STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Rehabilitation & Healthcare at Washington	378 Fries Mill Road Sewell, NJ 08080

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 37547 Complaint #NJ172198 Based on interview, review of the medical record and other pertinent facility documentation, it was determined that the facility failed follow their policy to develop and implement a person-centered, comprehensive baseline care plan within 48 hours of a resident's admission. This deficient practice was identified for 1 of 35 residents (Resident #154) reviewed for baseline care plan implementation. This deficient practice was identified by the following: Refer to F684 A review of Resident #154's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: Paroxysmal atrial fibrillation (abnormal heart beat), pseudocyst of pancreas (a large gland behind the stomach with development of a collection of leaked pancreatic fluids), cognitive communication deficit, anemia (lack of healthy red blood cells to carry oxygen through the blood), dizziness and giddiness, need for assistance with personal care. A review of Resident #154's Admission Minimum Data Set (MDS), an assessment tool, revealed that the assessment tool remained in progress and was not yet completed due to the resident's short length of stay at the facility prior to hospitalization (less than 14 days). During the review of Resident #154's electronic health record (EHR) and closed record on 09/19/24 at 9:36 AM, the surveyor requested a copy of the resident's care plan. On 09/19/24 at 11:28 AM, the Director of Nursing (DON) provided the surveyor with Resident #154's Care Plan (CP) which was printed on a single page dated 03/08/24, and only listed one Focus of: I am at risk for malnutrition [sic.] r/t (related to) chronic disease, recent hospitalization , h/o (history of) poor intake with wt loss PTA (prior to admission). The entry listed goals and interventions that pertained to the resident's food intake, weight, diet, and laboratory values. There were no other Focuses, Goals or Interventions/Tasks identified for the resident's plan of care. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 09/19/24 at 11:41 AM, the DON stated that she was only able to view the one page, and something was not right. The DON stated that she had put a call out. When the surveyor informed the DON that both the EHR and the closed record were reviewed and the CP only consisted of a single entry on page 1 (one) of 1, she stated that the nurse or the unit manager was supposed to do the baseline CP upon admission. The DON further stated that the baseline CP was supposed to identify if the resident was at risk for falls, skin, adls (activities of daily living), pain and whatever other diagnosis the resident had. A review of the facility policy, Care Plans-Baseline (Revision Date March 2022) revealed the following: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of the admission. .The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for resident including, but not limited to the following: Initial goals based on admission orders and discussion with the resident/representative; Physician orders; Dietary orders; Therapy services; Social services; . The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. .The resident and/or representative are provided with a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: The stated goals and objectives of the resident; A summary of the resident's medications and dietary instructions; Any services or treatments to be administered by the facility and personnel acting on behalf of the facility; and Any updated information based on the details of the comprehensive care plan, as necessary. Provision of the summary to the resident and/or resident representative is documented in the medical record. NJAC 8:39-11.2(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 37547 Complaint #NJ172198 Based on interview, record review, and review of other pertinent documentation, it was determined that the facility failed to ensure that a resident was provided with a discharge summary and post discharge instructions to ensure a safe and effective transition of care for 1 of 2 closed records (Resident #155) reviewed for appropriate discharge planning. This deficient practice was evidenced by the following: A review of Resident #155's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to: Encounter for surgical aftercare following surgery on the digestive system, acute cholecystitis (gallbladder inflammation), protein-calorie malnutrition, dysphagia, unspecified (difficulty swallowing food or liquids), acquired absence of other specified parts of the digestive tract, cognitive communication deficit, difficulty in walking, muscle weakness (generalized), and a need for assistance with personal care. A review of Resident #155's Admission Minimum Data Set (MDS), an assessment tool, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated that the resident was moderately cognitively impaired. Further review of the MDS included skin and ulcer/injury treatments which included: surgical wound care. A review of Resident #155's Order Listing Report included the following physician's orders (PO): 1. On 03/06/24 an order was written to: Change choleycystectomy (surgical removal of the gallbladder) dressing 2 (two) x/week and PRN (as needed) for soilage and lifting. Cleanse the skin around catheter with NSS (normal saline (salt in water) solution), pat dry. Place drain gauze and cover with tegaderm (transparent) dressing. Do cover with plastic wrap when showering every shift every Mon (Monday), Fri (Friday) for Chole Drain Tube Care. 2. On 03/07/24, an order was written that specified: Choleycystectomy: Empty choleycystectomy bag every shift and as needed for Choleycystectomy care. 3. On 03/07/24, an order was written to: Flush the choleycystectomy catheter daily with 5 cc (cubic centimeters, a unit of measurement equal to one milliliter) of NSS if drainage is slowing down (less than 10 ml) 1. Disconnect the catheter from the drainage bag 2. Clean the end of the catheter with an alcohol wipe 3. Connect syringe to catheter 4. Flush slowly with NSS, then pull back on the syringe plunger so that content comes back into syringe and discard contents 5. Clean ends with alcohol wipe and reconnect catheter to drainage bag every evening shift for Chole Drain/Tube Care. 4. On 03/07/24, an order was written to: Notify MD (Medical Doctor) if s/sx (signs and symptoms) of infection, complication or no output (the amount of drainage). The drain should stay in place for at least 6 (six) weeks or until F/U (follow up) appointment every shift for Choleycystectomy Care. