=Not intact, If Not intact document findings in skin observation tool in assessment tab. The order was discontinued (dc'd) on 8/14/25.Further review of the MR revealed that the above PO for skin assessment was transcribed to the August 2025 eTAR and was signed on 8/1/25 and 8/8/25 by LPN#2. LPN#2 coded the two separate dates with NI. A PO with a SD of 8/5/25, cleanse left lateral blister site with NS, pat, dry, apply bacitracin and cover with border gauze every day shift for 14 days. The order was dc'd on 8/14/25.Further review of the MR revealed that there was no documented evidence as to why the PN on 8/4/25 for an MD order of Xerofom was not followed. There was no documented evidence that the MD was notified of the change in the PO for left hip. In addition, there was no documented evidence on what happened to the right hip blister.On 10/23/25 at 12:33 PM, the surveyor interviewed LPN#2, who informed the surveyor that as per facility's practice, when a nurse noted a resident's skin impairment, the nurse would notify the Director of Nursing (DON), Wound Nurse (WN) and the MD

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Complaint #: NJ2611374 and NJ2621276Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to: a) follow the care plan and appropriate safety precautions to provide a two person assist with bed mobility to prevent a fall incident for 1 of 2 residents reviewed for falls (Resident #2) and b) follow a resident's plan of care for two person assist with use of Hoyer lift transfer to ensure safety, for a resident who had a limited physical mobility related to right hemiplegia, for 1 of 2 residents reviewed for accidents (Resident #1). This deficient practice was evidenced by the following: 1. On 10/23/25 at 9:19 AM, Surveyor #1 (S #1) requested from the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) a list of residents with falls in the last six months. On 10/23/25 at 10:23 AM, the LNHA provided the list of residents who had fall incidents in the last six months which included Resident #2, who had one fall event which occurred on 9/8/25. On 10/23/25 at 10:49 AM, S #1 reviewed the electronic medical record (eMR) of Resident #2. A review of the admission Record or face sheet (AR; an admission summary) documented that the resident had diagnoses that included but were not limited to; lesion of the lumbar spinal cord, secondary malignant neoplasm (cancer) of the bone, cord compression, morbid obesity, chronic kidney disease, right hand contracture (a permanent tightening of soft tissue that restricts movement and range of motion in a joint), and type 2 diabetes. A review of the comprehensive Minimum Data Set (cMDS), an assessment tool to facilitate the management of care, with an Assessment Reference Date (ARD) of 7/31/25, revealed a Brief Interview Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact. A review of the care plan (CP) with a focus area on limited physical mobility with a last revised date of 9/4/25, included interventions for bed mobility-assist- two, bed mobility- assist rail- left; and bed mobility- assist rail-right. A CP with a focus area on risk for falls with a last revised dated of 9/4/25, included interventions to be sure the resident's call light was within reach and encourage resident to use it for assistance as needed; and ensure that the resident was wearing appropriate footwear when ambulating/transferring as needed. A review of the progress note (PN) dated 9/6/25, by Registered Nurse #1 (RN#1), documented Resident #2 was awake, alert, and oriented with forgetfulness. The resident was on pain management, safety maintained, and plan of care to continue. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Situation Background Assessment Recommendations (SBAR) PN dated 9/8/25 at 8:00 AM (8 AM), by RN#1, documented Resident #2 was awake lying on bed alert and confused; post fall at 4:00 AM (4 AM). Resident #2 had a bump with swelling to left forehead above the eyebrow, mouth was bloody, had skin tear to left upper arm and wrist, back of right shoulder, bruising to both knees, left calf, and skin tear to right lower leg. Resident #2 complained of pain 4-5 level on a pain scale. The Assistant DON (ADON) and Physician were notified, the resident was medicated for pain, and the resident was sent to emergency room (ER) at an acute care hospital for further evaluation. Resident's Representative #1 (RR #1) was notified. A review of the PN dated 9/8/25 at 11:01 PM, by Licensed Practical Nurse #1 (LPN#1), documented, as per an ER nurse the resident was transferred due to a fall incident and was admitted to the hospital for pneumonia. Further review of the eMR revealed, there was no documented evidence by the night shift nurse regarding the resident's fall incident and assessment on 9/8/25, at the time of the incident. An