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	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Post Acute Care of 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49078 Based on observation, interview, and review of facility-provided documents, it was determined that the facility failed to ensure that a.) meals were consistently provided in a dignified and homelike manner. The deficient practice was observed in the recreation dining area for 2 of 6 residents (Residents #103 & #147). The deficient practice was evidenced by the following: The surveyor reviewed the electronic medical records (EMR) for Resident #103 and Resident #147. Resident #103: The Admission Record (AR; an admission summary), revealed that the resident was admitted with diagnoses which included but are not limited to, type 2 diabetes and essential hypertension (also called primary hypertension, or idiopathic hypertension) is a form of hypertension without an identifiable physiologic cause). A comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 10/09/24, indicated the facility assessed the resident's cognition using a Brief Interview for Mental Status (BIMS) test, Resident #103 scored a 15 out of 15, which indicated the resident had no cognitive impairment. Resident #147: The AR revealed that the resident was admitted with diagnoses which included but are not limited to, essential hypertension and chronic kidney disease, a disorder where the kidneys do not function well. The MDS with an ARD of 12/3/24 of Resident #147 had a BIMS score of 15 out of 15, which indicated the resident had no cognitive impairment. On 1/7/25 at 12:33 PM, the surveyor observed the Dietary Staff (DS) deliver a food truck marked 3W #1 to the floor. On that same date at 12:43 PM, a second food truck marked 3W #2 brought to the floor. (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: 315438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:51 PM, the surveyor observed 1 of 2 residents, Resident #103, at a table in the recreation dining area of Unit 3W, receive a meal tray and begin to eat. The other resident at the table, Resident #147, did not receive a meal tray. The surveyor observed staff members removed trays from the food trucks and delivered 1 tray at a time to various residents located on the unit in their rooms or in the hallway. At 12:55 PM, the surveyor observed a 3rd food truck brought onto the floor by DS and left. At 12:59 PM the surveyor observed a staff member with an ID (identification) that reflected that they were a Certified Nursing Aide Student (CNAS) brought a tray to another resident at a different table and began to assist the resident to eat. Another staff member brought another tray to a second resident at the same table. The CNAS then helped that resident begin eating and was actively helping the resident to eat. The surveyor did not observe any hand hygiene for either residents or for the CNAS. The surveyor asked the CNAS if those 2 residents required help eating. The CNAS stated, yes, they are both feeders. The surveyor asked the CNAS if hand hygiene was performed for the residents. The CNAS did not have a clear answer for the surveyor. At 1:17 PM, the surveyor observed Resident #147, who was seated at the 1st table with Resident #103, got a meal tray. The surveyor observed the finished meal trays of several residents. The meal trays contained individually wrapped hand wipes/moist towelettes. The surveyor observed that at least three (3) of the packs of wipes were unopened and not used. On 1/8/25 at 12:59 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Assistant Administrator (AA) to discuss concerns with residents in the dining area not being served at the same time and hand hygiene. On 1/9/25 at 10:37 PM, the survey team met with the LNHA and DON for responses to the dining concerns. The LNHA stated that during the lunch meal pass, some residents that sit together may have trays in different trucks. The surveyor asked the LNHA if serving residents at same table 26 minutes apart would be considered dignified and home-like. The LNHA stated, no, but they will try to have all residents a table served at the same time. The LNHA stated that staff will be educated on hand hygiene for residents at mealtimes. A review of the facility's Food and Dining Service Policy, with a reviewed date of 10/2024 revealed: Policy Explanation and Procedures: Nursing staff will remind all residents of the meal. Nursing is responsible for those needing help. Individuals are assisted to prepare for the meal (hands washed, etc.). Individuals are offered (or assisted to use) a hand wipe or cloth to wipe their hands prior to leaving the dining room. Eating Environment: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Services personnel will help to seat and position residents and identify factors that might adversely affect food intake. All residents seated at a table will be served together, when feasible. On 1/10/25 at 11:26 AM, they survey team met with the DON, LNHA and AA. The facility did not provide any further pertinent information. NJAC 8:39-4.1(a),12,28;27.1(a);27.3(a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48781 COMPLAINT #NJ172916 Based on observation, interview, and record review, it was determined that the facility failed to maintain residents' environment in a safe, clean, comfortable, and homelike surrounding for 3 of 35 residents reviewed, Resident #2, #121 and #109. The deficient practice was evidenced by the following: 1. On 1/8/25 at 9:59 AM, the surveyor and the 3 [NAME] Unit Manager (UM) observed in room [ROOM NUMBER]-D Resident #2 sitting on the wheelchair (w/c), privacy curtain was missing, and a black, portable fan on top of the bedside table was on with a large amount of dust accumulation on the front grill. The surveyor and UM observed 411-W Resident #121 sitting on the w/c. The surveyor and the UM observed in the room [ROOM NUMBER] the broken shade by the window; the bottom part of the two overbed tables with splattered white substances; the bathroom soap dispenser broken off the wall and laying on the garbage can; the floors in the residents' room and bathroom with dark black stains. The UM completed a finger swipe test on the surface of the overbed lighting for dust on room [ROOM NUMBER]-D and found an accumulation of dust. The UM confirmed all the findings. At that time, the Housekeeping Director (HKD) entered the room and confirmed all the issues found. Resident #121 stated, They know about the blinds, and the curtains for months now, and Resident #2, stated, Curtains have been missing for months, they took it down to clean it but never put it back. The surveyor reviewed the medical records and revealed: Resident's #2's Annual Minimum Data Set (MDS), an assessment tool used to facilitate the plan of care, with an assessment reference date (ARD) of 11/20/24, revealed a Brief Interview of Mental Status (BIMS) score of 14 out of 15 indicated intact cognition. Resident #121's Quarterly MDS (QMDS), with an ARD of 12/20/24 revealed a BIMS score of 15 out of 15, indicated intact cognition. 2. On 1/8/25 at 10:06 AM, the surveyor in the presence of the HKD observed the wall near the doorway in the room [ROOM NUMBER] with large amount of brown substances splattered and also observed the broken window shades in the room. The HKD confirmed the findings and stated, The resident will throw coffee, drinks on the wall. The surveyor observed Resident #109 was inside the room. A review of the Resident #109's QMDS dated [DATE] revealed a BIMS score of 15 out of 15, indicated intact cognition. A review of the maintenance log for 3 [NAME] Unit from 5/2024 -12/25/24 revealed no work orders for the concerns above mentioned in rooms [ROOM NUMBERS]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 1:07 PM, the surveyor discussed the concerns above with the License Nursing Home Administrator (LNHA), Director of Nursing (DON) and the Assistant Administrator. On 1/9/25 at 10:39 AM, the LNHA and the DON responded to the survey team, We are in the process of doing deep cleaning in all the rooms. On 1/9/25 at 11:31 AM, the surveyor requested for the facility Maintenance/Work Order policy and the LNHA stated, What they do is they call maintenance right away for work orders, a lot of verbal things between staff, or they write it on the maintenance log binder, each unit has one, and maintenance people also work on weekends. They should be writing it on the binder and once maintenance knows they will fix it right away. We follow the good practice policy. Let me see if we have a policy for Maintenance and good practice policy. A review of the facility's Cleaning and Disinfection of Environmental Surfaces Policy and Procedure, revised 10/2024 revealed that the housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily three times per week) and when surfaces are visibly soiled. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. Horizontal surfaces will be wet dusted regularly (e.g., daily, three times per week) using clean cloths moistened with an registered hospital disinfectant (or detergent). A review of the facility Policy and Procedure Maintenance Reporting, reviewed 12/2024 revealed that the facility maintains systems to report and resolve all maintenance related concerns, to sustain a safe and comfortable environment If the item is deemed irreparable, Maintenance will tag the equipment, take it out of service, and will arrange to order new parts/equipment. NJAC 8:39-31.4(a)(c)(f), 31.8(c)5,7

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on interviews and record review, it was determined that the facility failed to transmit the completed Minimum Data Set (MDS), an assessment tool used to facilitate the management of care within fourteen days as required for 2 of 3 residents, Residents #110 and #155 reviewed for system selected for MDS over 120 days, and 1 of 38 residents, Resident #589, in accordance with federal guidelines. This deficient practice was evidenced by the following: 1. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #110 and revealed: 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, muscle weakness, essential (primary) hypertension (abnormally high blood pressure that is not the result of a medical condition), and adjustment disorder with depressed mood. The most recent Discharge Return Not Anticipated (DRNA) MDS revealed that the assessment was completed but not transmitted. 2. The surveyor reviewed the hybrid medical records of Resident #155 and revealed: The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, muscle weakness, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance mood disturbance and anxiety, and repeated falls. The most recent DRNA MDS revealed that the assessment was completed but not transmitted. On 1/8/25 at 8:33 AM, the surveyor interviewed the MDS/Lead Registered Nurse (MDS/LRN). The MDS/LRN informed the surveyor that the facility followed the RAI (Resident Assessment Instrument) Manual as their policy for doing MDS. The surveyor asked the MDS/LRN when the MDS should be completed and transmitted, and the MDS/LRN responded that she would get back to the surveyor because she did not want to give a wrong answer. The surveyor asked the MDS/LRN to review Residents #110 and #155's MDS and to let the surveyor know the concerns with both residents' MDS. The surveyor also notified the MDS/LRN that the surveyor had concerns with residents' MDS transmission. On 1/8/25 at 11:30 AM, the MDS/LRN stated that Resident #110's and Resident #155'2 DRNA MDS were completed but were not submitted (transmitted). On 1/8/25 at 12:59 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), and the Director of Nursing (DON). The surveyor notified of the above concerns for Residents#155 and #110's MDS that both MDS's were completed but were not submitted in accordance with federal regulations. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 11:45 AM, the survey team met with the LNHA, DON, AA, Infection Preventionist Nurse, Registered Dietitian, Rehab Director, Regional DON, Activity Director, MDS/LRN, and the Assistant Director of Nursing for an exit conference, the facility did not provide additional information. 46889 3. The surveyor reviewed the hybrid medical records of Resident #589 and revealed the following: The AR reflected that Resident #589 was admitted to the facility with diagnoses that included but were not limited to atrial fibrillation (irregular, rapid heart rate). The most recent Discharge Return Anticipated (DRA) MDS dated [DATE] revealed that the assessment was completed but not transmitted until 1/17/24. A review of the Final Validation Report given by the MDS/LRN on 1/8/25 at 11:52 AM revealed that Record Submitted Late: The submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment. On 1/8/25 at 10:49 AM, the surveyor interviewed the Regional MDS Coordinator, who said they reviewed the DRA MDS assessment and confirmed it was transmitted late. NJAC 8:39-11.1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 39885 Based on interview and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 4 of 38 residents, (Residents #38, #118, #176, and #188), reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: A review of the latest version of the MDS 3.0 Manual (updated October 2024), Chapter 1, page 1-5, revealed .An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT (Interdisciplinary Team) completing the assessment . Chapter 3, page A-42-43, revealed Item Rationale o This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. Coding Instructions o Code 04, Short-Term General Hospital (acute hospital/IPPS): if the resident was discharged to a hospital . 1. On 01/06/25 at 12:19 PM, the surveyor observed Resident #38, seated in a wheelchair in their room. The surveyor interviewed the resident regarding a facility acquired pressure ulcer. Resident #38 stated that they had a sore that was being treated and that they had gotten them in different places and the facility treated them and they healed. A review of Resident #38's Admission Record (AR; or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to hemiplegia (paralysis of one side of the body) hypertension (high blood pressure) and benign prostatic hyperplasia (age-associated prostate gland enlargement that can cause urination difficulty). A review of Resident #38's most recent significant change MDS (scMDS), indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which reflected that the resident's cognition was intact. A review of Resident #38's most recent Discharge Return Anticipated MDS, indicated that Resident #38 did not have any pressure/ulcer/injury (PU) when the resident left the facility. A review of Resident #38's most recent readmission MDS indicated that the resident had one unstageable PU covered by slough (the yellow or white viscous material composed of dead cells, fibrin, and pus that may accumulate on the surface of a wound) and/or eschar (is a dry, thick, black, or brown covering that forms over wounds as a result of tissue necrosis and desiccation) which was present upon admission/readmission and one unstageable pressure injury (PI) which was present upon admission/readmission. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #38's most recent scMDS indicated that the resident had one unstageable PU covered by slough and/or eschar which was not present upon admission/readmission and one unstageable pressure injury (PI) which was not present upon admission/readmission. A review of Resident #38's wound consultant progress notes (PN) indicated that the resident returned from the hospital with the wounds and that the wounds were not facility acquired. Further review reflected that the resident's PU/PI were resolved (healed). Further review of the medical records revealed that there was discrepancy on what was documented in the MDS and what was documented in the PN. On 01/08/25 at 11:35 AM, the surveyor interviewed the MDS/Lead Registered Nurse (MDS/LRN) regarding the process for coding the MDS related to PU/PI. The MDS/LRN stated that she would review the all the assessments and would code the MDS based on that information in the lookback period. The surveyor asked for information on Resident #38's MDS. On 01/08/25 at 12:52 PM, the MDS/LRN stated that Resident #38's most recent readmission MDS was correct and the resident had one right ankle unstageable PU and one right heel PI that were present on readmission. The MDS/LRN stated that Resident #38's most recent scMDS the resident had the right ankle unstageable PU present on admission and that the right heel changed from a PI to an unstageable PU. The MDS/LRN confirmed that the MDS was coded incorrectly. She then stated she would modify the MDS. On 01/08/25 at 01:41 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA) and Director of Nursing (DON) the concern that Resident #38's MDS was coded incorrectly. On 01/09/25 at 11:23 AM, the LNHA stated that the resident's MDS had been revised. The facility did not provide any additional information. 39399 2. On 1/6/25 at 12:03 PM, the surveyor observed Resident #118 in bed, with eyes closed. The surveyor further observed the resident using an air mattress (a specialized mattress that is used to prevent or treat pressure injuries). The surveyor reviewed Resident #118's medical records and revealed: The AR reflected that Resident #118 was admitted to the facility with medical diagnoses which included but not limited to, Alzheimer's Disease, type 2 diabetes Mellitus, and acute kidney failure. A review of the quarterly MDS (qMDS), with an assessment reference date (ARD) of 12/13/24, had a BIMS score of 7 out of 15 indicating that the resident had severely impaired cognition. The qMDS under Section GG0120 for Mobility Devices revealed that resident used a walker for mobility. The Resident Interdisciplinary Screen dated 12/10/24 for Resident #118 revealed under Mobility, Ambulation Distance/Device and Assistance - non ambulatory. (continued on next page)

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F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 1/8/25 at 11:37 AM, the surveyor interviewed the Licensed Practical Nurse taking care of the resident who confirmed that Resident #118 does not ambulate.