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. On 03/06/24, an order was written to: Record choleycystectomy drainage output BID (twice daily); send output record to follow up appointment every day and evening shift for output. A review of Resident #155's Treatment Administration Record (TAR) revealed an entry dated 03/06/24 at 0700 (7:00 AM) for Ostomy (an artificial opening in an organ of the body, created during an operation) teaching with patient every shift and as needed every shift for Choleycystectomy care. A review of the resident's electronic health record (EHR) revealed that there was no documented evidence within the progress notes to indicate that resident verbalized understanding or demonstrated competency of the teaching that was provided. A review of the Social Services Assessment (SSA) and Documentation note that was dated 03/06/24 at 12:58 PM, revealed that the resident's discharge plan was to return to the community in the care of his/her family member, an identified health care proxy at their home. A review of the Progress Notes revealed a Physician/Practitioner Progress Note dated 03/15/24 at 9:34 AM, which detailed .Patient seen and examined this morning resting comfortably in bed. Appears non-toxic, NAD (no apparent distress), VSS (vital signs stable). Pt denies any issues at this time .Pt slated for dc (discharge) this day, SW following, durable medical equipment (DME) to be delivered to patient today as per notes. DC scripts on chart. No further issues reported by pt or nursing at this time . During an interview with the surveyor on 09/17/24 at 10:18 AM, Licensed Practical Nurse (LPN) #2 stated that social work was involved in the discharge process. LPN #2 stated that nursing did the teaching for wound management and the facility used home care services to follow-up in the resident's home. LPN #2 stated that either nursing or the Unit Manager did the discharge instructions and printed a copy out for both the nurse and the resident to sign to indicate that the resident was in receipt of the instructions. LPN #2 stated that nursing was also required to document any teaching that was provided during review of the discharge instructions in the progress notes. During an interview with the surveyor on 09/17/24 at 10:40 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that typically, a care conference was held with both the resident and their family to discuss discharge planning. The LPN/UM stated that education for wounds or drainage tubes care would be set up and care planned for the family to come in closer to discharge to learn how to perform the procedures at home. The LPN/UM stated that the nursing staff should have provided education on wound care and other applicable treatments such as dressing changes, emptying the drainage tube and how to look for signs and symptoms of infection. The LPN/UM stated that it should have been documented in a progress note if it were done with the family. The LPN/UM stated that nursing was required to give the discharge instructions to the resident or their family who then signed the last page of the instructions. The LPN/UM stated that they were then provided with a copy to take home. The LPN/UM stated that there should be a progress note documented on the last day to indicate that the resident was discharged from the facility with any medical equipment that was ordered. The LPN/UM stated that after the prescriptions and discharge instructions were reviewed, nursing should then document that all questions were answered at that time. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 09/17/24 at 11:43 AM, the Director of Nursing (DON) stated that she would have expected for training and education to be done by the nurse for wound treatments and tube care. The DON stated that the training should have been documented in the progress notes. The DON stated that she thought that social work held a meeting and had the family come in for training. The DON stated that either the nurse or unit manager reviewed the discharge instructions with the patient or family if the resident were not able, and they were given a hard copy to take home. During an interview with the surveyor on 09/17/24 at 12:31 PM, the Director of Social Services (DSS) stated that she had not sent anyone home with a biliary drainage tube (choleycystectomy drainage tube) before. She stated if she did, it would have been through their home health. The DSS stated that she recalled Resident #155, and she did not recall if there was an initial meeting. The DSS stated, It looks like we did not to have time for an official meeting, a team meeting, or care conference meeting. The DSS further stated that it was just a bunch of calls with the resident's family member who wanted the resident to be discharged back to his/her home by the end of the week. The DSS stated that she had to scramble to put everything together and that she did not remember what services were ordered for home care which depended on the prescription that was provided by the doctor. On 09/17/24 at 1:38 PM, the surveyor received Resident #155's closed record after multiple requests to view the record on that date. The surveyor reviewed a copy of the prescriptions that that were dated 03/14/24 and were written by the PA. Further review of the prescriptions revealed that there was no documented evidence that the resident was provided with a prescription for the care of the choleycystectomy drainage tube site for dressing changes, emptying and recording of drainage output, or flushing of the drainage tube with NSS as indicated in the physician's orders and that were reflected on the resident's MAR/TAR. Further review of Resident #155's closed record revealed an IDT: Discharge Instructions and Summary form, dated 03/15/24 with an effective time of 08:10 AM, which was electronically signed by LPN #4 on 03/15/24. The surveyor observed a hand written note that was documented beneath LPN #4's electronic signature which revealed the following: This nurse completed the discharge instructions with the patient, he/she verbalized understanding and all questions were asked and answered at the time of discharge. The DON who was present at that time, confirmed that the signature of the handwritten entry belonged to the LPN/UM. During an interview with the surveyor on 09/18/24 at 10:18 AM, the surveyor showed LPN #4 a copy of Resident #155's discharge instructions and asked LPN #4 to explain why his signature was electronically signed on the document, but there was no documented evidence within the progress notes to suggest that LPN #4 reviewed the instructions with the resident. LPN #4 stated that if he worked nights he may have started the discharge instructions, but someone else may have given it to the resident. LPN #4 stated that the resident was then supposed to sign the discharge instructions and a copy of it was placed in the resident's chart. There was no resident signature noted to indicate resident receipt of the discharge instructions as previously described by LPN #4. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 09/18/24 at 10:27 AM, the LPN/UM stated that it was her expectation that a resident signature were obtained when the discharge instructions were provided. The LPN/UM confirmed that her signature was on the discharge instructions. The LPN/UM stated that she may have called the resident to confirm that the resident received the instructions the day after discharge. When the surveyor asked the LPN/UM why she did not document the date and time on the discharge instructions beside her signature she stated, After it was brought to your attention yesterday that the resident may or may not have received his/her discharge information, she conferred with LPN #4 who stated that he did give the resident the instructions and the resident understood them. She stated that she did not date the discharge instructions or write a note in the computer because the resident was already discharged . The LPN/UM stated, It was brought to my attention yesterday that I needed to find out if the the nurse provided the discharge instructions to the resident. The LPN/UM further stated, I was asked to document whether the resident received them. There was no documented evidence within the EHR or the closed record to indicate that Resident #155 or their responsible party received a copy of the discharge instructions prior to the resident's discharge. A review of the facility policy, Transfer and Discharge (including AMA (against medical advise) (Reviewed and Revised on 07/10/24) revealed the following: .Anticipated Transfers or Discharges-resident-initiated discharges. Obtain physicians' orders for transfer or discharge and instructions or precautions for ongoing care. A member of the interdisciplinary team completes relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following: A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results. A final summary of the resident's status. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). A post-discharge care plan that is developed with the participation of the resident, and the resident's representative (s) which will assist the resident to adjust to his or her new living environment. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team. .The comprehensive, person-centered care plan shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Supporting documentation shall include evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge plan, and documented discussion with the resident and/or resident representative. NJAC 8:39-5.4 (a) (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. 37547 Complaint #NJ168202 and NJ172198 Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to a.) document a physician notification in response to a resident's change of condition, b.) obtain an order for supplemental oxygen use, c.) obtain an order to send the resident to the hospital, d.) document a Registered Nurse (RN) assessment, and e.) document a resident's clinical status after the resident was sent to the hospital in accordance with professional standards. This deficient practice was identified for 1 of 2 residents (Resident #154) reviewed for change in condition. This deficient practice was evidenced by the following: Refer to F655 The surveyor reviewed the closed Electronic Health Record (EHR) of Resident #154 and noted a Health Status Note within the Progress Notes (PN) that was written by Licensed Practical Nurse (LPN #2) on 03/14/24 at 14:25 (2:25 PM) which revealed, Patient received in bed with eyes opened, easily aroused. Able to make all needs known. Requires on person assist with care and transfer. Continent of bowel and bladder. vitals stable. oxygen 87% apply oxygen via nasal cannula (plastic tubing inserted into the nostrils to delivery oxygen). no slurred speech noted. Resident daughter talked to one of the staff, request resident to send out 911 for slurred speech. Patient was seen and assessed by . the Registered Nurse/Infection Preventionist (RN/IP), neuro check normal. 0930 (9:30 AM) 911 transported resident to emergency .There were no additional progress notes within the resident's EHR that detailed the resident's status after the resident was transferred to the hospital via 911. A review of Resident #154's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: Paroxysmal atrial fibrillation (abnormal heart beat), pseudocyst of pancreas (a large gland behind the stomach with development of a collection of leaked pancreatic fluids), cognitive communication deficit, anemia (lack of healthy red blood cells to carry oxygen through the blood), dizziness and giddiness, need for assistance with personal care. A review of Resident #154's Admission Minimum Data Set, an assessment tool, revealed that the assessment tool remained in progress and was not yet completed due to the resident's short length of stay at the facility prior to hospitalization (less than 14 days). A review of Resident #154's Order Listing Report (OLR) failed to include an order to apply oxygen via nasal cannula to the resident or to send the resident to the hospital via 911. Further review of the OLR revealed a physician's order for: Vital signs. Notify MD/NP (Medical Doctor/Nurse Practitioner) if temp >100.4 every shift for New/Re-Admission for 100 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 09/17/24 at 10:08 AM, LPN #2 stated that if a family member expressed a concern about a resident, she told the Unit Manager (UM) and called the doctor. LPN #2 stated that she would have reassured the family that the resident could go to the hospital but would first assess the resident and then call the doctor for further orders. At that time, the surveyor read Resident #154's Health Status Note aloud that was written by LPN #2 on 03/14/24 at 2:25 PM. LPN #2 stated that she did not recall the resident but remembered the note. LPN #2 stated that she should