interdisciplinary team PN dated 9/9/25 at 12:21 PM, by the ADON, documented the interdisciplinary CP team met to discuss the resident's fall; a CNA (Certified Nursing Aide) was providing care to Resident #2, stepped away from the resident who was laying on the bed on their right side to get a dry towel. Upon returning with the dry towel, the CNA observed the resident on the floor laying on their right side in their room. The CNA called the Supervisor and Nurse on duty immediately and the resident was assessed. Resident #2 was observed with ecchymosis (bruising) and tear to their skin; bleeding was observed from the resident's mouth. Resident #2 was asked what happened and stated they were being washed and fell, BIMS=12 (moderately impaired cognition). RR #1 and Physician were notified, and the Physician gave orders to send resident out for further evaluation. On 10/23/25 at 11:40 AM, S #1 requested investigations for Resident #2 and their closed (paper) medical record. On 10/23/25 at 12:01 PM, S #1 interviewed RN #1 about fall protocols and facility policy. RN #1 stated if a resident had a fall, the nurse assessed the resident, performed a head-to-toe body assessment to check for visible injuries, checked their vital signs (blood pressure, heart rate, temperature, respirations, and oxygen saturation), assessed their pain level, range of motion (ROM) of extremities, and asked the resident what happened. RN #1 further explained if a resident hit their head or it could not be excluded, then neurological (neuro) checks (exam to assess function and health of nervous system) would be initiated. On that same date and time, S #1 asked RN #1 about documentation at the time that a fall occurred. RN #1 stated an incident report for risk management would be completed, and witness statements by staff at time of the incident would be obtained. RN#1 continued that the nurse would document a PN regarding their assessment and who was notified, and the fall event would be included in the 24-hour (shift to shift) report to endorse monitoring of the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that same time, S #1 asked RN #1 about Resident #2's fall incident. RN #1 stated at the start of the shift, the 11-7 nurse notified her that Resident #2 had a fall incident around 4-5 (4 AM – 5:00 AM). RN #1 stated she conducted her rounds, and the resident was observed with black and blue bruising around the eyes, bleeding from mouth, and skin tears. RN #1 continued that Resident #2 was assessed, she notified the 11-7 RN Supervisor (RN/S), the ADON, and the DON. The Physician was called and notified of the resident's assessment and sent out for further evaluation at the ER. RN #1 stated she administered the resident's PRN (as needed) pain medication prior to their transfer to the hospital. RN#1 stated the resident was usually AAOx3 (alert and oriented times three), had a history of periods of forgetfulness/confusion, was dependent with mobility, and received pain management for chronic pain. On 10/23/25 at 12:30 PM, S #1 interviewed Certified Nurse Aide #1 (CNA #1) about protocol for staff caring for a resident while in bed. CNA #1 stated that staff should not leave a resident unattended in the middle of care. CNA #1 further explained if a staff had to step away from the resident's bedside, they should make sure the bed was low to the floor, the resident was covered to ensure privacy, and that the resident was comfortable and safe. CNA #1 stated if a CNA could not assist a resident alone, they should ask for assistance before providing care and follow the CP for safety. On 10/23/25 at 12:48 PM, the investigation for Resident #2 and their closed record was provided to S #1 and revealed an investigation dated 9/8/25 5:15 AM, prepared by LPN #2. The fall investigation included that CNA #2 entered the resident's room to provide care at about 5:20 AM by herself, when CNA #2 turned Resident #2 to their right side to wash their backside and needed help to hold the resident in place. The nurse was with another resident and the CNA continued to wash resident and needed a dry towel. CNA #2 wrote she had the resident laying on their right side and went to get a dry towel. When CNA #2 arrived in room, Resident #2 was observed on the floor on their left side. CNA #2 immediately went to call the Supervisor and Nurse. Under Incident Description: LPN #2 was called by the Supervisor for assistance. Upon walking into the room, Resident #2 was noted laying on their right side with their head against the wall and mouth noted to be bloody. The Supervisor assessed the resident who had ecchymosis noted on bilateral arms, skin tear to their left upper arm and wrist, and to their back of right shoulder, hematoma noted on left eyebrow, ecchymosis to right knee, left knee, left calf, right side forehead, and skin tear to