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	315515	A. BUILDING _____ B. WING _____	08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

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F 000	INITIAL COMMENTS CENSUS: 30 SAMPLE SIZE: 15 + 4 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to investigate the root cause of a facility-acquired [NJ Exec. Order 26:4.b] [redacted] for 1 of 3 residents reviewed for facility-acquired [NJ Exec. Order 26:4.b.1] (Resident #12).	F 610	1. An investigation into the [NJ Exec. Order 26:4.b.1] on resident #12 [NJ Exec. Order 26:4.b.1] was completed. 2. All residents with potential for abuse can be affected by this practice.	8/20/21

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/25/2021

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.

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F 610	Continued From page 1 The evidence was as follows: During the initial tour of the facility on 8/2/21 at 11:38 AM, the surveyor observed Resident #12 in the small day room. The resident was seated in a [redacted] in the corner of the room and did not verbally respond when addressed by the surveyor. Resident #12 appeared calm and in no distress. On 8/2/21 at 1:43 PM, the Director of Nursing (DON) stated to the survey team that Resident #12 had a [redacted] that was facility-acquired. The DON did not indicate the stage of the [redacted]. On 8/3/21 at 10:41 AM, the surveyor observed Resident #12 seated in a [redacted] in the large dining/activity room. The surveyor observed that Resident #12 was wearing [redacted] on both [redacted]. The resident had kicked his/her soft slippers onto the floor. Through the [redacted] the surveyor observed a [redacted] on the underside of the [redacted], just below the small [redacted] The resident's [redacted] had extra padding on both [redacted]. The surveyor reviewed the medical record for Resident #12. A review of the face sheet (an admission summary) reflected that Resident #12 had diagnoses that included [redacted]	F 610	3. An in-service was held with all nurses, C.N.A's on the importance of completing an incident report as well as initiating an investigation was completed. A review of all MD orders, incident reports, 24 hour report and nurses notes will be performed five (5) X weekly by the DON to ensure an investigation was initiated and will follow up to ensure completion of investigation five (5) X weekly for six (6) months. The DON was educated on conducting investigations on [redacted] 4. The results of the audit will be reported and reviewed during the quarterly QAPI meeting for six months.	

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The resident's most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, was a quarterly review dated 6/11/21. This MDS indicated that Resident #12 was NJ Exec. Order 26:4.b.1), but the staff assessed the resident's cognition as having a NJ Exec. Order 26:4.b.1 and a NJ Exec. Order 26:4.b.1 decision-making capacity. The resident was NJ Exec. Order 26:4.b.1 on staff for assistance for all activities of daily living including bed mobility, transfer, dressing, eating, toilet use and personal hygiene. According to the MDS, Resident #12 was always NJ Exec. Order 26:4.b.1

A review of the resident's individualized care plan included interventions dated 9/22/20 included to monitor and report NJ Exec. Order 26:4.b.1, referral for a NJ Exec. Order 26:4.b.1 as needed, and NJ Exec. Order 26 4.b.1 when in bed.

A review of an initial NJ Exec. Order 26 Consultant evaluation dated 2/3/21 reflected that the Nurse Practitioner (NP) evaluated a new NJ Exec. Order 2 to the residents NJ Exec. Order 26 area of the NJ Exec. Order 26:4 t that measured NJ Exec. Order 26 centimeters (cm) which was intact without evidence of NJ Exec. Order 26:4.b. . The NP noted that the NJ Exec. Order 26 was an "NJ Exec. Order 26:4.b.1 The NP further noted that the resident was NJ Exec. Order 26:4.b.1, had

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NJ Exec. Order 26:4.b.1 affecting NJ Exec. Order 26:4.b.1, and was wearing sneakers with over the counter inserts which was "obviously NJ Exec. Order 26:4.b.1 to the area." The NP recommendations included to use NJ Exec. Order 26:4.b.1 in lieu of NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4.b.1 while in bed, NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 while in the NJ Exec. Order and limit NJ Exec. Order time to NJ Exec. Order 26:4.b.1 per episode.

Further review of the medical record revealed that Resident #12 was NJ Exec. Order 26 4.b.1 from NJ Exec. Order 26:4 to NJ Exec. Order 26:4. The New Jersey Universal Transfer Form (UTF) that was prepared by a Licensed Practical Nurse (LPN) from the facility dated NJ Exec. Order 26:4 indicated that Resident #12 had a NJ Exec. Order on the NJ Exec. Order 26:4.b.1 when he/she was NJ Exec. Order 26 4.b.1 to the NJ Exec. Order 26:4.1

A review of most recent NJ Exec. Order 26 Consultant evaluated dated 8/3/21 reflected that the resident had a NJ Exec. Order 26:4.b.1 to the NJ Exec. Order 26 4.b.1 beneath the NJ Exec. Order 26 that was NJ Exec. Orde and measured NJ Exec. Order 26:4.b.1. The plan included to NJ Exec. Order 26:4.b.1 with NJ Exec. Order 26:4.b.1 to the NJ Exec. Order 26 4.b.1 daily and cover it with a NJ Exec. Order 26 4.b.1.