have written the vital signs down. LPN #2 stated that we always called the doctor and were given a prn (as needed) order for oxygen. LPN #2 stated that we might have forgotten to write the order and include it in our note, but we always called the doctor if we have a pulse ox (pulse oximetry, a probe that is placed on the finger to detect the oxygen level in the blood) of 87% (normal parameters are between 95-100%). LPN #2 stated that the RN/IP should have written a note when she did a neurological assessment on the resident. When the surveyor asked how frequently vital signs (blood pressure, pulse oximetry, pulse, heart rate, and respirations) were performed on the subacute unit LPN #2 stated, every shift. The surveyor reviewed Resident #154's Weights and Vitals Summary and noted that Resident #154's vital signs were last recorded on 03/13/24 at 20:38 (8:38 PM) which failed to contain a pulse oximetry level, only a blood pressure pulse, and temperature were recorded. The resident's last recorded pulse oximetry level was recorded on 03/13/24 at 13:10 (1:10 PM) and was 97% on room air. During an interview with the surveyor on 09/17/24 at 10:23 AM, the Licensed practical Nurse/Unit Manager (LPN/UM) stated that she would have responded to a family member's concern about the resident's condition by evaluating the resident's vital signs, doing a stroke assessment and go from there. The LPN/UM stated that if the resident's pulse ox level was 87%, she would first reposition the resident to see if that were a factor, then place the resident on oxygen, and phone the doctor to obtain orders and go forward from there. The LPN/UM stated that typically, if we only do one neurological assessment we write the outcome in a progress note. The LPN/UM stated that if a Registered Nurse (RN) assessed the resident, I would expect the RN to document her own findings, not second hand. The LPN/UM stated that the doctor gives the order to send the resident out for further evaluation or if further interventions were warranted here at the facility. The LPN/UM stated that the nurse should have phoned the hospital to follow up on the resident's status and possible return. At that time, the LPN/UM reviewed Resident #154's Health Status Note that was written by LPN #2 in the presence of the surveyor. The LPN/UM stated that vital signs were required to be done every shift and I would have expected to see them documented every shift or in the progress notes. The LPN/UM stated that she did not see an order for oxygen in the medical record. The LPN/UM further stated that it was her expectation that the doctor would have been notified and an order obtained to send the resident to the ER. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 09/17/24 at 10:50 AM, the Registered Nurse/Infection Preventionist (RN/IP) stated that if she were asked to do a resident assessment, she would do an assessment from head to toe and if no apparent neurological symptoms were noted, she would reach out to the physician no matter what. The RN/IP stated that she would document in the EHR in the notes about what occurred, and what we did, and document that the provider was called, and send the resident to the hospital if an order was given, after the doctor were notified of our assessment findings. The RN/IP stated that she would tell the LPN to document and then follow up with her own documentation. When the surveyor reviewed the documentation aloud to the RN/IP she stated, I did not do a follow-up note? The RN/IP further stated that she normally would do a follow-up note. The RN/IP reviewed the resident's orders and stated that she did not see an order to discharge the resident to the hospital or to place the resident on oxygen, but she would have expected to see orders to send the resident out to the hospital and to place the resident on oxygen. The RN/IP stated that she did not see any vital signs documented that coincided with the incident on 03/14/24. The RN/IP stated, It appears the resident was sent out to the hospital and received oxygen without an order. The RN/IP stated that there was nothing in the progress note that was written by LPN #2 that said the doctor was notified, and there was no order. The RN/IP further stated, If not documented, it was not done. During an interview with the surveyor on 09/17/24 at 11:24 AM, the surveyor asked the DON if it were permissible for a LPN to document an RN assessment in the progress notes, rather than the RN writing a narrative to detail the assessment herself? The DON stated, If the LPN wrote the note, I think that would be okay. When asked if an order were required to send a resident to the hospital the DON stated, Do we always write the order? We send them, and let the doctor know afterward, they do not always put the order in. The DON further stated that she did not know if it was required. The DON stated, Just because you did not document it, does not mean you did not do it. The DON stated that it sounded like LPN #2 wrote the RN/IP's note. When the DON was asked if the nursing staff were required to call the hospital to follow-up on the resident's status and document the resident's condition, she stated they normally called the hospital and checked on their status and documented what that status was. The surveyor asked the DON how frequently vital signs were required to be done on the subacute unit? The DON responded, Vital signs were done every shift, but it depends. The DON stated that if a resident presented with slurred speech and or shaking, they should have definitely been monitored, but it was not necessary to do vital signs every shift. The DON further stated, they are supposed to do vital signs every shift for five days, I think that is what it is here. On 09/18/24 at 12:35 PM, the surveyor reviewed the closed record of Resident #154 and noted a handwritten interim telephone order dated 03/14/24, that was written by the LPN/UM which indicated, Send pt to ED for eval r/t (related to) slurred speech. The order was not found within the EHR. During an interview with the surveyor on 09/18/24 at 1:04 PM, the surveyor asked the LPN/UM in the presence of the survey team to explain why the handwritten interim order dated 03/14/24 to Send patient to the ED for eval r/t slurred speech was not found within Resident #154's EHR? The LPN/UM stated, I wrote the order today, I mean on 03/14/24. The LPN/UM then stated that the receptionist discharged the resident out of the system as soon as the resident left the building and I had to call the doctor for a