On 1/8/25 at 12:54 PM, the surveyor interviewed the MDS/LRN who stated the qMDS was coded in error. The MDS/LRN also confirmed Resident #118 does not ambulate and does not use a walker.

On 1/8/25 at 1:20 PM, the survey team met with the LNHA, AA, and DON to discuss the above concern. No further information was provided.

38327

3. The surveyor reviewed the medical records of Resident #176 and revealed:

The AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to, unspecified displaced fracture (break in bone) of the first cervical vertebra (first vertebra (C1), also called the atlas, is a ring-shaped bone that begins at the base of skull), subsequent encounter for fracture with routine healing, metabolic encephalopathy (change in how brain works due to an underlying condition and can cause confusion, memory loss and loss of consciousness), and benign neoplasm of unspecified kidney (a non-cancerous tumor of the kidney is a growth that does not spread (metastasize) to other parts of the body).

The most recent (modified) comprehensive MDS (cMDS), with an ARD of 12/8/24 revealed in Section C Cognitive Patterns, BIMS score of 10 of 15 which reflected that the resident was cognition was moderately impaired. Section Q Participation in Assessment and Goal Setting included that the resident responded in the interview with regard to the discharge plan. Section V Care Assessment (CAA) Summary #2 for Cognitive Loss revealed that the resident had a diagnosis of Alzheimer's. Section V CAA Summary #4 for Communication revealed that the resident's communication status was impaired, the resident's ability to make self-understood and to understand others when spoken to was very limited and may be related to cognitive deficit, and all the resident's needs were anticipated by staff.

Further review of the above cMDS revealed that there was a discrepancy in how the resident was able to answer Section Q and Section V CAA summaries.

On 1/8/25 at 8:33 AM, the surveyor interviewed the MDS/LRN. The MDS/LRN informed the surveyor that the facility followed the RAI (Resident Assessment Instrument) Manual as their policy for doing MDS. The surveyor notified the MDS/LRN of the above concerns and findings regarding Resident #176's cMDS, and the MDS/LRN responded that she would get back to the surveyor.

On 1/8/25 at 11:01 AM, the surveyor notified the DON of the concerns regarding the resident's MDS.

On 1/8/25 at 11:30 AM, the MDS/LRN stated that Resident #176's MDS with an ARD of 12/8/24 Section Q was miscoded. She further stated that there were many PN that showed that the resident's responsible party (RP) was interviewed for the discharge plan, and that Section Q should have been coded for RP and not the resident. The MDS/LRN also stated that Section B for communication was also miscoded.

On 1/8/25 at 12:59 PM, the survey team met with the LNHA, AA, and the DON. The surveyor notified the LNHA, DON, and AA of the above findings and concerns for Resident #176.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 10:37 AM, the survey team met with the LNHA and the DON. The LNHA stated that the MDS staff had been educated with regard to MDS accuracy. On 1/10/25 at 11:45 AM, the survey team met with the LNHA, DON, AA, Infection Preventionist Nurse, Registered Dietician, Rehab Director, Regional DON, Activity Director, MDS/LRN, and Assistant Director of Nursing for an exit conference and there was no additional information provided. 46889 4. The surveyor reviewed the medical records of Resident #188 and revealed the following: The AR revealed that Resident #188 was admitted to the facility with diagnoses that included but were not limited to encounter for surgical aftercare following surgery on the digestive (group of organs that break down food into nutrients). A review of the most recent discharge MDS, with an ARD (the last day of the observation period) of 10/12/24 indicated in Section A Type of Discharge 2. Unplanned. discharged Status 01. Home/Community (e.g., private home/apartment .) A review of the PN dated 10/12/24 revealed that the RP brought the resident to the hospital because they felt sick. On 1/8/25 at 10:49 AM, the surveyor interviewed the Regional MDS/Registered Nurse (RMDS/RN). The RMDS/RN informed the surveyor that Resident #188 was brought to the hospital by a family member and added that the discharge MDS was miscoded. On 1/8/25 at 01:22 PM, the survey team met with the LNHA, AA and DON regarding the above concern and the facility did not provide further information. NJAC 8:3-11.1, 11.2(e)(1), 33.2 (d) 46049

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 39399 Based on observation, interview, and record review, it was determined that the facility failed to revise the comprehensive care plans (CP) for 1 of 35 residents reviewed (Resident #118). This deficient practice was identified by the following: On 1/6/25 at 12:03 PM, the surveyor observed Resident #118 in bed, with eyes closed. The surveyor further observed the resident using an air mattress (a specialized mattress that is used to prevent or treat pressure injuries). The surveyor reviewed Resident #118's hybrid (computer and paper chart) medical records. The Admission Record reflected that Resident #118 was admitted to the facility with medical diagnoses which included but not limited to, Alzheimer's Disease, Type 2 Diabetes Mellitus, Acute Kidney Failure. A review of the Quarterly Assessment Minimum Data Set, an assessment tool used to facilitate the management of care, dated 12/13/24 reflected that the resident had a Brief Interview for Mental Status score of 7 out of 15 indicating that the resident had severely impaired cognition. A review of the January 2025 Order Summary Report revealed a physician's order dated 3/20/24 for DNR (Do not resuscitate) (does not want to be resuscitated if they suddenly go into cardiac arrest or stop breathing). The surveyor reviewed Resident #118's list of comprehensive CP's which included a CP titled, [Name Redacted] is an elopement risk/wanderer r/t (related to) impaired safety awareness, at times wanders aimlessly with a date initiated on 7/19/23 and was revised on 2/1/24. The CP interventions included but were not limited to, wander alert- wander guard (a device bracelet worn by elderly people with Dementia to prevent from wandering) to right wrist. Another CP titled, [Name redacted] is full code (if a person's heart stops beating or stop breathing, they want resuscitation and all life saving measures). A review of the form titled, Resident Interdisciplinary Screen dated 12/10/24 for Resident #118 revealed under Mobility, Ambulation Distance/Device and Assistance - non ambulatory. On 1/8/25 at 11:37 AM, the surveyor interviewed the Licensed Practical Nurse taking care of the resident who confirmed that Resident #118 does not ambulate and does not have a wander guard to the right wrist. On 1/8/25 at 1:20 PM, the survey team met with the facility's Licensed Nursing Home Administrator (LNHA), Assistant LNHA, and Director of Nursing (DON) to discuss the above concern. On 1/9/25 at 10:40 AM, the DON met with the survey team and stated that the CP for Resident #118 was not updated to reflect the current plan of care they are providing the resident. The DON further stated the resident does not have a wander guard and was not at a high risk for elopement. The DON also confirmed that Resident #118 was a DNR. No further information was provided. (continued on next page)

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Atrium Post Acute Care of Park Ridge	120 Noyes Drive Park Ridge, NJ 07656

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Care Plans-Comprehensive under #9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: . NJAC 8:39-11.2(i)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 38327 Based on the interview, record review, and review of pertinent documents it was determined that the facility failed to ensure residents who were discharged to the community had a discharge order, discharge summary, and care plan. This deficient practice was identified for 2 of 5 residents, Residents #110 and #176, reviewed. This deficient practice was evidenced by the following: 1. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #110 and revealed: 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, muscle weakness, essential (primary) hypertension (abnormally high blood pressure that's not the result of a medical condition), and adjustment disorder with depressed mood. A review of the most recent Discharge Return Not Anticipated (DRNA) Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, of Resident #110 revealed in Section A Identification Information that the discharge (d/c) status was coded #1, to the community. Further review of the hybrid medical records revealed that there was no physician order (PO) for d/c, no d/c summary from the physician, and no d/c care plan (CP) was initiated for Resident #110. 2. The surveyor reviewed the hybrid medical records of Resident #176 and revealed: The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, unspecified displaced fracture (break in bone) of the first cervical vertebra (first vertebra (C1), also called the atlas, is a ring-shaped bone that begins at the base of skull), subsequent encounter for fracture with routine healing, metabolic encephalopathy (change in how brain works due to an underlying condition and can cause confusion, memory loss and loss of consciousness), and benign neoplasm of unspecified kidney (a non-cancerous tumor of the kidney is a growth that does not spread (metastasize) to other parts of the body). A review of the most recent DRNA MDS of Resident #176 revealed in Section A that the d/c status was coded #1, to the community. Further review of the hybrid medical records revealed that there was no PO for d/c, no d/c summary from the physician, and no d/c CP was initiated for Resident #176. On 1/07/25 at 11:47 AM, the surveyor asked the Director of Nursing (DON) to review the provided closed record documents by the Assistant Administrator (AA). The surveyor asked the DON if a resident should have a d/c order, a d/c summary from the physician, and a d/c care plan. The DON stated that there should be a d/c order and summary from the physician and all residents should have a d/c care plan. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that same time, after reviewing Resident #176's medical records, the DON stated that there was no d/c order, and the d/c summary of the physician was incomplete. The DON acknowledged that the d/c summary was only dated and signed by the physician but did not include any information about the resident's stay in the facility and status. On 1/8/25 at 12:59 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), AA, and the DON. The surveyor notified the LNHA, DON, and AA of the above findings and concerns regarding Residents #110 and #176's no d/c summaries and d/c orders from the physicians, and no d/c CP. On 1/9/25 at 10:37 AM, the survey team met with the LNHA and the DON. The LNHA stated that the facility will be doing QA (Quality Assurance) about d/c summaries of the physicians and that the LNHA will be working with the Medical Director to enforce it. A review of the facility's Transfer and D/c Policy with a reviewed date of 10/2024 that was provided by the LNHA revealed: Policy Explanation and Procedures: 2. Resident-initiated transfer or d/c . a. The comprehensive, person-centered CP shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the d/c . 9. Anticipated Transfer or D/C-initiated by the resident a. Obtain PO for transfer or d/c and instructions or precautions for ongoing care. b. A member of the interdisciplinary team completes relevant sections of the D/C Summary. The nurse caring for the resident at the time of d/c is responsible for ensuring the D/C Summary is complete . On 1/10/24 at 11:45 AM, the survey team met with the LNHA, DON, AA, Infection Preventionist Nurse, Registered Dietician, Rehab Director, Regional DON, Activity Director, MDS/Lead Registered Nurse, and Assistant Director of Nursing for an exit conference and there was no additional information provided. NJAC 8:39-36.1(b)(c)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37175 REPEAT DEFICIENCY Based on observation, interview, review of medical record, and other pertinent documentation, it was determined that the facility failed to ensure skin conditions were addressed by professional standards by failing to: a.) document a surgical wound on the admission assessment, obtain a physician order to assess, document and monitor the surgical site, develop a care plan which addressed the surgical site and ensure surgical follow up for the removal of the staples for 1 of 5 residents, Resident #119, reviewed for skin impairment and b.) failed to set the air mattress (AM) (a specialized mattress that is used to prevent or treat pressure injuries) to reflect the weight of Resident #118 to ensure proper support and comfort. This deficient practice was evidenced by the following: 1. On 1/7/25 at 10:00 AM, the surveyor observed Resident #119 lying in a low bed against the wall in their private room. According to the Admission Record (AR; or face sheet, an admission summary), Resident #119 was admitted to the facility with diagnoses that included but were not limited to syncope (dizziness) and collapse, osteoarthritis, and chronic kidney disease (progressive damage and loss of function of the kidneys). According to the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 12/19/24, the resident had a brief interview for mental status (BIMS) score of 1 out of 15, which indicated that the resident's cognition was severely impaired. The MDS included that the resident had surgical wounds. According to the facility's Nursing Admission-Readmission Screening, skin evaluation, dated 12/12/24, revealed the resident had a current skin breakdown or skin condition. The site that was identified was on the sacrum. There was no documentation that the resident had surgical wounds. According to the facility's Skin Assessment/Observation, dated 12/13/24, under known skin impairments, the resident had a colostomy (a surgical procedure that create an opening in the abdomen) to the right lower quadrant of the abdomen with colostomy care to be given every shift and as needed. The area had no signs or symptoms of infection, and the stoma and stool were to be assessed every shift. The abdomen had a JP ([NAME]-pratt; a medical device that removes excess fluids and air from a surgical site after surgery) drain to the left lower quadrant of the abdomen and was monitored for signs and symptoms of infection every shift. There was a left knee scab, which no treatment was needed at the time. Sacral redness was identified, and a treatment was to apply a skin barrier every shift and as needed for skin protection. Further review revealed that under the question Are there any other skin problems that are currently not being addressed/monitored? the area checked was no. The Progress Notes (PN) dated 12/12/24, included that the resident had a colostomy in the right lower quadrant of the abdomen and a JP drain in the left lower quadrant of the abdomen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the PN labeled history and physical completed by the resident's physician dated 12/12/24 at 11:53 PM included that the resident was admitted to the facility with sepsis secondary to infected iliopsoas hematoma/abscess (soas (or iliopsoas) abscess is a collection of pus in the iliopsoas muscle compartment) and that the resident was status post exploratory laparoscopic surgery and drainage of the abscess on 12/24/24. A review of a PN dated 12/13/24 7:23 PM, late entry with a created date of 12/25/24 by the Unit Manager/Licensed Practical Nurse (UM/LPN) indicating that there were 15 staples to the abdomen and that there was a follow-up with the orthopedic physician on 12/27/24. A review of a PN dated 12/19/24 at 3:57 PM, indicated that the nurse followed up with the resident's physician regarding having bowel movements from the rectum. The physician verbalized that he spoke to the surgeon and stated that the surgeon said that this was to be expected. There was no documentation that the physician talked to the surgeon about the staples on the abdomen. Further review of the medical records revealed that there were no orders that addressed the 15 staples on the resident's abdomen that would include assessment, follow-up, and the removal of the staples. The staff did not consistently address or assess the staples and that there were no indications as to when to remove them or how to care for the surgical site. A review of the resident's personalized Care Plan (CP) included a focus area indicating an actual skin impairment to the skin integrity of the sacrum. There was no CP that addressed the resident's surgical site and the 15 staples. On 1/8/25 at 9:38 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN), who stated that she was aware of the staples on the resident's abdomen and that the Resident's Representative (RR) was to transport the resident to the surgeon's office for a follow-up appointment. The UM/LPN further stated that the RR was unable to take them to the appointment. The UM/LPN was unable to explain why there was no further follow-up or documentation of the event. On 1/8/25 at 9:40 AM, the surveyor interviewed the resident's primary Licensed Practical Nurse #1 (LPN#1), who stated that she was the admission nurse, and that the resident when admitted at the facility, the surgical area was covered at that time. LPN#1 further stated that the physician was aware of the staples on the abdomen. LPN#1 was unable to explain why there was no documentation in the admission notes or assessment about the surgical area with 15 staples. On 1/8/25 at 9:42 AM, the surveyor interviewed the Unit Clerk (UC), who stated that the resident was to be transported by the RR on 12/27/24 for a surgical follow-up, however, the RR stated that it was too far to transport the resident. The UC did not provide further information as to why the resident was not seen for a follow-up appointment. On 1/8/25 at 9:45 AM, the surveyor interviewed the UM/LPN, who stated that there should have been documentation for the surgical site and follow-up and that the staples do not usually stay in for that long. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 10:05 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the staff should have called the physician to inform him of the staples and the follow-up that was needed. She further stated that the nurses should have called the specialist's office for further instructions and requested the hospital records and the staff should have had documentation. On 1/8/25 at 1:11 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON. The surveyor notified the LNHA and the DON of the above findings and concerns. On 1/8/25 at 2:10 PM, the surveyor interviewed the resident's physician, who stated that the resident had had laparoscopic surgery and that he spoke to the staff at the hospital and said that he was unable to find out the exact date of the surgery and was unable to determine how long the staples were intact. He further stated that the resident took a while to heal and that he was aware of the staples, which were left intact because the resident had had radiation treatment. The physician further acknowledged that there was no documentation of the abdominal staples on the history and physical or physician's PN. A review of a nurses PN dated 1/8/25 at 5:10 PM, revealed that the Physician removed the 15 staples from the resident's abdomen. Further review of the medical records revealed that there was no documented evidence that the resident's 15 staples were identified, assessed, care planned, and obtained an order for care until the surveyor's inquiry. On 1/9/25 at 10:38 AM, the surveyor met with the LNHA and the DON, and the LNHA stated that she acknowledged that the staples were not addressed or monitored consistently and that the staples should have been addressed and monitored because doing so would ensure that the staff would not lose sight of the staples. A review of a facility's Nursing Skin Assessment Policy, effective 10/18 with a review date of 10/24, included that a resident received a full body assessment upon admission, daily for three days, and weekly thereafter. The nurse should document the skin assessment and other information as indicated or appropriate. A review of the facility's Care Plans - Comprehensive Policy, dated 2001, with a revised date of October 2010, revealed that the facility should develop a comprehensive CP that identifies the highest level of functioning the resident may be expected to attain. CP is based on a thorough assessment that includes but is not limited to the MDS. The CP are designed to identify problem areas, incorporate risk factors identified with the problem, reflect treatment goals, timetable, and objectives in measurable outcomes, and reflect currently recognized standards of practice for problem areas and conditions. 39399 2. On 1/6/25 at 12:03 PM, the surveyor observed Resident #118 in bed, with eyes closed. The surveyor further observed the resident using an air mattress which showed the AM setting at 450 lbs. (pounds) patient weight. The surveyor reviewed Resident #118's medical records (MR) and revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The AR reflected that Resident #118 was admitted to the facility with medical diagnoses which included but not limited to, Alzheimer's Disease, type 2 diabetes mellitus, acute kidney failure. Further review of the resident's MR indicated that the resident's most recent weight was 92 lbs. A review of the Quarterly MDS, with an ARD of 12/13/24 reflected that the resident had a BIMS score of 7 out of 15 indicating that the resident had severely impaired cognition. On 1/6/25 at 12:05 PM, the surveyor interviewed LPN#2 who was assigned to Resident #118 inside the resident's room. The surveyor showed the AM setting to LPN#2 who stated that the nurses do not check the AM settings. LPN#2 also stated that the Certified Nursing Assistant's would call the nurses' attention if the air mattress would beep or alarm. LPN#2 in the presence of the surveyor acknowledged that Resident #118 did not weight 450 lbs. and changed the setting of the AM to 100 lbs. On 1/8/25 at 1:20 PM, the surveyor met with the LNHA, AA and DON to discuss the above concern. On 1/9/25 at 10:39 AM, the DON stated to the surveyor that the facility does not have a specific policy on how and when to check the AM. The DON also stated that the AM was delivered on 9/12/24. The DON further acknowledged that the AM must be set according to the resident's weight as indicated. The facility could not provide any accountability of when to check the air mattress. NJAC 8:39-11.2(i); 27.1