right lower leg. The resident's vital signs were assessed. LPN #2 documented the resident seem confused and stated, They were washing me, and I fell. Under Immediate Action Taken: Resident #2 was assisted back in bed by LPN #2 and two CNAs via Hoyer lift (a mechanical lift used to transfer residents), Resident #2 was assessed by the Supervisor, the supervisor notified RR #1 and the physician, skin tear was cleansed and dressing treatment applied, vital signs obtained, and neuro checks started. Under Statements included statements from LPN #2, RN/S, and CNA #2. The RN/S documented she was called by CNA#2, the resident's assigned CNA for help. The RN/S went to the resident's room and noted the resident lying on left side on the floor by their bed with head against the wall. When asked what happened the resident was unable to describe what happened. The CNA reported to the RN/S that the resident fell off their bed while changing their incontinent brief. (continued on next page)

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	315438	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Post Acute Care at Park Ridge	120 Noyes Drive Park Ridge, NJ 07656

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under Notes dated 9/10/25, by the DON, revealed CNA #2 was re-interviewed and stated she did not step out of the room, she turned her back to the resident to grab the dry towel on the overbed table where she had her supplies, and by the time she grabbed it Resident #2 was already on the floor. The DON noted the CNA's statement indicated a time of 5:20 AM but neuro checks were initiated at 4:20 AM by the nurse. The CNA was in-serviced by the RN/S on not leaving residents unattended during care. Post fall event the resident had the skin tears treated and the blood on their lips, was cleaned and no active bleeding was noted. The DON documented post fall the resident was stable until 8:30 AM when he presented a change in condition with bleeding from the mouth and generalized pain 4-5 out of 10 on numerical pain scale. On 10/23/25 at 1:39 PM, S #1 interviewed the DON who stated she was notified by RN #1 that Resident #2 fell on the previous shift, the resident was bleeding from the mouth, and she wanted to send the resident to the hospital. The DON stated after investigating, they determined CNA #2 left the resident on their side to get a towel, turned to get the towel and the resident fell on the floor. The DON added the resident had a low air loss mattress in use which could have contributed to the resident sliding off the side of the mattress and the bed had quarter size side rails. The DON stated contracted CNA #2 was provided education on the same day interviewed regarding not leaving a resident unattended on their side; and if needing to step away from the bedside to ensure the bed was at a low height, the resident was left on their back, and to bring all supplies into room prior to starting care. At that same time, S #1 notified the concern that the CP was not followed for two person assist with bed mobility, and the DON had no response. On 10/23/25 at 2:01 PM, S #1 interviewed the RN/S, who recalled she was passing near the resident's room when CNA #2 called for assistance. The RN/S stated that according to the CNA, she was changing the resident, went to get something and the resident fell out of the bed. The RN/S stated that she assessed the resident, ROM (range of motion) was within normal limits, the resident had skin tear, and some blood on their mouth. The RN/S did not recall seeing any bump or swelling at the time and the RN/S told LPN #2 to start neuro checks. The RN/S stated she called RR #1 and the Physician to notify them of the fall incident. The RN/S could not recall when she spoke with the Physician but stated it would be documented in the in the incident report/risk management report. The RN/S stated after the resident's fall the resident was being monitored for the rest of the shift. On 10/23/25 at 2:19 PM, S #1 interviewed CNA #2 via a phone conference, who stated that approximately 4 AM she was rounding on residents and Resident #2 needed hygiene care. CNA #2 stated that she went to ask the nurse to assist her as she would need another person's assistance (two person assist). CNA #2 stated that the nurse was assisting another resident, could not assist her, and there was no one else who could help. CNA #2 further stated that Resident #2 had a bowel movement and needed to be changed. She added that she gathered the supplies needed to clean and went to change Resident #2. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that same time, CNA #2 stated the side rail was down on the side she was standing, and Resident #2 was turned to the side with the siderail up. CNA #2 stated it was not a half or full side rail and that the side rail was only at the head area of the resident. She also stated she reached for a towel, that she had not fully turned away from the resident and Resident #2 fell to the floor. CNA #2 acknowledged she did not see the resident's fall. CNA #2 stated she immediately called for assistance and the nurse Supervisor, Nurse, and another staff member arrived to help the resident. CNA #2 acknowledged that she needed assistance to provide care for the resident. CNA #2 stated that she was not permitted and did not return to work at the facility. On 10/23/25 at 2:36 PM, S #1 interviewed LPN #2 via a phone conference, who was assigned to care of Resident #2 at the time of the incident. LPN #2 stated that at some time after 4:00 AM she was notified by the RN/S that her assistance was needed with Resident #2 as the resident fell. LPN #2 stated at the time of the resident's fall she was assisting another resident with care. LPN #2 stated the RN/S assessed the resident, the resident appeared to have hit their head and was bleeding from the mouth. LPN #2 stated with the assistance of the two CNAs via Hoyer lift the resident was transferred back to bed. LPN #2 stated the incident report in risk management was done and was not sure if the RN/S wrote a PN in the eMR. LPN #2 stated she was still at facility when resident was transferred by oncoming shift. LPN #2 stated she was interviewed by the DON and ADON that day. LPN #2 stated she was not permitted and did not return to work at the facility. On 10/23/25 at 2:45 PM, S #1 interviewed the ADON who stated when she came to work that morning RN #1 notified her that the resident had fell on the previous shift during hygiene care. The ADON interviewed LPN #2 who stated she was assisting other resident at time of the resident's fall, initiated the neuro checks, and started an incident report in risk management. The RN/S reported at the time of the fall to assessing the resident, the staff assisted the resident back to bed, RR #1 and Physician were notified of the incident. On that same date and time, S #1 asked the ADON about protocol when caring for resident at the bedside. The ADON stated that patient safety came first and if a staff member had to step away from the bed, they should ensure the resident was covered, make sure the bed was at a low position, informed the resident they were stepping away and ensure call light was within reach. The ADON further stated the resident should not be left on their side and should be positioned in the center of the bed and to follow the resident's CP. At that same time, S #1 asked about documentation at the time of the fall event. The ADON stated documentation would be done in the incident report under risk management. S #1 asked the ADON if the incident report was part of the resident's medical record. The ADON replied that it was separate from the medical record but could be linked into a PN in the eMR. The ADON added some nurses do create a separate PN. The ADON stated neuro checks was a paper document and would be in the paper chart. On 10/23/25 at 3:34 PM, the Regional DON (RDON) provided the neuro check dated 9/8/25 for Resident #2. The neuro checks started at 4:25 AM and ended at 9:00 AM at the time of the resident's transfer to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/25 at 4:09 PM, S #1 notified the LNHA, the DON, the ADON, and the RDON of the concern that CNA #2 did not follow the facility's protocol and the resident's CP while providing care to the resident which resulted in a resident's fall with injury, and there was no documentation in the resident's medical record at the time of the resident's fall. The DON and LNHA stated the LPN and RN/S at the time of the fall incident documented in the incident report under risk management. The LNHA stated and confirmed that the incident report under risk management was not part of Resident #2's medical record. The DON added the neuro checks initiated after the fall event included the resident's vital signs and neurological assessment. On 10/23/25 at 4:59 PM, the LNHA, DON, ADON and the RDON met with the survey team. The DON provided a printout of the resident's CP and stated that the bed mobility intervention, two assist was applied for all residents as a precaution, and that not all residents needed a two staff assist. The LNHA, DON, ADON, and RDON acknowledged that the CP should reflect the resident's current status and updated accordingly. A review of the facility's Falls-Clinical Protocol Policy with a revised date of 10/1/25, revealed under Assessment and Recognition:.5. The staff will evaluate, and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. A review of the facility's Change in a Resident's Condition or Status Policy with a revised date of October 2025, revealed under Policy Interpretation and Implementation, Documentation of Changes in