verbal order to send the resident out via 911. The LPN/UM clarified that all orders to send the resident to the hospital should be written while the resident were still in the building. The LPN/UM explained that the EHR could not be accessed once the resident was discharged from the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 09/18/24 at 1:35 PM, the Receptionist stated that she logged the resident into the LOA (leave of absence) book and into the EHR once they passed the Receptionist Desk with 911. The Receptionist stated that she did not discharge or remove the resident from the EHR until she received confirmation that the resident was not coming back to the facility. A review of the facility policy, Resident Examination and Assessment (Revision date February 2014) revealed the following: .Documentation: The following information should be recorded in the resident's medical record: The date and time the procedure was performed. The name and title of the individual (s) who performed the procedure. The assessment data obtained during the procedure. How the resident tolerated the procedure. .The signature and title of the person recording the data. .Reporting: .Notify the physician of any abnormalities such as, but not limited to: abnormal vital signs .change in cognitive, behavioral or neurological status from baseline; A review of the facility policy, Vital Signs (Reviewed/Revised 04/02/24) revealed the following: The purpose of this policy is to provide guidelines for the measurement and reporting of vital signs: Definition: vital signs are indicators of health status, including temperature, pulse, blood pressure, respiratory rate, oxygen saturation, and pain. Licensed nurses are responsible for knowing the usual range of a resident's vital signs, analyzing and interpreting routine vital signs, and notifying the physician of abnormal findings. Oxygen saturation and pain are to be obtained and interpreted by licensed nurses. Vital signs shall be obtained at least in the following circumstances: .At least daily for a resident receiving skilled services. When the resident's general condition changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Oxygen saturation is assessed for residents requiring oxygen at intervals specified by the physician . A review of the facility policy, Change in a Resident' Condition or Status (Revision date February 2021) revealed the following: Policy Statement: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of the changes in the resident's medical/mental condition and/or status . The nurse will notify the resident's attending or physician on call when there has been a (an): .significant change in the resident's physical/emotional/mental condition; .Need to transfer the resident to a hospital/treatment authority; and/or discharge without proper medical authority; and/or Specific instruction to notify the physician of changes in the resident's condition. A review of the facility policy: Charting and Documentation (Revision July 2017) revealed the following: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. .The following information is to be documented in the resident medical record: Objective observations; .Changes in the resident's condition; .Documentation of procedures and treatments will include care-specific details, including: .notification of family, physician or other staff, if indicated; . A review of the facility policy, Verbal Orders (Revision February 2014) revealed the following: .The practitioner will review and countersign verbal orders during his or her next visit. NJAC 8:39-27.1 (a), 13.1(d), 35.2(d)(16), 35.2(e), 35.2(g)(3)(i-iv)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41260 Based on interview, record review, and review of facility documents, it was determined that the facility failed to address recommendations from the Wound Care Consultant in a timely manner for 1 of 1 resident (Resident #74) reviewed for pressure ulcers. This deficient practice was evidenced by the following: On 09/15/24 at 9:54 AM, the surveyor observed Resident #74 lying in bed. The resident stated he/she had a wound. According to the Admission Record, Resident #74 had diagnoses which included, but were not limited to, pressure ulcer of sacral region, diabetes mellitus type 2, paraplegia, and morbid obesity. Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 08/23/24, included the resident had a Brief Interview for Mental Status score of 15, which indicated the resident's cognition was intact. Further review of the MDS included the resident had a pressure ulcer that was present on admission to the facility. Review of the Care Plan included a focus, initiated 11/16/23, that the resident had actual skin breakdown with interventions for treatments as ordered, and, Wound Care Consultant as ordered. Review of the Wound Care Consultant (WCC) report, dated 08/28/24, included the resident was seen for a sacral pressure ulcer which measured 0.1x 0.1x 0.1 centimeters (cm) and was improving. Further review of the WCC report included recommendations for a collagen treatment (a wound dressing that promotes healing). Review of the WCC report, dated 09/04/24, included the resident was seen for a subsequent visit for the sacral pressure ulcer which revealed the wound progress had no change. Further review of the WCC report included a recommendation for a collagen treatment. Review of the WCC report, dated 09/11/24, included the resident was seen for a subsequent visit for the sacral pressure ulcer which revealed the wound progress had no change, and the WCC again recommended a collagen treatment. Review of the September 2024 Treatment Administration Record (TAR) included a treatment order to, Cleanse sacrum wound with NSS [normal saline solution] and pat dry. Pack wound with collagen and CDD [clean dry dressing] and PRN [as needed] for soilage every Day Shift for Wound Care for 7 days, with a start date of 08/30/24 and an end date of 09/05/24. Further review of the September 2024 TAR did not include a collagen treatment order for the sacral wound from 09/06/24 through 09/16/24. Review of the September 2024 Progress Notes did not include any documentation related to the WCC recommendations, wound treatment re-evaluation, or notification to the physician for new wound treatment orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 09/17/24 at 10:52 AM, Licensed Practical Nurse (LPN) #1 stated the WCC would come to the facility weekly and pass on any recommendations to the floor nurse or Unit Manager (UM). The LPN