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39885 Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to ensure that a new intervention was implemented and documented in the resident's care plan after a resident's fall, in order to prevent any additional falls for 1 of 3 residents reviewed for falls (Resident #26). This deficient practice was evidenced by the following: On 1/6/25 at 11:57 AM, the surveyor observed Resident #26 seated in a wheelchair (w/c) in the resident's room. The surveyor observed that Resident #26's bed had one side against the wall and was in the low position. The surveyor did not observe a floor mat in the room. A review of Resident #26's 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 hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebrovascular disease (a general term for a group of conditions that affect the blood vessels in the brain and spinal cord), hypertension (high blood pressure) and vascular dementia (a common form of dementia caused by an impaired supply of blood to the brain, such as may be caused by a series of small strokes). A review of Resident #26's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which reflected that the resident's cognition was severely impaired. Further review of the MDS indicated that under Section J-Health Conditions, the resident had a fall with no injury since admission/entry or reentry or the prior assessment. A review of the Resident #26's Progress Notes (PN) included the following notes: 10/26/2024 at 4:00 PM, Nursing Note Text: Heard a cried for help. Proceeded to resident room observed resident sitting on floor next to the w/c. Resident stated that they slides off w/c. Vital signs checked and as follows: BP (blood pressure) 116/ 70, RR (respiration rate) 18, Pulse 76, T (temperature) 97.7, Denied pain or discomfort. Assisted resident to bed. Encouraged resident to use call light for assistance. Resident's Representative (RR) made aware. MD (medical doctor) made aware awaiting call back. 8/13/2024 4:08 PM, PN included: Situation: Resident had a fall on Sunday evening. S/P (status post) fall, pain in left hip. Xray obtained today 8/13/24. Background: Resident had a fall on Sunday evening. Complained of pain Monday afternoon in left hip area. Tylenol (pain medication) given and order for Xray. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment (Registered Nurse [RN])/Appearance (Licensed Practical Nurse [LPN]): Resident unable to range Left Leg, difficulty straightening leg. Remained in bed. Vitals obtained BP 126/74, P 66, T 98 RR 18. Pain 7/10, Tylenol given with effect. Recommendations: Nurse contacted MD after Xray result showing acute slightly impacted comminuted intertrochanteric fracture. Order to send to ER (emergency room). RR aware. 8/12/2024 12:12 AM Nursing Note Text: CNA (Certified Nursing Aide) notified this writer that the resident is found on the floor in the resident's restroom. Resident tried to get up from the w/c to the toilet but lost strength in their legs and went down to the floor. Resident's vital signs taken and assessed for pain and range of motion. Incident endorsed to the next shift nurse to notify the MD and RR in the morning. On 1/7/25 at 11:00 AM, another surveyor requested from the Licensed Nursing Home Administrator (LNHA) the files of any incidents or investigations that Resident #26 had in the last 6 months. A review of Resident #26's individualized care plan (CP) included a focus area of at risk for falls r/t (related to) poor balance due to L (left) hemiplegia and use of psychotropic medication. also transfers self in and out of bed and toilet without calling for assistance. Hx (history) of falls. Intervention included but were not limited to the following: Anticipate and meet needs. Date Initiated: 12/27/2018 Be sure the call light is within reach and encourage to use it for assistance as needed. Date Initiated: 5/27/2016 CUSTOM Fall Risk Intervention- Encourage to use the call bell and/or ask for assistance when needs to be toileted. Date Initiated: 11/14/2018 Educate resident to used the side of her w/c pouch to place personal items. Date Initiated: 04/04/2022 Nursing will check on resident periodically during shifts. Date Initiated: 4/6/2022 The following intervention was initiated after Resident #26's fall in August 2024: Frequent rounding and offer assistance to the toilet when awake. Date Initiated: 8/12/2024 Further review of the CP, did not have a new intervention initiated after Resident #26's October 2024 fall. On 1/7/25 at 12:34 PM, the surveyor reviewed the one facility provided incident for Resident #26 which was a fall in August 2024 with an injury. The facility did not provide an incident report and investigation for Resident #26's fall that occurred in October 2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 12:45 PM, the surveyor asked the LNHA if the incident that was provided was the only incident Resident #26 had in the past 6 months. The LNHA stated that she gave the incidents. The surveyors checked if there was another incident provided and notified the LNHA that there was only the 1 incident provided. The LNHA stated that she would check on the other incident. On 1/8/25 at 9:07 AM, the surveyor reviewed the additional facility provided incident which was an unwitnessed fall dated 10/26/24 which indicated the resident slid off w/c and team agreed to check on resident periodically each shift and respect resident's desire to remain as independent as possible. On 1/8/25 at 9:11 AM, the surveyor requested that the Director of Nursing (DON) provide a printed copy of Resident #26's CP. On 1/8/25 at 9:43 AM, the surveyor interviewed Resident #26's LPN regarding the process after a fall. The LPN stated that the resident would be evaluated and then a PN and incident report would be made. The LPN stated that the cause of fall would be investigated and a new intervention would be put in place to try to prevent another fall. A review of the facility provided printed copy of Resident #26's CP included the intervention of Nursing will check on resident periodically during shifts which had an initiated date of 4/6/22 and a revision and resolved date of 1/07/25. The same intervention that was resolved was then listed again with an initiated date of 10/27/24 and a revision date of 1/7/25. The intervention was not a new and different intervention after the October 2024 fall and was placed on the CP with a new imitated date after surveyor inquiry. On 1/8/25 at 10:50 AM, the surveyor interviewed the DON regarding the process when a resident had a fall. The DON stated that the nurse after assessment of the resident would fill out an incident report. The DON stated that the team would do an investigation of the cause of the fall and implement a new intervention that would be placed on the CP. The surveyor asked the DON for clarification of the revised intervention that was created after surveyor inquiry. The DON stated that she did not know who revised the CP. The surveyor asked if there was a new intervention placed after Resident #26's fall in October. The DON stated that she would have to check. On 1/8/25 at 1:40 PM, the surveyor notified the LNHA, Assistant Administrator (AA) and DON, the concern that Resident #26 did not have a new intervention implemented and documented on the CP prior to surveyor inquiry. On 1/9/25 at 11:22 AM, in the presence of the survey team, AA and DON, the LNHA stated that the new intervention was missed being entered into the CP and that it was entered into the CP after the surveyor inquiry. The facility did not provide any additional information. A review of the facility's Falls and Fall Risk, Managing Policy, with a revised date of December 2007, included the following: Policy Statement (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Prioritizing Approaches to Managing Falls and Fall Risk. 4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . N.J.A.C. 8:39-27.1 (a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 39885 Based on observations, interviews, record review, and review of pertinent facility documents, the facility failed to: a.) obtain an order and develop a care plan that included interventions for a resident that had an indwelling catheter and was placed on enhanced barrier precautions (EBP) based on current professional standards of practice for 2 of 5 residents reviewed for urinary catheter care or urinary tract infection (UTI), Residents #40 and #115 and b.) ensure an indwelling urinary catheter drainage bag and tubing did not touch the floor for 1 of 5 residents, Resident #289, reviewed for urinary catheter. This deficient practice was evidenced by the following: 1. On 1/6/25 at 12:03 PM, the surveyor observed Resident #40 seated in a wheelchair in the resident's room, had a urinary catheter that was in a blue privacy bag. The surveyor observed that there was a sign outside Resident #40's room that indicated the resident was on EBP. A review of Resident #40's Admission Record (AR; or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to dementia (group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), neuromuscular dysfunction of bladder (a condition that occurs when the nerves and muscles of the urinary system are damaged, resulting in bladder control issues) and benign prostatic hyperplasia (age-associated prostate gland enlargement that can cause urination difficulty). A review of Resident #40's quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which reflected that the resident's cognition was intact. Further review indicated under section H for bladder and bowel, that the resident had an indwelling catheter and that urinary continence (the ability to control movements of the bladder) was not rated (resident had a catheter). A review of Resident #40's Order Summary Report (OSR) included the following orders: 18 FR catheter placed for neuromuscular dysfunction of bladder. Foley catheter output every shift. Foley catheter care every shift. Further review of Resident #40's OSR did not include an order for EBP. A review of Resident #40's individualized care plan (CP) did not include a focused area and interventions related to EBP. On 1/9/25 at 10:15 AM, the surveyor asked the Director of Nursing (DON) if a resident was placed on EBP if the expectation was to have an order and a CP for EBP. The DON stated that there should be an order and a CP. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 12:49 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA) and DON, the concern that Resident #40 did not have an order and a CP for EBP. On 1/10/25 at 11:23 AM, in the presence of the survey team, LNHA and AA, the DON stated that Resident #40 had the EBP signage on the wall and that an order and CP were put in place after surveyor's inquiry. A review of the facility's Care Plans-Comprehensive Policy, with a revised date of October 2010, included the following: Policy Statement An individualized comprehensive CP that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, their family or representative (sponsor), develops and maintains a comprehensive CP for each resident that identifies the highest level of functioning the resident may be expected to attain 2. The comprehensive CP is based on a thorough assessment that includes, but is not limited to, the MDS. 3. Each resident's comprehensive CP is designed to: i. Reflect currently recognized standards of practice for problem areas and conditions. A review of the facility's Novel and Targeted Mutli-Drug Resistant Organisms (MDROs): Transmission-Based Precautions Policy, with a revised date of 12/16/24, included the following: EBP are infection control interventions designed to reduce transmission of MDROs in nursing homes. It involves gown and glove use during high-contact resident care activities for residents with known colonization or infection with a MDRO, as well as those at increased risk of MDRO acquisition. If splashes and sprays are anticipated during the high-contact care activity, eye and/or face protection should be used in addition to the gown and gloves Procedure: 1. EBP are indicated for a resident with any of the following: a. Infection and colonization with an MDRO when Contact Precautions do not otherwise apply. b. Wounds and/or indwelling medical devices (indwelling urinary catheters, .etc.) regardless of MDRO status. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. EBP require the use of gown and glove use during high-contact resident care activities for the indicated resident. 39399 2. On 1/7/25 at 10:06 AM, the surveyor observed Resident #115 in bed with eyes closed. The surveyor interviewed the facility's Assistant Director of Nursing (ADON) who stated the resident was on an EBP due to the use of indwelling catheter (closed sterile system that drains urine from the bladder through the urethra or abdominal wall). On 1/7/25 at 12:06 PM, the surveyor reviewed Resident #115 's hybrid medical record and revealed: A review of the qMDS, reflected that the resident had a BIMS score of 7 out of 15 indicating that the resident had severely impaired cognition. Further review of the qMDS revealed Resident #115 had an indwelling catheter. A review of the January 2025 OSR, revealed a physician's order (PO) dated 11/1/24 to document indwelling catheter output every shift. The surveyor reviewed the CP for Resident #115 which did reflect the current plan of care for the use of indwelling catheter. On 1/8/25 at 1:20 PM, the survey team met with the LNHA, Assistant Administrator (AA), and DON to discuss the above concern. On 1/9/25 at 10:40 AM, the DON met with the survey team who stated the CP did not reflect the current plan of care for the resident who had an indwelling catheter. No further information was provided 37791 3. On 1/6/25 at 12:00 PM, the surveyor observed Resident #289 sitting in bed with a urinary catheter drainage bag that was observed touching the floor. On 1/06/25 at 12:10 PM, the surveyor interviewed a licensed Practical Nurse (LPN) who acknowledge that the resident's catheter bag which was in a privacy bag was touching the floor. The LPN acknowledge that the bag should have been affixed to the resident's bed and should not have been touching the floor. A review of Resident #289's medical record revealed the following: The AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to metabolic encephalopathy (a brain dysfunction that occurs when there's an imbalance of chemicals in the blood, usually due to an underlying medical condition), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), retention of urine (difficulty urinating and completely emptying the bladder) and cardiomyopathy (an acquired or hereditary disease of heart muscle, this condition makes it hard for the heart to deliver blood to the body, and can lead to heart failure). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission MDS), reflected that Resident #289 had a BIMS score of 5 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS included the resident had an indwelling catheter. On 1/8/25 at 1:00 PM, the surveyor discussed the above concerns with the LNHA and the DON. No further information was provided. NJAC 8:39 - 27.1(a)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to a.) identify, assess, and implement interventions for a resident (Resident #35) with an unplanned significant weight loss of 7 pounds (lbs) or 5.1% in one month and 25.2 lbs or 25. 71% significant weight loss in six months from 4/12/24 through 10/7/24, b.) identify, assess, and implement interventions for a resident (Resident #92) with a significant weight loss of 14 lbs. or 10.03% in one month for 48 days; c.) identify, assess, and implement interventions for a resident (Resident #3) with a significant weight loss of 18 lbs. or 13.4% in one month; d.) obtain, record, and monitor weights in accordance with physician's orders; e.) obtain re-weights to verify a significant weight change; and f.) monitor the effectiveness of interventions for a resident with a significant weight loss. The deficient practice was identified in 3 of 7 residents (Residents #3, #35, and #92) reviewed for nutrition. This deficient practice was evidenced by the following: 1. On 1/6/25 at 12:06 PM, the surveyor observed Resident #35 lying in bed, who was alert and verbally responsive to the surveyor's greeting. The resident stated, I'm hungry. The surveyor observed the lunch meal trays had just arrived on the unit, and Resident #35 received their lunch tray which was set up by the nursing staff. On 1/7/25 at 11:13 AM, the surveyor observed Resident #35 lying in bed with an opened health shake (a nutrition supplemental drink) that was within the resident's reach. Resident #35 stated to the surveyor I'm hungry. At that time, the Hospitality Aide entered the room, spoke with the resident, and went to get assistance for the resident. On 1/8/25 at 9:30 AM, the surveyor reviewed the electronic medical records (EMR) of Resident #35. A review of the Admission Record (AR; an admission summary) reflected the resident was admitted to the facility with diagnoses that included but were not limited to; osteoporosis (a condition in which bones become weak and brittle), hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), unspecified psychosis (group of symptoms that affect a person's mind and cause them to lose touch with reality), fracture of the humerus (long bone of the upper arm) and compression fracture of the thoracic vertebrae (a bone in the spine breaks and collapses). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 10/4/24, reflected a Brief Interview Mental Status (BIMS) score of 6 out of 15, which indicated the resident had severe cognitive impairment. A review of Section K (Swallowing/Nutritional Status) revealed the resident was 73 lbs. and was coded for having a weight loss of 5% or more in the last month or loss of 10% or more in the last six months and was not on a physician prescribed weight loss regimen. A review of Resident #35's weights revealed: 4/12/24: 98.0 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	5/3/24: 93.0 lbs. (7 lbs loss or a 5.1% significant weight loss in one month) 6/25/24: 96.0 lbs. 10/7/24: 72.8 lbs. (25.2 lbs loss or a 25.71% significant weight loss six months) 10/15/24: 73.0 lbs. 10/29/24: 73.0 lbs. 12/9/24: 66.2 Lbs. 12/19/24: 73.2 lbs. 12/23/24: 71.2 lbs. 12/30/24: 71.2 lbs. There were no documented weights for Resident #35 for July 2024, August 2024, September 2024, and November 2024, and there were no corresponding notes or orders in the medical record as to why the resident's weights were not obtained. The resident had a significant weight loss of 23.2 lbs or 24.7% in three months (6/25/24 to 10/7/24) with no documentation of the resident's weight loss until it reached 23.2 lbs. A review of Progress Notes (PN) revealed: A Nutrition/Dietary Note dated 5/24/24, written by the Registered Dietician (RD #1), documented the resident was noted with weight loss and had edema (swelling caused by fluid buildup in the body's tissues) upon admission. RD #1 indicated that the resident was on a diuretic medication (helps increase urine production, helping the body get rid of excess fluid and salt) and weight loss may be expected. An Interdisciplinary Care Plan (IDCP) Note dated 7/9/24, written by RD #1, documented a quarterly nutrition assessment that cultural foods were provided. The resident's weight was stable since admission, and the resident's intake was 75-100%. The RD indicated to continue the current diet for the resident and to monitor nutritional intake. An IDCP Note dated effective 10/4/24, written by RD #1, included the resident's weight on 4/12/24, was 98 lbs. and the resident's current weight on 10/7/24, was 72.8 lbs. RD #1 documented that she spoke with the Resident's Representative (RR #1) about the weight loss, who indicated the resident had a history of variable intake at meals, very small portion sizes with meals, and that weight loss was noted with legs look smaller. RD #1 indicated that Resident #35 had edema upon admission, a diuretic medication (med) was in use, and the team was made aware of the weight loss. RD #1 recommended a three-day calorie count, weekly weights for four weeks, a magic cup (a calorically dense frozen supplement) at lunch, and a health shake twice a day at 10:00 AM and 2:00 PM. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A Nurse Practitioner (NP) PN dated 10/10/24, documented the resident had severe weight loss. The note indicated a calorie count for three days, weekly weights for four weeks, and laboratory tests were ordered for the next day. A Nutrition/Dietary Note dated 10/15/24, documented the results of the three-day calorie count that the resident was eating between 25-75% of meals and referred to a NP note regarding the resident's weight loss. The note included the RD recommended to continue fortified foods, monitor weekly weights and the resident's nutritional status. A review of Physician's Orders (PO) for Resident #35 included: A PO dated 4/11/24, for a no-added salt (NAS) diet, regular consistency texture, and thin liquids. A PO dated 4/13/24, for hydrochlorothiazide (a diuretic) oral tablet (tab) 25 milligram (mg); give one tab by mouth one time a day for hypertension. The order was discontinued (d/c) on 11/14/24. A PO dated 10/8/24, to give a four ounce (4 oz) health shake two times a day for supplement and record the percentage consumed. A PO dated 10/8/24, to give magic cup one time a day for supplement and record the percentage consumed. A PO dated 10/8/24, for a three-day calorie count every shift for three days and to ensure calorie count paper was completed after each meal or snack, including supplements. A PO dated 10/8/24, with a start date of 10/15/24, and an end date of 11/12/24, to document the resident's weights weekly for four weeks every day shift every Tuesday. These interventions were implemented after the resident lost 25.2 lbs. since admission to the facility. A review of the October and November 2024 electronic Medication Administration Record (eMAR) for the weekly weights for four weeks order entries revealed the following: The 10/22/24, entry was left blank. A review of the corresponding PN did not include the resident's weight or any documentation as to why the resident's weight was not obtained. The 11/5/24, entry was signed 9 by the nurse which indicated to Other/See PN. A review of the corresponding PN did not include a note regarding the resident's weight. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The surveyor continued to review the PN which revealed the next documented note the RD wrote regarding the resident's significant weight loss was a Nutrition/Dietary Note dated 12/18/24. The note indicated it was for a follow-up for a 9% weight loss; that the resident weighed 72.8 lbs. on 10/7/24, and 66.2 lbs. on 12/9/24. RD #1 documented that weight loss persisted despite nutrition interventions and that weight loss may also be attributed to diuretic use. RD #1 indicated a re-weigh would be completed to confirm the weight. The RD did not include the missing weights from October and November, and did not assess the effectiveness of the interventions added on 10/8/24, which were implemented after the resident had a 25.71% significant weight loss since admission to the facility. There was no evidence that the RD continued to monitor the resident's nutritional status as documented in the 10/4/24, Nutrition/Dietary Note. A review of the Nutrition/Dietary Note dated 12/19/24, documented the weight committee met to review unplanned weight loss for Resident #35. The RD included the resident's weight on 12/19/24 was 73.2 lbs. The RD recommended to continue the current nutrition interventions which included super cereal (a calorically dense cereal) at breakfast, a 4 oz health shake supplement twice a day, and a magic cup at lunch. The resident's nutritional status will continue to be monitored. A review of an IDCP Note dated 12/31/24, written by RD #2, indicated that cultural foods were provided and the resident's meal intake was between 25-75%. Weekly weights were ordered on 12/23/24. RD #2's recommendations included to continue current nutrition interventions and monitor nutritional status. An additional review of the Physician's Orders included a PO dated 12/18/24, with a start date of 12/23/24, for weekly weight every Monday. A review of the corresponding December 2024 and January 2025 electronic Treatment Administration Record (eTAR) revealed the following weights: 12/23/24: 71.2 lbs. 12/30/24: 71.2 lbs. 1/6/25: 71.2 lbs. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 4/11/24, that the resident was at risk for malnutrition and was revised on 10/8/24, to include actual weight loss and variable intake. Interventions included to monitor nutritional status initiated on 4/11/24; communicate with the [RR #1] initiated on 10/8/24; and to provide health shake and magic cup initiated on 10/8/24. On 1/8/25 at 10:37 AM, the surveyor interviewed the Registered Nurse (RN) assigned to care for Resident #35, who stated that the facility's protocol was for residents to be weighed once a month, and the weight was documented in the weights section of the EMR. The RN stated that if the resident had a PO for weights obtained more frequently, the weights were documented on the eMAR or eTAR and may also be included in the weights section. The RN further stated Resident #35 sometimes did not like to eat at mealtime; that they consumed approximately 45-50% of meals; and in between meals, they informed staff that they were hungry. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 1/8/25 at 10:56 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) regarding weights, who stated that the resident's weights were obtained at least monthly and more frequently if there was a PO. The RN/UM stated the nursing staff obtained monthly weights in the first seven days of the month. The RN/UM further explained that she or the assigned nurses informed the Certified Nurse Aides (CNA) which residents needed to be weighed that day, and the CNA informed the nurse or RN/UM of the residents' obtained weights that they documented in the weights section of the EMR. The RN/UM stated the list was given to the RD to review. The RN/UM stated if there was a significant weight discrepancy from the previous weight, the resident was reweighed to confirm accuracy. The RN/UM stated if the resident lost a significant amount of weight, the RD and Physician were notified for recommendations. The RN/UM stated if a weight could not be obtained for a resident, the nurses documented the reason why it was not completed. At that time, the surveyor and the RN/UM reviewed the weights for Resident #35, and the RN/UM confirmed there were no weights in July 2024, August 2024, September 2024, and November 2024. The RN/UM could not speak to why there were no weights for those months, and the RN/UM acknowledged there should have been documentation for why the resident's weights were not obtained. The RN/UM confirmed the resident had a significant weight loss that was attributed to a poor appetite and was a selective eater. On 1/8/25 at 11:18 AM, the surveyor interviewed RD #1 about the facility's weight protocol, who stated the weights for all residents were taken once a month unless otherwise indicated in a PO. RD #1 stated all weights were documented in the weights section of the EMR, and she ran a report daily to review the weights. RD #1 stated if there was a discrepancy in the weight or a significant weight loss, a new weight was obtained immediately. At that same time, the surveyor notified RD #1 of the concern for Resident #35's significant weight loss and the missing weekly weights on 10/22/24 and 11/5/24. RD #1 stated she would review the EMR and provide additional information. On 1/8/25 at 1:01 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), and the Director of Nursing (DON) of the concern for Resident #35's significant weight loss and missing weights identified for the resident. The LNHA stated they would review and provide further responses the next day. On 1/9/25 at 10:37 AM, the LNHA, the DON, RD #1, and the Medical Director (MD) met with the survey team. The MD stated that he examined the resident yesterday (1/8/25) as per facility request and the MD stated that the resident had dementia, non-compliance at home with care regimen, a history of hypothyroidism, and edema which the resident received a course of diuretics. The MD added that the resident was a picky eater, finicky with eating, and was observed eating that morning their super cereal at breakfast and two-thirds of eggs. The MD stated their current weight was probably their baseline and would recommend to lower blood pressure (BP) meds and thyroid meds. The surveyor asked why the BP and thyroid meds were not lowered prior to surveyor inquiry, and there was no response. (continued on next page)