Medical Record:.6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. There was no additional information provided by the LNHA. 2. On 10/23/25 at 10:00 AM, Surveyor #2 (S #2) the paper and eMR of Resident #1. A review of the AR revealed Resident #1 with diagnoses that included but not limited to; cerebral infarction, hemiplegia and hemiparesis (hemiplegia and hemiparesis are neurological conditions that affect movement on one side of the body, with hemiplegia being a complete paralysis and hemiparesis representing partial weakness) following a cerebral infarction affecting right dominant side, aphasia, muscle weakness, need for assistance with personal care, and other abnormality of gait and mobility. A review of the cMDS, with an ARD of 9/11/25, revealed a BIMS score of 9 out of 15 indicating moderate cognitive impairment. A review of the PN dated 9/6/25, revealed that a CNA reported to RN #2 that during a transfer from the bed to wheelchair (w/c) by Hoyer lift, one of the hooks of the Hoyer lift slightly tapped left side of resident's forehead above eyebrow. RN #2 immediately assessed Resident #1, neuro checks were initiated, notified the Physician, Supervisor, and RR #2 (who was present during the transfer). RN #2 documented that there were no injuries and pain at that time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the CP with a created date of 9/4/25 and a revised date of 9/6/25, revealed a focus that Resident #1 had a limited physical mobility related history of CVA (cerebrovascular accident or stroke) with right hemiplegia. The interventions included but not limited to, allow RR to actively participate in the care of Resident #1 as they had at home, educate RR as needed, and transfer assist of two person by Hoyer lift. A review of the Physical Therapy (PT) evaluation (eval) dated 9/6/25, revealed an initial assessment that prior to the stroke on 6/20/25, Resident #1 lived their family and was independent in bed mobility, functional transfers and in ambulation with a wide base quad cane. Resident #1 was in another subacute rehabilitation (rehab) and had been non-ambulatory and totally dependent since the stroke. The current functional assessment indicated transfers total dependence Hoyer lift. A review of the Occupational Therapy (OT) eval dated 9/6/25, revealed initial assessment that upon discharge from acute care, due to resident being unsafe to return home, Resident #1 was referred to skilled rehab facility. The prior level and current functional level also revealed the same as PT eval had documented above. Further review of the eMR revealed that there was no documented evidence that RR #2 was educated on proper transfer and use of Hoyer lift device. On 10/23/25 at 12:07 PM, S #2 observed from the hallway, Resident #1 in their room lying in an air mattress bed. S #2 and CNA #3 entered the resident's room, and the resident was unable to respond to S #2's questions. CNA #3 stated that Resident #1 required total care, a transfer with a Hoyer, and always a two person assist. On 10/23/25 at 1:41 PM, S #2 interviewed CNA #4, who transferred Resident #1 on 9/6/25 from the bed to the w/c. CNA #4 stated that RR #2 was in Resident's #1 room and asked her to transfer resident from bed to w/c. She further stated that she told RR #2 she needed to get help to transfer, and RR #2 said they would help because they were scared no one would come to help. CNA #4 confirmed, That's the mistake I did, I should not have listened to RR #2. She also stated that she was unsure if RR #2 was previously educated on how to transfer Resident #1 with use of a Hoyer lift. At that same time, CNA #4 further explained the Hoyer pad swung from the back and the holder grazed the resident's forehead. CNA #4 stated she was educated and disciplined by management after the incident. On 10/23/25 at 3:00 PM, S #2 requested from the LNHA for any education provided to RR #2 regarding Hoyer transfer. On 10/23/25 at 4:00 PM, RR #2 confirmed via phone conference that they did not receive an education with regard to use of Hoyer lift transfer for Resident #1. On 10/23/25 at 4:15 PM, the surveyors met with the LNHA, DON, RDON, and ADON regarding the above concern for Hoyer transfer on 9/6/25, that the resident's CP was not followed for two person assist and that RR #2 assisted with no training. The LNHA confirmed that the RR #2 did not receive any formal training, and that RR #2 was always at the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Lifting Machine, Using a Portable Policy dated 10/2025, revealed, review the resident's CP to assess for any special needs of the resident.The portable lift can be used by one nursing assistant if the resident can participate in the lifting procedures. If not, two nursing assistants will be required to perform the procedure. NJAC 8:39-27.1(a); 33.1 (d)