further stated that recommendations should be addressed within 24 hours to prevent any delay in resident care. The LPN also stated that for treatment orders that contained a duration, the floor nurse assigned on the day the treatment ended would have to document on the wound condition and notify the physician for treatment orders if needed. When asked about Resident #74, the LPN stated she was assigned to the resident, but that the resident did not have a treatment order for a sacral wound. During an interview with the surveyor on 09/17/24 at 12:17 PM, the Registered Nurse/Unit Manager (RN/UM) stated that the UMs would conduct wound rounds with the WCC weekly and would be immediately notified of any new wound treatment recommendations. The RN/UM further stated that recommendations were implemented as soon as wound rounds were completed to prevent a delay in resident care. The RN/UM also stated that for treatment orders that contained a duration, the UM would re-evaluate the resident's wound to determine if a new wound treatment needed to be ordered. When asked about Resident #74, the RN/UM reviewed the resident's medical record and confirmed the resident did not have a collagen treatment order for the sacral wound. The RN/UM then reviewed the WCC reports and verified the WCC recommended a collagen treatment for the sacral wound on 09/04/24 and 09/11/24. The RN/UM stated she had only been the UM for two weeks, but that it was still her responsibility to ensure the WCC recommendations were addressed. During an interview on 09/17/24 at 1:13 PM, the Director of Nursing (DON) stated the WCC would come to the facility weekly on Wednesdays and the facility would receive the WCC recommendations the following day. The DON further stated it was important to address the WCC recommendations timely to provide the best wound care for the resident. At that time, the surveyor informed the DON of Resident #74's WCC recommendations that were not addressed, and the DON stated that the UM or the floor nurse should have addressed the recommendations and that if the resident was supposed to receive a wound treatment, there should be a treatment order in place. During an interview with the surveyor on 09/18/24 at 8:43 AM, the WCC stated she comes to the facility weekly on Wednesdays and makes recommendations for wound treatments. The WCC explained that before she leaves the facility, she discusses all resident recommendations with the DON and UM in an exit meeting. The WCC stated that if the facility was not going to follow her recommendations, she would expect the facility to notify her of the reasoning. When asked about Resident #74, the WCC stated she discussed her recommendations with the DON and UM on 09/11/24 prior to leaving the facility and that she never received notification that the treatment was not ordered. Review of the facility's Pressure Injuries Overview policy, revised 03/2020, did not include the facility's policy related to the WCC or their recommendations. Review of the facility's Medication and Treatment Orders policy, revised 07/2016, did not include re-evaluation of wound treatments with a duration. 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. 40041 Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure a resident's medication times were adjusted to accommodate their dialysis schedule for 1 of 1 resident (Resident #57) reviewed for dialysis. This deficient practice was evidenced by the following: On 09/15/2024 at 9:54 AM, Resident #57 was observed sitting in his wheelchair with his eyes closed. A review of the Electronic Medical Record revealed Resident #57 was admitted to the facility with diagnoses including but not limited to, Acute Kidney Failure, Chronic Kidney Disease, Dependence on Renal Dialysis. A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 08/07/24, revealed a Brief Interview for Mental Status score of 10/15, indicating Resident #57 has moderately impaired cognition. The MDS further revealed Resident #57 received dialysis while a resident at the facility. A review of the Physicians Orders (PO)revealed the following; PO dated 8/3/24 Dialysis treatment (3) times a week on (: Tue [Tuesday], Thu [Thursday], Sat [Saturday] at 5 AM. A further review of the physician's order revealed the following orders: Change medication and treatment timing from facility's medication and treatment administration time to accommodate hemodialysis treatment. PO dated 7/31/24 Insulin Lispro-aabc injection Inject as per sliding scale: if 151-200 = 2 unit call MD if BS less than 70/greater than 400; 201-250 = 4 unit; 251-300 = 6 unit; 301-350 = 8 unit; 351-400 = 10 unit subcutaneously before meals for BS (blood sugar). A review of the Medication Administration Record (MAR) revealed the following administration times for Insulin Lispro sliding scale, 4:00 AM, 7:30 AM, 12:00 AM, and 5:30 PM. The Physician order and MAR did not indicate the days and times in accordance with Resident #57's dialysis schedule. A review of the Medication Administration Record (MAR) dated 9/1/2024-9/30/2024 revealed the physician order for Insulin Lispro There were nurses' initials and a check mark to indicate the blood sugar was checked at approximately 4:00 AM on the following dates that Resident #57 remained at the facility and was not scheduled for dialysis: Resident #57's accuchecks were not done at 730 AM on the mentioned days. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 09/18/2024 at 10:07 AM, the Unit Manager Registered Nurse #2 (UM/RN) stated that the resident goes to dialysis on Tuesdays Thursdays, and Saturdays at 5:00 AM and usually returns around lunchtime. She also stated that the accucheck were done at the incorrect time on 09/11/2024, 09/13/2024, 09/15/2024, 09/16/2024, and 09/18/2024 and it should have been done at 7:30 AM on those days that the resident was not scheduled for dialysis. The blood sugar levels on the above-mentioned days were below 150 mg/dl therefore the resident did not require Lispro insulin coverage. During an interview with the surveyor on 09/18/2024 at 12:42 PM, the Director of Nursing (DON) stated usually we call the doctor to get the medications around the time that the resident is in the building and we coordinate things with dialysis. Everything should be based around the time that he is in the building. Review of facility policy titled Administering Medications, dated April 2019 revealed, 4. Medications are administered in accordance with prescriber orders, including any required time frame. NJAC 8:39-27.1(a)