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

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At that time, the surveyor asked about the missing weights from July to September 2024, and the concern for the significant weight loss that was identified in October 2024 based on the weights. RD #1 acknowledged the resident's significant weight loss and the missed monthly weights. RD #1 stated that her assessments were not only based on the resident's weights, that she did rounds on the units to observe the resident and the nursing staff informed her if there were concerns with the resident's intake. The surveyor asked RD #1 if she had reviewed the four weekly weights requested in October 2024 for Resident #35 after the significant weight loss was identified, and RD #1 stated she reviewed the weights on 10/7, 10/15, and 10/28. The RD stated the resident's weights were stable and acknowledged there were some missing weights. Additionally, RD #1 stated a calorie count was completed, and the team discussed the resident being on a diuretic. There was no additional information provided by the facility. 2. On 1/6/25 at 12:30 PM, the surveyor observed Resident #92 lying on their bed with their eyes closed. The resident had a meal tray unopened on their bedside table. On 1/7/25 at 11:25 AM, the surveyor observed Resident #92 sitting up at the side of their bed with their breakfast tray on the bedside table in front of them. The resident was alert and did not respond to the surveyor's greeting. Resident #92 was eating eggs that were on their breakfast meal tray. On 1/9/25 at 9:20 AM, the surveyor reviewed the EMR of Resident #92. A review of the AR reflected Resident #92 was admitted to the facility with diagnoses that included but were not limited to; dementia, anxiety disorder, sleep disorder, gastroesophageal reflux disease (GERD), orthostatic hypotension (low BP while standing up from sitting or lying position), depression, and muscle weakness. A review of the most recent quarterly MDS dated [DATE], indicated a BIMS score of 9 out of 15, which indicated the resident had moderate cognitive impairment. A review of Section K revealed the resident was coded for having a weight loss of 5% or more in the last month or loss of 10% or more in the last six months and was not on a physician-prescribed weight loss regimen. The resident's weight was coded 126 lbs in the MDS. A review of Resident #92's weights revealed: 8/16/24: 139.6 lbs. 9/16/24: 139.6 lbs. 10/11/24: 125.6 lbs. (14 lbs loss or a 10.03% significant weight loss in one month) 11/18/24: 122 lbs. 12/4/24: 119 lbs. 12/8/24: 118.6 lbs. 12/12/24: 117.8 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	12/18/24: 123 lbs. 12/25/24: 121 lbs. 1/6/25: 120 lbs. A review of PN revealed the following: A Nutritional assessment dated [DATE], written by RD #1, documented that RR #2 was present, the resident's food preferences were reviewed and per the resident's history, their weight had been stable. The resident's current weight was 139.6 lbs and their body mass index (BMI; calculation based on weight to height) was within normal limits. The note included recommendations to continue to monitor the resident's nutritional status and for the resident to continue a therapeutic diet of fat-controlled, regular texture, and thin liquid diet. A Nutrition/Dietary Note dated 11/5/24, written by RD #1, documented that the resident had a 10% weight loss with a weight of 139.6 lbs on 9/16/24, and a weight of 125.6 lbs on 10/11/24. RD #1 indicated recommendations were to follow up weight, liberalize therapeutic diet, super cereal at breakfast, and super mash (calorically dense mashed potatoes) at dinner. A review of the Physician's Orders did not include a PO for super cereal or super mash. A review of an IDCP Note dated 11/15/24, written by RD #1, indicated a weight follow-up was pending, weight loss notes, provided liberalized diet, and to continue to monitor. A review of a Nutrition/Dietary Note dated 11/28/24, written by RD #1, indicated a reweigh was pending and weight loss was reviewed with the IDCP team. The RD indicated recommendations for a 4 oz health shake to be given twice a day, a three-day calorie count, weekly weights for four weeks, liberalize therapeutic diet, super cereal at breakfast, and super mash at dinner. A review of the corresponding Physician's Orders included the following POs: A PO dated 4/11/24, for a regular diet, regular consistency texture, and thin liquids. A PO dated 11/5/24, to obtain weight one time only for one day. A PO dated 11/28/24, to give a 4 oz health shake two times a day for supplement mouth and record the percentage consumed. A PO dated 11/28/24, for three-day calorie count every shift for three days and to ensure calorie count paper was completed after each meal or snack, including supplements. A PO dated 11/28/24, for weekly weights for four weeks every day shift on Wednesday. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The interventions that were implemented on 11/28/24, which to give a health shake twice a day, a three-day calorie count, and weekly weights for four weeks were added 48 days after the resident had a significant weight loss of 14 lbs. on 10/11/24. The resident also had continued weight loss with an additional 3.2 lbs. from 10/11/24 to 11/18/24. There was no PO for super cereal at breakfast or super mash at dinner. A review of a Nutrition/Dietary Note dated 12/2/24, written by RD #1, documented the results of a three-day calorie count indicated that the resident was meeting estimated nutritional needs. The RD recommended to continue current nutrition interventions, superfoods (cereal and mash), health shake supplements twice a day, and to continue to monitor weight trends. A review of a Nutrition/Dietary Note dated 12/18/24, written by RD #1, documented the resident had a weight gain with an improved weight status. The RD recommended to continue current nutrition interventions. A review of a Nutrition/Dietary Note dated 12/19/24, written by RD #1, documented a weight committee meeting took place to review the resident's unplanned weight loss. The resident had a weight gain with an improved weight status. The note indicated a message was left for RR #2. The RD recommended to continue the current nutrition interventions and to continue to monitor. A review of the November 2024 eMAR which revealed that on 11/5/24, the resident was documented with a weight of 125.6 lbs. A review of the December 2024 eMAR which revealed the following weights: 119 lbs on 12/4/24 117.8 lbs on 12/11/24 123 lbs on 12/18/24 121 lbs on 12/25/24 A review of the ICCP included a focus area dated 8/16/24, for the resident being at risk for malnutrition and revised on 11/5/24, to reflect an unplanned weight loss. Interventions included to: monitor nutritional status initiated on 8/16/24; regular diet initiated on 11/5/24, and health shake twice a day initiated on 11/28/24. The ICCP did not include super cereal at breakfast and super mash at dinner. On 1/9/25 at 11:39 AM, the surveyor interviewed RD #1 about Resident #92's 10% weight loss from September to October 2024 that was not documented as assessed until 11/5/24. RD #1 stated she would review her notes to provide a response to the surveyor's questions. The surveyor requested any documentation for any weight committee meetings for the resident. (continued on next page)

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

On 1/9/25 at 2:10 PM, RD #1 provided weight committee meeting sign-in sheets for 9/27/24 and 12/19/24. The sheet for 9/27/24, did not include Resident #92. A review of the untitled form dated 12/19/24, included the name, title, and signature of staff who attended the meeting and the name of the residents discussed in the meeting which included Resident #92. The meeting was attended by RD #1, a MDS staff, Director of Rehab, Assistant DON, LNHA, AA, Social Services, unit manager of 2 E unit, and the DON. RD #1 did not provide any weight committee meetings for October or November 2024, and provided no additional information regarding Resident #92's weight loss.

On 1/9/25 at 12:50 PM, the surveyor informed the LNHA, DON, and the AA of the above concerns for Resident #92's significant weight loss between September to October 2024, and requested additional information.

On 1/10/25 at 11:15 AM, the LNHA, DON, and AA met with the survey team. The LNHA stated there was no additional response or information regarding the concern for Resident #92.

37791

3. On 1/7/25 at 9:08 AM, the surveyor observed Resident #3 in bed and watching television. The surveyor attempted an interview but the resident declined.

A review of Resident #3's medical records revealed:

A review of the AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to; metabolic encephalopathy (a brain dysfunction that occurs when there's an imbalance of chemicals in the blood, usually due to an underlying medical condition), congestive heart failure (chronic condition in which the heart does not pump blood as well as it should), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and unspecified intestinal obstruction (blockage in the small or large intestine that prevents food and liquid from passing through).

A review of the most recent quarterly MDS dated [DATE], reflected a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.

A review of the weights revealed:

9/23/24: 138.0 lbs.

10/23/24: 120.0 lbs. (18 lbs or 13.4% significant weight loss in a month)

11/19/24: 122.6 lbs.

12/9/24: 118.6 lbs.

1/2/25: 117.8 lbs.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of the resident's Admission Nutritional assessment dated [DATE], included that RD #1 identified that the resident was 138 lbs. and the resident's ideal body weight was 80-98 lbs and the BMI was 32 (obese). The resident was on a NAS, fat-controlled diet. The RD identified the resident reported having a poor appetite. A review of the Nutritional assessment dated [DATE] at 1:24 PM, revealed that the resident's current weight was 119 pounds, and that weight loss was expected with the resident was on a diuretic (Lasix). The resident's BMI was 27.6 and was overweight. The RD recommended a therapeutic diet and to continue monitoring the resident's nutritional status. There was no Nutrition/Dietary Note to address the 18 lbs weight loss on 10/23/24, or a reweigh. On 1/9/24 at 1:00 PM, the surveyor interviewed RD #1, who stated Resident #3 had multiple hospitalization s and comorbidities including congestive heart failure that contributed to their weight loss. RD #1 stated that she saw the resident after their re-admission on 10/21/24, and she was waiting for the resident to be weighed; that the weight loss could have happened during the resident's hospitalization . RD #1 acknowledged that the resident had a significant weight loss on 10/23/24, and that the resident should have been re-weighed, and that she should have written a Nutrition Note to address the 18 lbs or 13.4% weight loss. The RD stated that the resident's weight was now stable, and that she was monitoring the resident's weight. On 1/9/24 at 1:30 PM, the surveyor discussed the above concerns with the LNHA, DON, and the RDON. No further information was provided. A review of the facility's Weight Assessment and Intervention Policy with a last revised date of October 2024, include: Policy Statement: The multidisciplinary team [MDT] will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Policy Interpretation and Implementation: Weight Assessment 1. The nursing staff will measure the resident's weight on admission, the next day, and weekly for four weeks thereafter. If no weight concerns are noted, weights will be measure monthly thereafter. 2. Weights will be recorded in the Weights and Vitals tab in the EMR. 3. Any weight change of 5% or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will immediately notify the RD. 4. The RD will respond within 24 hours of receipt of notification. 5. The RD will review the unit's weight record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change have been met. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	6. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month- 5% weight loss is significant; greater than 5% is severe. b. 3 months-7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months-10% weight loss is significant; greater than 10% is severe. Analysis: 1. Assessment information shall be analyzed by the MDT and conclusions made regarding the: a. The resident's target weight range including rationale if different from ideal body weight. b. Approximate calorie, protein, and other nutrient needs compared with the resident's current intake. c. Relationship of current medical condition or clinical situation and recent fluctuations in weight. d. Whether and to what extent weight stabilization or improvement can be anticipated. 2. The physician and the MDT will identify conditions and medication that may be causing anorexia, weight loss or increasing the risk of weight loss. Care Planning 1. Care planning for weight loss or impaired nutrition will be an MDT effort. 2. Individualized CP should address to the extent possible: a. The identified causes of weight loss. b. Goals and benchmarks for improvement. c. Time frames and parameters for monitoring and reassessment. NJAC 8:39 - 11.2(e)(1)(f), 17.1(c), 17.2(c)(d), 27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44605 REPEAT DEFICIENCY Based on observation, interview, and record review, it was determined that the facility failed to follow a Physician's Order in accordance with professional standards of practice for 2 of 4 residents, Resident #58 and Resident #105), reviewed for respiratory care. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 1/6/25 12:08 PM, the surveyor observed Resident #58 in bed with eyes closed, with an oxygen (O2) via nasal cannula (NC) (medical device to provide supplemental oxygen therapy to people who have lower O2 levels) at 1.5 Liters Per Minute (LPM), O2 running. The surveyor reviewed the Admission Record (AR; or face sheet; an admission summary) which revealed that the resident had been admitted to the facility with diagnosis that included ataxia (is a neurological sign consisting of lack of voluntary coordination of muscle movements that can include gait abnormality, speech changes, and abnormalities in eye movements, that indicates dysfunction of parts of the nervous system that coordinate movement), hyperlipidemia, bipolar disorder, and hypertension. A review of the Significant Change Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 12/2/24, revealed that the resident had a score of 2 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated that the resident had severely impaired cognition. The MDS also reflected that the resident received continuous O2 therapy. A review of the physician order (PO) for Resident #58 revealed a PO, dated 6/27/2024, for O2 at 2 LPM per NC. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 10:30 PM, the surveyor observed Resident #58 in bed with eyes closed, with an O2 via NC at 1. 5 LPM. The Surveyor was joined by Licensed Practical Nurse #1 (LPN#1) confirmed O2 was running at 1.5 LPM. LPN #1 could not state why the O2 was not set correctly according to the PO at 2 LPM. 49078 2. On 1/7/25 at 12:10 PM, the surveyor observed resident #105 in bed with eyes closed, with an O2 via NC at a set between 1.5 LPM and 2 LPM. The surveyor reviewed the AR which revealed that the resident had been admitted to the facility with diagnosis that included end stage heart failure (a condition where the heart no longer pumps effectively), acute congestive heart failure (a condition where the heart is surrounded by excess fluid), and pulmonary hypertension. A review of the Annual MDS, with an ARD of 11/15/24, revealed that the resident had a score of 3 out of 15 on the BIMS, which indicated that the resident had severely impaired cognition. The MDS also revealed that the resident received continuous O2 therapy. A review of the PO for Resident #105 revealed a PO, dated 6/5/2024, for O2 at 2 LPM PRN via NC Continuous. On 1/9/25 at 10:37 AM, the survey team met with the LNHA, Assistant Administrator (AA), and DON to review concern. The DON stated all O2 setting should be set per PO. On 1/9/25 at 12:04 PM the surveyor observed Resident #105's O2 at a rate of 1.5 LPM. The surveyor interviewed the Unit Manager for the 3 [NAME] unit (UM3W). The surveyor showed the UM3W the resident's O2 setting. The UM3W agreed that it looked like 1.5 LPM. The UM3W adjusted the rate to 2 LPM. On 1/9/25 at 12:10 PM the surveyor interviewed LPN#2 assigned to resident #105. The surveyor asked LPN#2 what the O2 concentrator should be set for. LPN#2 proceeded to check the PO and stated 2 LPM. The surveyor showed LPN#2 the concentrator gauge, LPN#2 stated it looked like 2 LPM. On 1/9/25 at 12:53 PM, the survey team met with the DON, LNHA, AA for response to concerns. The DON stated that the staff may be looking at the gauge at a down angle and not reading the rate correctly. A review of the facility's Oxygen Administration Policy, with a revised date of 10/2010, that was provided by the LNHA revealed that the preparation guidelines it states, 1. Verify that there is a PO for this procedure. Review the PO for facility protocol for O2 administration. On 1/10/25 at 1:30 PM, the survey team met with the LHNA and DON for an exit conference. The facility did not provide any further pertinent information. NJAC 8:39- 27.1 (a)

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39885

Based on observation, interview and record review, it was determined that the facility failed to a.) complete the Hemodialysis Communication Record, pre dialysis and/or post dialysis treatment for 7 of 16 days and b.) ensure a resident was placed on a fluid restriction as recommended by the dialysis center or documented the reason the recommendation was not followed for 1 of 1 resident reviewed for dialysis, Resident #76.

This deficient practice was evidenced by the following:

On 1/6/25 at 11:43 AM, the surveyor interviewed Resident #76 who was seated in a wheelchair in the resident's room. Resident #76 stated that they received dialysis services 3 times a week. The surveyor asked Resident #76 if they were on a fluid restriction. Resident #76 stated yes.

A review of Resident #76's 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 end stage renal disease (a condition where the kidneys have permanently lost their ability to function properly), dependence on renal dialysis (a state of chronic dependence on a machine and medical professionals to maintain life when the kidneys are no longer able to function properly) and chronic congestive heart failure (a long-term condition that occurs when the heart is unable to pump blood efficiently throughout the body).

A review of Resident #76's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which reflected that the resident's cognition was intact. Further review indicated the resident was receiving hemodialysis (HD) services while a resident.

On 1/8/25 at 10:01 AM, the surveyor interviewed Resident #76's Licensed Practical Nurse (LPN) regarding the process of the communication between the facility and the dialysis center. The LPN stated that the resident had a binder filled with Hemodialysis Communication Record (HCR) and that the facility filled out the top section of the HCR prior to the resident going to the dialysis center and the bottom section when the resident returned from the dialysis center. She added that the dialysis center filled out the middle section. The surveyor asked the LPN if the expectation was that all 3 sections were to be filled out. The LPN stated that all 3 sections should be filled out. The surveyor then asked to view Resident #76's binder.

A review of Resident #76's HCR included the following:

The HCRs dated 12/18/24, 12/22/24, 12/27/24, 12/29/24 and 1/6/25 did not have the post dialysis treatment section on the form filled out. Some of these forms did not have a section on the form labeled for post dialysis.

The HCRs dated 12/31/24 and 1/3/25 did not have the pre dialysis treatment and post dialysis treatment section filled out by the facility.

The LPN confirmed that some of the HCRs were not filled out completely.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 10:59 AM, the surveyor interviewed the Director of Nursing (DON) regarding the process for HCR. The DON stated that the resident had a dialysis binder which contained forms for the facility nurse to fill out prior to going to the dialysis center, a section for the dialysis nurse to fill out and a section for the facility nurse to fill out when the resident returned to the facility after the dialysis treatment. The surveyor showed the DON Resident #76's incomplete HCRs. The DON stated that the HCRs should have been filled out. On 1/8/25 at 11:53 AM, the surveyor reviewed Resident #76's electronic medical record which revealed the following: A review of an uploaded document to the miscellaneous tab included a Progress Note (PN) from the sister facility that Resident #76 resided at prior to the residents transfer to the resident's current facility. A review of the PN with an effective date of 09/16/2024 included the following: Patient returned from dialysis around 7:45 pm with communication to monitor fluid intake and maintain fluid restriction of 1000 ml/day (milliliters/day). Fluid intake is being monitored, patient is noncompliant with fluid restriction at times. re-education provided. Will continue to monitor. A review of the PN with an effective date of 9/07/24 included the following: Picked up by ambulance for extra HD .Resident on strict fluid restriction 1000 ml/day. A review of Resident #76's Physician Order (PO) Summary Report did not include an order for a fluid restriction. A review of Resident #76's nutrition assessment dated [DATE] included the following: Fluid Range (ml/day) 2000 -2500ml. A review Resident #76's nutrition assessment dated [DATE] included the following under plan/recommendation: re-admission diet . 9% wt (weight) loss during hospitalization , +1 edema on admission, risk of malnutrition - fluid accumulation A review of Resident #76's nutrition note dated 12/23/2024 included the following: Spoke with RD (Registered Dietician) at HD center. Weight gains a little High at times. Noted with gradual beneficial weight loss during past 6 months. On 1/8/25 at 01:41 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA) and DON the concern that 7 of 16 HCRs for Resident #76 were not filled out completely. On 1/9/25 at 9:36 AM, the surveyor, via phone call on speaker, interviewed the Clinical Manager (CM) of Resident #76's dialysis center. The CM stated that the recommendation for Resident #76 was a 1000 ml (1 liter) fluid restriction per day. The surveyor asked if there should be an order for the fluid restriction. The CM stated that she did not know how the facility managed a fluid restriction. The CM stated that she would expect that Resident #76 would be on a fluid restriction and that she was pretty sure she spoke with the facility's dietician about the fluid restriction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Atrium Post Acute Care of Park Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Noyes Drive Park Ridge, NJ 07656	

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 9:40 AM, the surveyor via phone call on speaker, interviewed the dialysis center's Registered Dietician (DCRD) regarding Resident #76. The DCRD stated that Resident #76's diet order at the center included a 1000 ml fluid restriction. The DCRD stated that she had started in October and that the previous dietician's assessment had a 1000 ml fluid restriction. The DCRD stated that she checks in with the facility dieticians each month with labwork (laboratory work). On 1/9/25 at 11:23 AM, in the presence of the survey team and DON, the LNHA stated that education was provided to staff regarding filling out HCRs. On 1/9/25 at 11:39 AM, the surveyor interviewed the facility's Registered Dietician (RD) regarding the process for a dialysis resident. The RD stated that she started with a regular nutrition assessment and that she communicated with the dialysis nurse. The surveyor asked if Resident #76 was on a fluid restriction. The RD stated that Resident #76 was not on a fluid restriction. She stated that she spoke with the DCRD on 12/23/24 and that she had said that the resident's weight gain was a little high at times. The surveyor asked the RD if a fluid restriction was discussed. The RD stated that she did not write in her note about a discussion. She added that she does not initiate a fluid restriction unless it was ordered by the physician or recommended by the DCRD. On 1/9/25 at 11:51 AM, the surveyor interviewed Resident #76 who confirmed that he/she was on a fluid restriction. On 1/9/25 at 11:52 AM, the surveyor interviewed Resident #76's LPN regarding a fluid restriction. The LPN stated that the resident was not on a fluid restriction. The surveyor asked the LPN what the process was when a resident was admitted from the hospital and/or another facility. The LPN stated that the nurse that admitted the resident would review the papers that came from the hospital or other facility and would confirm with the physician if an order for fluid restriction would be continued. On 1/9/25 at 12:03 PM, the surveyor interviewed Resident #76's Physician (MD) regarding the resident and if the resident was on a fluid restriction or if it was recommended. The MD stated that he did not believe it was recommended. He added that it was patient preference and if the resident wanted to eat more and enough fluid was coming out during dialysis. The MD stated that he rather the resident eat their food and not be on restriction and that if the resident wanted to drink something then they should have it. He added that he may be going against the nephrologist wishes. On 1/9/25 at 12:20 PM, the surveyor requested from the LNHA Resident #76's hospital record and transfer forms from the facility that the resident resided at prior to the hospitalization . The surveyor also requested the HCRs that were not in Resident #76's HCR binder prior to December 1, 2024. On 1/9/25 at 12:49 PM, the surveyor notified the LNHA, AA and DON, the concern that Resident #76's order for a fluid restriction from the previous facility was not addressed by the new current facility and the recommendation for a fluid restriction was not followed. On 1/9/25 at 12:55 PM, the surveyor reviewed the facility provided PO Summary Report from Resident #76's previous facility which included an order for Fluid Restriction of 1000 ml in 24 hours. (continued on next page)

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	315438	A. Building B. Wing	01/10/2025

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #76's electronic medical record did not include any documentation that addressed an assessment for the continuation or discontinuation of a fluid restriction order for Resident #76. On 1/10/25 at 11:21 AM, in the presence of the survey team, LNHA and AA, the DON stated that they had missed the order that Resident #76 was on a fluid restriction. She added that they did not see any communication from the dialysis center regarding a fluid restriction. The DON stated that the facility could not find the HCRs that were prior to the ones that were in the binder that the surveyor reviewed. The DON stated that the MD did not feel that the resident needed a fluid restriction anymore. The facility did not provide any further information. A review of the facility's Care of the Resident Receiving Dialysis Treatments Policy, with a reviewed date of 10/2024 included the following: Policy: To prevent complications such as fluid overload, infection or clotting of the access area, or hemorrhage in residents receiving dialysis. Policy Explanation and Procedures 1. Monitor for signs of fluid overload secondary to little or no renal function: a. Monitor feet and hands for edema b. Monitor for elevated blood pressure, shortness of breath or chest pains . 9. Dialysis communication form will be sent with the resident on each visit. 10. Upon return from dialysis, the nurse will complete the post dialysis information located on the bottom of the dialysis communication record. N.J.A.C. 8:39-27.1 (a)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 38327 Based on interviews, and record review, it was determined that the facility failed to ensure that the responsible physician supervising the care of residents conducted face-to-face visits and wrote progress notes at least once every sixty days from September 2023 through December 2024 according to the facility's policy and procedure. This deficient practice was identified for 1 of 38 residents, Resident #187 was reviewed for physician visits and was evidenced by the following: The surveyor reviewed the closed hybrid (paper and electronic) medical records of Resident #187 and revealed: Resident#187's Admission Record (or face sheet; an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to Alzheimer's disease with late onset (a common form of dementia that starts after the age of 65 and can cause memory and cognition issues, impaired judgment, and other symptoms as it progresses), unspecified osteoarthritis unspecified, and unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, revealed in Section A Identification Information the reason for completing the assessment or tracking record was coded #12 for death in the facility tracking record. A review of Resident #187's hybrid medical records revealed that the Physician's Progress Notes (PN) were done on 4/29/24 and 8/7/24. A review of the PN dated 10/30/24 for SBAR (S - Situation, B - Background, A - Assessment, R - Recommendation; can be used to communicate information between healthcare professionals, that is, from nurse to physician or allied healthcare professional, as well as when relaying information to a patient or their caregivers) that was electronically signed by the Licensed Practical Nurse (LPN) regarding the change in condition of Resident #187 for difficulty swallowing, shortness of breath, and thickened sputum. The PN included that the Physician was notified and with orders. Further review of the hybrid medical records of the resident revealed that there were no other Physician visit notes except for the above dates on 4/29/24 and 8/7/24. On 1/8/25 at 12:59 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), and the Director of Nursing (DON). The surveyor notified the LNHA, DON, and AA of the above concerns that the physician did not have routine PN and visit notes according to the requirements. At that same time, the LNHA stated that the residents for LTC (Long Term Care) should be seen by the physician monthly and as needed in between. The LNHA further stated that she reviewed the facility's policy and there was no clear cut when they should document during the visit, but the common practice that every time they visit, they document. The surveyor asked for the facility's policy with regard to physician services. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 2:17 PM, the DON confirmed that the facility had an issue with the Physician's visits and PN which was why some Physician's residents were given to other physicians and the physicians were aware of the concerns. At that same time, the DON checked and reviewed the closed records of the resident, and stated that she did not see any documentation from the Physician in the PN except for the previously identified on 4/29/24 and 8/7/24. A review of the facility's Physician Services with a revised date of August 2006 that was provided by the LNHA revealed: Policy Interpretation and Implementation: 2. The resident's attending Physician is responsible for prescribing new therapy, ordering a transfer to the hospital, conducting routine visits, delegating and supervising follow-up visits from Nurse Practitioners or Physician Assistants, etc., to ensure that the resident receives quality care and medical treatments. 3. Physician orders and PN shall be maintained in accordance with current OBRA (Omnibus Budget Reconciliation Act; a set of regulations that improve quality of care in nursing homes) regulations and facility policy. 4. Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy . 9. After the initial 30-day visit, all visits must then occur at 30-day intervals up until 90 days after the admitted . After the first 90 days, a visit must be conducted at least every 60 days thereafter . 10. For the first 90 days, the Medicaid beneficiary shall be visited and examined every 30 days. Thereafter, with written justification, the interval between visits may be extended for up to 60 days. 11. Additional visits shall be made when significant clinical changes in the Medicaid beneficiary's condition require medical intervention. On 1/10/25 at 11:45 AM, the survey team met with the LNHA, DON, Infection Preventionist Nurse, Registered Dietician, Rehab Director, Regional DON, Activity Director, MDS/Lead Registered Nurse, and Assistant Director of Nursing for an exit conference, and there was no additional information provided by the facility. NJAC 8:39-23.2(d)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 46049 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to ensure the daily report of licensed nurses, certified nursing assistant staffing, and the resident census was posted at the beginning of the current shift for 2 of 5 days during the survey. This deficient practice was evidenced by the following: On 1/6/25 at 11:03 AM, upon entry to the facility, Surveyor #1 observed a Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the main entrance. The NHRCSR posted was dated 12/16/24, for the [7:00 AM to 3:00 PM] day shift. There was no NHRCSR for 1/6/25 posted. On 1/7/25 at 8:29 AM, upon entry to the facility, Surveyor #2 observed a NHRSCR posted at the front desk by the main entrance. The NHRCSR posted was dated 1/5/25 for the day shift. There was no NHRCSR for 1/7/25 posted. On 1/8/25 at 11:32 AM, Surveyor #1 interviewed the staffing coordinator (SC). The SC stated when she came into work around 7:00 AM, she would confirm if any callouts, would update staffing data in the computer for the NHRCSR and then would post at reception desk. The SC further explained she posted the NHRCSR for the next shift at 3:00 PM. The surveyor asked who was responsible for posting the NHRCSR for the night [11:00 PM to 7:00 AM] shift. The SC replied that the supervisor who was working that shift. The surveyor asked about if the SC worked on the weekends. The SC replied she did not. The surveyor asked who was responsible for posting the NHRCSR on the weekends. The SC stated that no one does on the weekends. The surveyor informed the SC about the observations of the NHRCSR posted on 1/6/25 and 1/7/25. The SC could not speak to why the NHRSCR was dated 12/16/24 on Monday and for Tuesday, she stated it was a misunderstanding. The SC explained that the LNHA told her it was to be the day before and then after it was corrected. The SC was not sure about the regulations about the posting of the NHRSCR. On 1/8/25 at 1:01 PM, Surveyor #1 notified the Licensed Nursing Home Administrator (LNHA), the Assistant Administrator, and the Director of Nursing about the concern of the NHRCSR for the current day and shift not being posted on two days. The LNHA stated the expectation was for the NHRCSR to be posted for today's date. Surveyor #1 discussed with the facility that the SC stated no one was responsible for posting the NHRCSR on the weekends. The LNHA stated she would follow up and provide additional information. On 1/9/25 at 11:25 AM, the LNHA stated the SC was educated yesterday on the right way to post the NHRCSR, including that the report for the current date should be posted. Surveyor #1 asked about who was responsible for posting the NHRSCR on the weekend. The LNHA replied moving forward the nursing supervisors would be posting. On 1/10/25 at 10:19 AM, Surveyor #1 asked for a policy regarding NHRCSR posting. The LNHA stated there was no facility policy and that regulations were followed. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-41.2