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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** 50913 Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner intended to prevent food borne illness. This deficient practice was evidenced by the following: On [DATE] from 9:19 AM until 10:00 AM, the surveyor observed the following in the presence of the Assistant Food Service Director (AFSD): 1. The AFSD turned on the faucet, wet her hands, applied soap to her hands, and lathered her hands with soap for a period of time too briefly to be counted, before she rinsed her hands under the running water, and dried her hands with a paper towel. The AFSD discarded the paper towel and obtained a second paper towel to turn off the faucet and then discarded it. 2. The oven was noted with heavy black soiling both inside the oven, on the outer ledge, and on the glass doors. The AFSD stated that, the cooks cleaned the oven two weeks ago, and that, the Food Service Director (FSD) just came down on us about cleaning the oven. When the surveyor asked for the cleaning schedule, the AFSD stated our paperwork went missing for the cleaning cycle, and, the new FSD has not started the new cleaning cycle yet. 3. The free-standing mixer was not covered. The AFSD stated that the mixer was cleaned the night prior and it should have been covered. 4. The deli slicer was not covered. The AFSD stated that the deli slicer was last used either Thursday, [DATE] or yesterday [DATE], and it was supposed to be covered. 5. The AFSD pulled the can opener out of the sheath when requested. The can opener had brown debris stuck on the top of the blade. The AFSD stated that the can opener was ran through the dishwasher the night prior. The AFSD then scraped the blade with her fingernail and returned the can opener to the sheathe that was mounted on the table in the food prep area. When asked what could happen if the blade were used to open a can with debris present on the blade, the AFSD stated that she did not know. Inside the walk-in refrigerator, the following was observed: 6. On the top of a three-tiered rack, an opened container of Apple sauce, that the AFSD stated contained less than a quart, was dated [DATE], and had no use-by date. The AFSD stated that it was good for three days. 7. On the bottom shelf of a three-tiered shelf, a two-quart container of chopped chicken dated [DATE], had no use-by date. The AFSD stated it was left over from the night prior and it should have a use-by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. A container of baked chicken was on the bottom shelf of a three-tiered rack and was dated [DATE] and had no use-by date. 9. An opened five-pound container of Cottage cheese, was on the top shelf of a three-tiered rack, had an opened date of [DATE]. The AFSD stated that it should have been used within three to five days and should have a use-by date. 10. Two pounds of sliced turkey deli meat, was on the second shelf of a four-tiered rack, was dated [DATE], and had no use-by date. In the walk-in freezer, the following was observed: 11. Ten pounds of pulled pork, was on the second shelf of a four-tiered rack, had a use-by date [DATE]. The AFSD stated that it should have only remained in the freezer for one year. The AFSD stated that weekly walk throughs were performed to ensure that foods were within date. 12. Two (2) five-pound boxes of pepperoni, were on the top shelf of a four-tiered rack and were dated [DATE]. The AFSD stated that it should have been discarded within one year. After returning to the kitchen from the trash area, the following was observed: 13. The surveyor observed the AFSD as she washed her hands for ten seconds. The AFSD stated handwashing should include lathering of the hands for 20 seconds and rinsing. The AFSD further stated that she determined that 20 seconds had passed by singing the happy birthday once. During an interview with the surveyor on [DATE] at 11:13 AM, the Registered Nurse/Infection Preventionist (RN/IP) explained the handwashing process, which included: Turn on water, wet hands, get soap, apply friction, wash hands, nails, wrists for at least 20 seconds, rinse hands, grab paper towels, dry, discard, then get another towel and turn off the faucet and discard that. The RN/IP stated, I do observations often on different departments, new hires, and kitchen staff. The kitchen staff are preparing food and you do not want bacteria to go into your food and make patients sick if they are not performing proper hand hygiene. The RN/IP further stated, It is very important that they wash their hands when they are handling food. During an interview with the surveyor on [DATE] at 11:48 AM, the Director of Nursing explained the handwashing process. She stated, We sing the alphabet song three times, so they go above and beyond. First, turn on water, then put soap on hands, wash hands and lather singing the song, get paper towel after rinse, dry hands off, take towel, place in trash, get another towel to turn the faucet off. The DON stated they are not properly washing their hands if they wash their hands for 10 seconds or less. The DON further stated, they get in-servicing and handwashing is something that we do. On [DATE] from 10:58 AM until 11:31 AM, the surveyor observed the following in the presence of the Food Service Director (FSD): (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. During the tray line service, the [NAME] placed a ladle (large, deep sppon) and a scooper directly on the prep counter of the steam table while she obtained food temperatures. The [NAME] then used the scoop to stir the food as she attempted to obtain food temperatures. The [NAME] then proceeded to hang the ladle on a hook that hung above the steam table. The [NAME] then placed the scoop into the spinach and used it to serve during the tray line service. 2. A Dietary Aide (DA) was observed as she washed her hands for 10 seconds. On [DATE] at 11:32 AM, during a later interview with the FSD he stated, He did not see a cleaning schedule, so he started one for accountability on Monday [DATE]. The FSD stated that the bowl mixer had a cover, but there was no requirement for either the bowl mixer or meat slicer to be covered. The FSD stated that the can opener should be cleaned after every use and should not have been placed back into the sleeve if it had debris on it. The FSD stated that his expectation for labeling and dating was for the item to be discarded within three days of the opened date, or the manufacturer's expiration date. The FSD stated that it was the Cook's responsibility to do a daily walk through, and he was surprised by the expired meat in the freezer. The FSD stated that once a ladle or scoop was placed on the counter it should have been replaced. The FSD stated that the DA may have missed the last handwashing in-service that was provided on Monday due to a call out. A review of the facility policy, Date Marking for Food Safety (Reviewed/Revised [DATE]) revealed the following: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food [sic.]