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49078 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medication per manufacturer specifications and standards of practice. This deficient practice was identified in 3 of 4 medication carts and 2 of 2 refrigerators observed on the 2nd and 3rd floors of the facility. 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 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 1/8/25 at 11:24 AM, the surveyor began to inspect selected medication (med) storage areas in the facility. The surveyor observed the following: The surveyor in the presence of Registered Nurse/med nurse (RN) inspected the med cart identified as Cart 1 located on 3 West. The surveyor observed 1 foil package of budesonide inhalant suspension (a med that is inhaled to reduce lung inflammation) that did not reflect a date when the foil was originally opened. The surveyor also observed 1 Novolog FlexPen (an insulin delivery system) and 3 unidentified tablets (tabs) located in the bottom of the 2nd drawer. The budesonide foil package label reflected once the foil envelope was opened, use the vials within 2 weeks and an area to write the date. The surveyor verified with the RN that there was no date on either the foil package or the FlexPen and if the RN could identify the loose tabs. The RN stated the budesonide should have a date opened and the FlexPen should have a date when put in the cart. The RN could not identify the tabs. The surveyor in the presence of the RN/med nurse, accessed the med storage room located on 3 [NAME] and the refrigerator located within. The surveyor observed the temperature (temp) of the refrigerator to be 27 degrees Fahrenheit (F), which was outside of the accepted range of 36 degrees to 46 degrees F. The surveyor observed a temp log sheet which reflected a temp entry for the day of 38 degrees F. The surveyor in the presence of the RN/med nurse, inspected the med cart identified as cart 1 located on the 2nd floor. The surveyor observed 1 Novolin R Pen (an insulin delivery device) with no date written on it. The surveyor asked the RN if the Novolin R Pen should have a date when placed in the cart. The RN stated, yes, there should be one written on it when taken out of the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor in the presence of the RN/med nurse, accessed the med storage room located on the 2nd floor and the refrigerator located within. The surveyor observed that there were 2 thermometers located within the refrigerator. One reflected a temp of 33 degrees F, which is outside of the accepted range of 36 degrees to 46 degrees F and one reflected a temp of 44 degrees F. The surveyor verified this discrepancy with the RN/med nurse. The surveyor in the presence of the Licensed Practical Nurse/med nurse (LPN/med nurse) and the Unit Manager (UM) inspected the med cart identified as Cart located on 3 East, 2nd floor. The surveyor observed 2 foil packages of ipratropium/albuterol vials (a med that is inhaled to reduce lung congestion) that did not reflect a date when the foil was originally opened. The surveyor also observed 2 unidentified tabs located in the bottom of the 2nd drawer. The ipratropium/albuterol foil package label reflected once the vials were removed from the foil pouch to use within 1 week. The surveyor verified with the LPN/med nurse and the UM that there was no date on the foil packages and could not identify the loose tabs. On 1/8/25 at 1:01 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Assistant Administrator (AA) to discuss the concerns with med storage. On 1/9/25 at 10:38 AM, the survey team met with the LNHA, DON and Medical Director for responses to concerns. The LNHA stated that the thermometers in the affected refrigerators were replaced, the medications (meds) under concern were disposed of and the staff educated. On 1/9/25 at 1:44 PM, The surveyor interviewed the facility Consultant Pharmacist (CP) by telephone and discussed the med storage concerns. The surveyor asked the CP if the meds observed by the surveyor should have appropriate dates on the labels. The CP agreed that they should be dated. The surveyor asked the CP what the proper temp range for med refrigerators was. The CP stated it should be between 36 degrees F and 46 degrees F. The surveyor asked the CP about loose unlabeled meds in a med cart. The CP stated there should be no loose meds in the carts. The surveyor reviewed the manufacturer packaging information for ipratropium/albuterol inhalation vials, budesonide inhalation vials, Novolog FlexPen and Novolin R Pen. The manufacturer label for DuoNeb reflected: Once removed from the foil pouch, the individual vials should be used within one week. The packaging information for budesonide, under storage and handling, reflected: When an envelope has been opened, the shelf life of the unused ampules is 2 weeks when protected. The manufacturer packaging information for Novolog FlexPen and Novolin R Pen reflected that they should be disposed of after 28 days at room temp. On 1/10/25 at 11:26 AM, the survey team met with the LNHA, DON and AA. No further information related to med storage was provided. The surveyor reviewed the facility policy titled Storage of Meds with a revision date of June 2024. The policy reflected: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. 8. Drugs shall be stored in an orderly manner . The policy did not reflect any pertinent information in relation to dating opened packaging of nebulizer solutions, dating of any insulin delivery system or temp maintenance of med refrigerators. NJAC 8:39-29.4(d)(g)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 39399 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure bedtime (HS) snacks were offered. This deficient practice was identified for 5 of 5 residents (Resident #124, Resident #53, Resident #140, Resident #70, Resident #189) during the Resident Council group meeting and was evidenced by the following: On 1/7/25 at 12:49 PM, the surveyor conducted a resident group meeting with five residents who were alert and oriented and were selected by the facility to attend the group meeting. All five residents at the group meeting stated that the HS snacks were not offered. All five residents also stated they would like to have a HS snack. The surveyor reviewed the Resident Council meeting minutes in the last 3 months from October 2024 through December 2024. The minutes did not address HS snacks. On 1/8/25 at 1:20 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), and Director of Nursing (DON) to discuss the above concern. The LNHA stated HS snacks must be offered to the residents but was unable to provide further information for any accountability if the HS snacks were offered to the residents. On 1/9/25 at 10:37 AM, the DON provided the surveyor with a facility policy titled Food, Dining Service and HS Snacks with a reviewed date of 6/2024. Under the policy, it stated, Snacks will be offered between meals and at HS, Nursing staff are responsible for offering snacks. There was no system in place or documented evidence to show that residents who wanted HS snacks were offered. There was no additional information provided. NJAC 8.39-17.2(f) 1(ii)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 1/6/25 at 11:16 am, the surveyor in the presence of the Assistant Food Service Director (AFSD) observed the following during the kitchen tour: 1. The surveyor observed in storage container 5 open bags of bread: 1 gluten free bread, 1 whole wheat bread, 2 rye breads, and 1 white bread all were missing open and use by labels. The AFSD could not state why the opened bags of bread were missing labels but acknowledged all opened items need to have an open and use by label. 2. The surveyor observed in dry storage room [ROOM NUMBER], one 6 pound (lb.) 10 ounce (oz) can of fruit mix with a large dent. The can was in the regular rotation with 5 other cans of fruit mix. The AFSD stated any dented cans should be removed from the regular rotation of canned items. 3. The Surveyor observed in the walk-in refrigerator, the fans had a black colored dust-like substance as well as 6 boxes were stored above 18 inches (in) from the ceiling. The AFSD stated they would contact the maintenance department for clean the fan and they would remove all boxes that were being stored too high. 4. The surveyor observed in the walk-in freezer, 12 boxes stored above 18 in from the ceiling. The AFSD stated they would remove all boxes that were being stored too high. 5. The surveyor observed 3 Dietary Aides (DA) with large hoop earrings. AFSD stated they should not be wearing earrings that can dangle as that us against their policy. On 1/7/25 the Licensed Nursing Home Administrator (LNHA) provided the surveyor with multiple kitchen policies. The Labeling and Dating of Dry, refrigerated and Freezer Food Items policy with a revised date of 10/2024 states under the policy section, All food products shall be dated upon receipt or when they are prepared and when they are opened. The Food Storage policy with a revised date of 10/2024, states under the procedure section, 7 .d. Food will be stored and handled to maintain the integrity of the packaging until ready for use., 10. Food should be stored a minimum, of 6 inches above the floor, 18 inches from the ceiling. The General Sanitation of Kitchen policy with a revised date of 10/2024 stated under the policy section, Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. The Employee Hygiene for Food Safety policy with a revised date of 10/2024 states under the procedure section, 5. Keep jewelry to a minimum. Only a plain band ring such as a wedding band, and watch can be worn. On 1/8/25 at 12:59 PM, the survey team met with the LNHA, Assistant Administrator, Director of Nursing (DON) to review concerns. The LHNA stated the kitchen concerns have been addressed and the staff have all been re-in-serviced. No additional information provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Atrium Post Acute Care of Park Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Noyes Drive Park Ridge, NJ 07656	

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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	On 1/10/25 at 1:30 PM, the survey team met with the LHNA and DON for an exit conference. The facility did not provide any further pertinent information. NJAC 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025

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Atrium Post Acute Care of Park Ridge	120 Noyes Drive Park Ridge, NJ 07656

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F 0836

Level of Harm - Potential for minimal harm

Residents Affected - Many

Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.

44605

Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in facility name in accordance with 42 CFR (Code of Federal Regulations) 424.516.

This deficient practice was evidenced by the following:

According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program:

(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements:

(1) Compliance with title XVIII of the Act and applicable Medicare regulations.

(2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare.

(3) Not employing or contracting with individuals or entities that meet either of the following conditions:

(i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act.

(2) All other changes in enrollment must be reported within 90 days.

On 1/6/25 at 8:40 AM, upon arrival of the survey team to the facility, the surveyor observed a signage outside the facility not in accordance to the approved CMS facility name.

A review of various documents and facility policies that were provided by the Licensed Nursing Home Administrator (LNHA), the facility name as part of the facility's policies and documents were not in accordance to the approved CMS facility name.

On 1/7/25 at 10:13 AM, the Surveyor met with the LHNA to discuss the facility medical documents did not match the documentation according to what they were licensed for. The LNHA stated the facility was now managed by [name of company], not aware of any issue with the name change, but would contact the Chief Operating Officer (COO) of the company for clarification.