. Refrigerated, ready-to-eat, time/temperature control for safety food [sic.] (i.e. perishable food) shall be held at a temperature of 41 F (Fahrenheit) or less for a maximum of 7 (seven) days. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as day 1 (one). (For example, food prepared on Tuesday shall be discarded on or by Friday). The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken a needed . A review of an undated facility policy, Steps that need to be taken when cleaning a conventional oven revealed the following: First the oven should be cleaned once it cools down after use if any spills occur. It should be clean [sic.] with proper oven cleaner with all racks removed. Let the oven cleaner sit for about thirty minutes, and then wipe away the grease and grime. The glass surfaces should be cleaned with soapy water using a soft cloth also a glass cleaner can be used. A review of the facility policy, Hand Hygiene (Reviewed/Revised [DATE]) revealed the following: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility. .Hand hygiene technique when using soap and water: Wet hand with water .Apply to hands the amount of soap recommended by the manufacturer, rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers, Rinse hands with water, Dry thoroughly with a single-use towel, Use clean towel to turn off the faucet. NJAC 8:,d+[DATE].2 (g), 19.4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315506	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Rehabilitation & Healthcare at Washington	378 Fries Mill Road Sewell, NJ 08080

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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. 40041 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) ensure hand hygiene was performed following medication administration, and b.) follow transmission-based precautions (TBP) to prevent the potential spread of infection by not utilizing personal protective equipment (PPE) for a resident on contact precautions for 1 of 2 residents (Resident #255) being observed during a medication observation. This deficient practice was evidenced by the following: On 09/16/24 at 8:12 AM, during a medication administration observation, the surveyor observed Licensed Practical Nurse (LPN) #3 enter Resident #255's room to administer medications. After the resident took their medication, LPN #3 took the empty medicine cup and drinking cup from the resident using her bare hands, discarded the cups, and exited the resident's room. LPN #3 proceeded to her medication cart and did not perform hand hygiene. Review of the Admission Record revealed Resident #255 had diagnoses including, but not limited to, parainfluenza (respiratory infection) virus pneumonia, chronic obstructive pulmonary disease with (acute) exacerbation, acute respiratory failure with hypoxia. A review of Resident #255's physician orders revealed an active physician order dated 9/6/24 at 5:49 PM for contact isolation secondary to MRSA (Methicillin-resistant staphylococcus aureus; a type of bacteria that's resistant to many antibiotics and can cause skin and serious infections) MDRGN (Multidrug resistant Gram-negative bacteria; bacteria resistant to multiple antibiotics.) There was no signage outside Resident #255's doorway indicating that he/she was on contact isolation. LPN #3 did not wear any PPE during the medication administration observation when entering Resident #255's room. On 09/17/24 at 09:38 AM during surveyor interview, the Licensed Practical Nurse/Unit Manager (LPN/UM) reviewed Resident #255's electronic medical record and confirmed there was an active order for contact isolation. The LPN/UM stated that when a resident was on contact isolation, PPE was set up adjacent to the resident's room and signage was placed outside of the doorway which indicated to any visitors to see the nurse prior to entry into the room. She continued by stating that the appropriate PPE should be donned prior to entering the resident's room. The LPN/UM also stated that hand hygiene should be performed prior to providing care, immediately after doffing PPE, and if contact is made with any soiled materials before, during, or after care. During surveyor interview on 09/17/24 at 11:20 AM, the Infection Preventionist (IP) stated, if the resident had an order for contact isolation, there should have been a sign posted on the door. During surveyor interview on 09/19/24 at 09:42 AM, the Director on Nursing (DON) stated her expectation was for staff to follow the contact isolation order. She continued by stating that if there was a discrepancy with the order it should have been clarified and/or discontinued. The DON also stated after surveyor inquiry, the medical director determined that contact isolation was no longer needed, and the order was discontinued. (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	A review of the facility policy Isolation- Initiating Transmission- Based Precautions, dated August 2019, revealed, Policy Interpretation and Implementation 2. Transmission-based precautions are utilized when a resident meets the criteria for transmissible infection AND the resident has risk factors that increase the likelihood of transmission. These may include (but are not limited to): a uncontrolled excretions/secretions; b. non- compliance with standard precautions; .3. When transmission-based precautions are implemented, the infection preventionist (or designee): a. clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used; .d. determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type pf precautions; (1) The signage informs the staff of the type of CDC [Center for Disease Control]precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room e. ensures that protective equipment (i.e. [example], gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment; .4. Transmission-based precautions remain in effect until the attending physician or infection preventionist discontinues them, which occurs after criteria for discontinuation are met. N.J.A.C 8:39-19.4(a)