(continued on next page)

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	On 1/8/25 at 12:59 PM, the surveyor met with the LNHA, Assistant Administrator (AA), and Director of nursing (DON) to discuss the licensed facility name and facility name on medical documents. LNHA stated the COO stated the application for name change was awaiting approval with the State but have not received approval at this time and they cannot apply with CMS until they get state approval. The surveyor asked if the facility had filed a 855B form to CMS and the LNHA explained that they have not done the 855B form. A review of the facility license that was issued by the New Jersey Department of Health Division of Certificate of Need and Licensing with an issue date of January 8, 2024, and an expiration date of February 28, 2025, revealed the name licensed to operate was the approved CMS facility name and not according to the newly acquired company name. On 1/10/25 at 1:30 PM, the survey team met with the LHNA and DON for an exit conference. The facility did not provide any further pertinent information. NJAC 8:39-5.1 (a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for 4 of 11 staff (3 Housekeepers and 1 Certified Nursing Aide) and b.) ensure nebulizer machine was properly stored and follow appropriate infection control practices to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and the facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. According to the CDC information on the Sequence for putting on PPE revealed: 2. Mask or respirator oSecure ties or elastic bands at middle of head and neck oFit flexible band to nose bridge oFit snug to face and below chin How to safely remove PPE: There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials . Here is one example. Remove all PPE before exiting the patient room . 1. On 1/6/25 at 11:24 AM, the Licensed Nursing Home Administrator (LNHA) informed the surveyor that the last day of COVID-19 (also called coronavirus disease 2019, is an illness caused by a virus) positive was yesterday. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 9:03 AM, the surveyor observed 3 Housekeepers (HKs) inside the elevator with surgical masks not properly worn, their masks were not covering their mouth and nose. The surveyor and 3 HKs exit the elevator to the 1st-floor unit. On 1/8/25 at 9:12 AM, the surveyor upon exiting the elevator, observed the Certified Nursing Aide (CNA) in the hallway wearing a surgical mask not covering her mouth and nose and with gloves while holding a plastic bag. Upon seeing the surveyor, the CNA removed her gloves while walking in the hallway and did not perform hand hygiene. The surveyor interviewed the CNA in the nursing station in the presence of the Assistant Director of Nursing (ADON). The surveyor observed the CNA with 3 surgical masks in use and was below her nose and halfway covering her mouth. At that same time, the CNA informed the surveyor that she had come out of room [ROOM NUMBER] and cleaned the floor because it was wet. The surveyor asked about the gloves in the hallway and her masks, the CNA was unable to directly respond to the surveyor's questions and the Assistant Director of Nursing (ADON) immediately educated the CNA that it was not appropriate for the CNA to wear gloves in the hallway and that the CNA should have removed it inside the resident's room and performed hand hygiene. The ADON also stated that the CNA had a small face and that was why the masks were falling off but otherwise, the CNA should have her mask worn properly covering her nose and mouth, and not wear more than one mask at the time. The surveyor also notified the ADON of the above concerns with the 3 Housekeepers. On 1/8/25 at 10:03 AM, the surveyor observed Housekeeper #1 (HK#1) with a surgical mask not properly worn, it was below the chin. The surveyor asked HK#1 about the mask and HK smiled at the surveyor and left. The HK did not respond when asked why the mask was below her chin and not properly covering her nose and mouth. On 1/8/25 at 12:59 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), and Director of Nursing (DON). The surveyor notified of the concerns regarding the 3 Housekeepers and CNA about PPE and hand hygiene. On 1/9/25 at 10:37 AM, the survey team met with the LNHA and the DON. The LNHA stated that the CNA and 3 Housekeepers observed with masks under their chins were educated and they have a history of educating in the past the above mentioned employees. A review of the facility's PPE-Face Masks Policy with a revised/reviewed date of 10/2024 that was provided by the LNHA revealed that there was no information about the proper way of wearing a face mask. A review of the facility's PPE-Gloves Policy with a revised/reviewed date of 10/2024 that was provided by the LNHA revealed: Policy Interpretation and Implementation: 2. Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed . 8. Wash your hands after removing gloves . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Handwashing/Hand Hygiene Policy with a revised/reviewed date of 10/2024 that was provided by the LNHA revealed: Policy Statement: The facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 5. Employees must wash their hands for at least 20 seconds using antimicrobial or non-microbial soap and water under the following conditions: f. after handling soiled or used linens, dressings, bedpans, catheters, and urinals; u. after removing gloves or aprons; and v. after completing duty . 7. Hand hygiene is always the final step after removing and disposing of PPE . On 1/10/25 at 11:45 AM, the survey team met with the LNHA, DON, Infection Preventionist Nurse, Registered Dietician, Rehab Director, Regional DON, Activity Director, MDS/Lead Registered Nurse, and ADON for an exit conference, and the facility did not provide additional information. 39399 2. On 1/6/25 at 12:06 PM, during the initial tour on the 1st floor, the surveyor observed a nebulizer (neb) machine (a small machine that creates a mist out of liquid medication, allowing for quicker and easier absorption of medication into the lungs) with black substance around it, and was next to the garbage can inside the resident's room. On 1/6/25 at 12:10 PM, the surveyor showed the neb machine to the Licensed Practical Nurse (LPN) who stated she was not aware who the neb machine belonged to. The LPN further stated to the surveyor that the neb was soiled and was not supposed to be placed on the floor. On 1/8/25 at 1:20 PM, the survey team met with the LNHA, AA and DON to discuss the above concern. The LNHA acknowledged that the neb machine was not supposed to be on the floor. There were no further information provided. NJAC 8:39-19.4(a)(1),(l,n)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 46889 REPEAT DEFICIENCY Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to ensure resident call devices were within reach of the residents for 1 of 35 sampled residents (Resident #79). This deficient practice was evidenced by the following: On 1/8/2025 at 9:21 AM, the surveyor observed Resident #79 lying in bed with the call bell tied to the right side rails out of the resident's reach. The Licensed Practical Nurse (LPN#1) stated that the call device should be within the resident's reach. On 1/8/25 at 12:36 PM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #79, which revealed the following: A review of the Admission Record (an admission summary) reflected that Resident #79 was admitted with diagnoses that included but were not limited to a non-displaced fracture of the anterior wall of the left acetabulum (a break in the hip socket, which is part of the pelvis) subsequent encounter for fracture with routine healing, and unspecified fall subsequent encounter. A review of the recent significant change status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) (the last day of the observation period) of 10/10/24 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had an intact cognition. A review of the Care Plan revealed a Focus area of Risk for Falls related to impaired balance. Interventions included, but were not limited to, making sure the call light was within reach. On 1/10/2025 at 9:15 AM, the surveyor observed Resident #79 lying in bed with the call bell on the floor. The call device was out of the resident's reach. The surveyor interviewed LPN #2, who was outside the resident's room and stated that the call bell should not be on the floor. LPN #2 picked up the call device from the floor and clipped it to the resident's bedsheet. On 1/10/25 at 9:30 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) to discuss the above concern regarding the call bell not being within reach of the resident. The LNHA stated that it should be clipped to the resident's bed sheets, but if not, it could fall on the floor. The LNHA added that the call bell should not be tied to the side rails; otherwise, the resident cannot reach it. A review of the Answering the call light policy with a revised procedure dated 10/2024 under General Guidelines 5. When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-29.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48781 Complaint #NJ172916 Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a safe, functional, sanitary, and comfortable environment in 1 of 1 laundry room in accordance with the facility procedures. This deficient practice was evidenced by the following: On 1/10/25 at 8:40 AM, Surveyor #1 (S#1) toured the laundry area on the 1st floor and there were four staff. The surveyor observed the folding area for personal clothing with two personal cellphones on top of the clean folded clothing and there was a radio/cassette recorder on top of the clean folded linens and incontinent pads (cloth). On that same date and time, during the tour with the Housekeeping Aide (HA), the surveyor observed used gloves on top of personal clothing washer, white gown, face towel, linen on the floor next to a big washer. There was an accumulation of grayish substances on the floor and dried brownish substances, as per the HA, the floor was dusty and was not sure about the brownish discoloration on the floor, and the white gown, face towel, and the linen on the floor next to the washer were considered dirty and were separated from other dirty laundry earlier when the washer was loaded. At that same time, the HA informed the surveyor that there were only two of washers and dryers that were operational, the one dryer was broken more than a month and will be replaced soon, and the other broken dryer had been broken for months and unable to state how long. On 1/10/25 at 8:49 AM, S#1 and the Environmental Services Director (ESD) went back to the laundry area. The surveyor asked about the cassette recorder/radio near the clean folded linens, and he stated that it should not be there and asked the laundry staff to remove it. He also stated that the personal cellphones should not be placed near the folded personal clothing, and he asked the staff to remove it. At that same time, in the dirty area of the laundry, the used gloves which were on top of the washer were removed by the ESD and stated that it should have been discarded to garbage. The HA confirmed to the ESD that the gown, face towel and linen were considered dirty; the ESD stated that they should not have been on the floor. Furthermore, S#1 asked the ESD if there were issues or concerns about overflowing dirty laundry in the residents' rooms that he was aware of. The ESD responded yes, there were concerns because some of their washers and dryers were broken and that he had requested new machines. The surveyor asked for the order requisition slips and for any complaints and he said he will get back to the surveyor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 9:00 AM, The ESD provided to the Surveyor #2 (S#2) an invoice dated 4/9/24 which revealed a repair for laundry equipment. The Licensed Nursing Home Administrator (LNHA) and the ESD confirmed of laundry issues. The ESD provided an additional invoices which revealed laundry equipment repairs have been ongoing since 3/31/23 to the current date. On 1/10/25 at 9:01 AM, S#1 interviewed the LNHA and notified of the concerns in the laundry area and what ESD stated regarding the broken machines. S#1 asked the LNHA if there were grievance for overflowing laundry that she remembered and she stated yes. The LNHA further stated that the Resident Representative (RR) complained, and we did not know that were supposed to do laundry and we said sorry. S#1 asked the LNHA what was the responsibility of the facility if the nurses, Certified Nursing Assistants (CNAs), Housekeepers went to the residents' room every day and saw the overflowing laundry. The LNHA stated that the staff should had reported it and that there should be no overflowing laundry. S#1 asked if that was considered grievance that the RR complained about laundry, and the LNHA responded yes, and the surveyor asked for the copy of grievances for that overflowing laundry, and the LNHA stated that she would get back to the surveyor. On 1/10/25 at 10:00 AM, S#2 reviewed grievances for 2024, which was provided by the Director of Social Services. A grievance dated on 4/27/24 and 3/1/24 reflected concerns that the laundry basket were overflowing with dirty clothes. On 1/10/25 at 10:48 AM, S#2 requested from the LNHA for the most current facility Policy and Procedure for Laundry and Laundry Equipment Maintenance. On 1/10/25 at 11:09 AM, the LNHA responded, We have no policy on the laundry equipment maintenance. We fix the equipment as they come along. On 1/10/25 at 11:15 AM, the LNHA stated, We understand that older equipment breaks down, the organization has ordered new equipment but due to financial limitation at that time, we just fixed it, now we can have new machines. The overflowing laundry, the staff should be sending that laundry that were overflowing down to the laundry room. We will educate the laundry department with infection control, cell phone, soiled clothes with the clean towels. On 1/10/25 at 11:41 AM, S#2 interviewed the ESD, who stated, The left dryer is completely broken for five months now, not working, it keeps breaking. The right dryer has been broken since I came here. We are getting a new washing machine one dryer and one washing machine next week. On 1/10/25 at 11:47 AM, S#2 notified the LNHA, DON, Assistant Director of Nursing, Minimum Data Set/Lead Registered Nurse, Activity Director, Regional DON, Rehabilitation Director, Registered Dietician, and Infection Preventionist of the above concerns and findings. A review of the most current facility policy and procedure titled Laundry and Bedding, Soiled revealed, Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. A review of the facility's Policy and Procedure Maintenance Reporting, reviewed on 12/2024, that was provided by the LNHA revealed: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility maintains systems to report and resolve all maintenance related concerns, to sustain a safe and comfortable environment If the item is deemed unrepairable, Maintenance will tag the equipment, take it out of service, and will arrange to order new parts/equipment. NJAC-8:39-21.1(d)(e)(j), 31.2(e)

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on interview, and review of facility documentation, it was determined that the facility failed to ensure that a Certified Nurse Aide (CNA) received at least 12 hours of mandatory in-service training for 4 of 5 CNA education reviewed (CNA #1, CNA #2, CNA #3, and CNA #4). The deficient practice was evidenced by the following: On 1/9/25 at 1:26 PM, the surveyor reviewed the provided in-service education for five randomly selected CNAs for the [AGE] year, which revealed the following: CNA #1 with a date of hire (doh) on 11/15/21, had 1 hour and 50 minutes of in-service training from date of hire anniversary dates. CNA #2 with a doh on 7/15/23, had 5 hours and 55 minutes of in-service training from date of hire anniversary dates. CNA #3 with a doh on 11/2/23, had 8 hours and 20 minutes of education from date of hire anniversary dates. CNA #3 was on leave between 9/16/24 to 11/11/24. CNA #4 with a doh on 6/5/23, had 8 hours and 20 minutes of education from date of hire anniversary dates. On 1/9/25 at 1:54 PM, the surveyor interviewed the Assistant Administrator (AA) about CNA education. The surveyor asked who was responsible for CNA education. The AA stated that a new Assistant Director of Nursing (ADON) was hired in December 2024 and would be responsible for CNA education. The surveyor asked who was previously responsible for ensuring CNA education was completed. The AA replied she believed the LNHA was and that the LNHA could further speak about it. The surveyor discussed concern with the 4 of 5 CNAs reviewed not meeting the annual 12 hours of mandatory in-service training. The AA stated the facility was aware of the concern as a Quality Assurance Performance Improvement (QAPI) was initiated prior to the survey on 12/23/24 to address mandatory 12 hours of CNA education not being met by some of the staff. On 1/9/25 at 2:01 PM, the surveyor interviewed the LNHA about CNA education. The LNHA stated the previous ADON who was responsible for overseeing CNA education left in August 2024 and did not return. The surveyor asked who was responsible for oversight after the ADON left in August. The LNHA replied that the Director of Nursing (DON) and the LNHA would have been responsible. The surveyor discussed the concern for 4 of the 5 CNAs reviewed not having at least 12 hours of mandatory in-service education training. The LNHA acknowledged the concern of CNA in-service training not being met. The LNHA stated an audit was done and a QAPI initiated at the end of December as it was found that the staff were not meeting the 12 hours of in-service training requirements. On 1/10/25 at 11:15 AM, the surveyor notified the LNHA, DON, and AA about the concern for 4 of the 5 CNAs reviewed who did not complete at least 12 hours of mandatory in-service training. The LNHA acknowledged the concern. (continued on next page)

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	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Post Acute Care of 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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no additional information provided by the facility. A review of the facility's Staff Education, dated August 2024. The policy revealed the following: 2. The facility will ensure that nurses aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, identified through resident assessment, and described plan of care . 6. Staff will demonstrate competency with the following training requirements including: preventing and reporting abuse neglect, and exploitation, dementia management, and infection control . 11. The amounts and types of training will also be based on the facility assessment. N.J.A.C. 8:39-43.17(b)