The surveyor reviewed the progress notes in the electronic medical record which reflected that Resident #12 had been receiving treatments to the NJ Exec. Order 26:4.b.1 from 2/10/21.

On 8/9/21 at 8:42 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to care for Resident #12. She stated that the resident gets his/her NJ Exec. Order 26:4.b.1 prior to

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F 610	Continued From page 4	F 610		

getting out of bed and that the [NJ Exec. Order 26] Consultant had come early that morning to evaluate the resident's [NJ Exec. Order 26] to the [NJ Exec. Order 26 4.b.1]. The LPN acknowledged that the resident has had the [NJ Exec. Order 26] for a little while but that it was almost [NJ Exec. Order 26]. She continued that the resident wore a soft, cushioned shoe to [NJ Exec. Order 26:4.b.1] to the area when out of bed.

On 8/9/21 at 8:47 AM, the surveyor observed Resident #12 sitting in a [NJ Exec. Order 26 4.b.1] being fed breakfast by the Certified Nursing Aide (CNA). The resident was wearing cushioned shoes and [NJ Exec. Order 26:4.b.1].

At 08:50 AM, the surveyor interviewed the resident's assigned CNA who stated that the resident was [NJ Exec. Order 26:4.b.1] but could sometimes let him know what he/she wanted by head nodding. He stated that the resident would often [NJ Exec. Order 26] such as [NJ Exec. Order 26:4.b.1] because he/she would [NJ Exec. Order 26:4.b.1] intentionally. The CNA confirmed that the resident had a [NJ Exec. Order 26] to the [NJ Exec. Order 26:4.b.1] that was possibly from a [NJ Exec. Order 26:4.b.1] or an [NJ Exec. Order 26:4.b.1]." He stated that they no longer use the shoes that possibly caused the [NJ Exec. Order 26] and that he believed that the [NJ Exec. Order 26] was [NJ Exec. Order 26]. He confirmed that the resident always had [NJ Exec. Order 26] to the [NJ Exec. Order 26 4.b.1] which the [NJ Exec. Order 26:4.b.1] helped to alleviate. He stated that if he saw any changes in the resident's [NJ Exec. Order 26] condition, he would inform the nurse right away.

On 8/9/21 at 9:36 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team and the facility's administration including the Licensed Nursing Home

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Administrator (LNHA). The DON stated that the facility did not conduct a formal investigation into the cause of the NJ Exec. Order 26:4.b.1. She stated that according to a NJ Exec. Order 26 timeline she was providing, the resident had a NJ Exec. Order 26:4.b.1 performed on 2/2/21 and there was no NJ Exec. Order 26, but the next day on 2/3/21 during morning care, the CNA observed NJ Exec. Order 26:4.b.1 when applying the NJ Exec. Order 26:4.b.1 and reported it. She added that all potential areas of pressure were discontinued including a NJ Exec. Order 26:4.b.1 on the bed, NJ Exec. Order 26:4.b.1 and the NJ Exec. Order. She stated that they thought that the NJ Exec. Order 26 may be from the NJ Exec. Order 26:4.b.1 because the resident was tall and sometimes the NJ Exec. 2 may touch the NJ Exec. Order 26:4.b.1 at the end of the bed. The surveyor asked when the facility would conduct an investigation, and she replied that if the resident developed any NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26 of an unknown origin, but stated they did not do an investigation because "we were pretty sure how it occurred it was the NJ Exec. Order 26 4.b.1 The DON was unable to provide any documentation that led to this conclusion within the resident's medical record or through an investigation prior to surveyor inquiry. She stated that the resident also had NJ Exec. Order 26:4.b consults which revealed that the resident had NJ Exec. Order 26:4.b.1 and very NJ Exec. Order 26:4.b.1 with NJ Exec. Order 26:4.b and NJ Exec. Order 26:4.b.1 temperature. The DON confirmed she did not have any witness statements or other investigative means to determine the root cause for the development of the facility-acquired NJ Exec. Order 26:4.b.1. The facility administration confirmed that there was no investigation policy other than what was included in their Elder Abuse policy.

A review of the facility's Abuse (Elder Abuse) policy revised 4/1/2020 included Guidelines for

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F 610	Continued From page 6 Recognizing Elderly Neglect "...Evidence of abandonment, poor hygiene, decubitis, or urine burns..." Investigation of any violation which is suspected and/or substantiated included that the nursing supervisor on duty shall "Immediately report any alleged violations of this prevention policy to the Administrator or designee...The nursing supervisor will assess the elder (including size, location etc of any injury), and properly document the date, time, and location of the reported or suspected incident on Elder Abuse Investigation Report Form...The Administrator or designee will interview the elder as well as all nursing, housekeeping, laundry, dietary, activity social staff, any visitors or others who may have knowledge of the occurrence or who may have been in the vicinity at the time of the incident happened. The Administrator or designee will prepare a written summary of each interview....The Administrator and/or a nursing supervisor will conduct a thorough investigation...The Administrator will keep all documentation related to the investigation secure." NJAC 8:39-4.1(a)5; 9.4 (f)	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the accuracy of an assessment tool used to facilitate the management of care, the	F 641	1. The MDS for resident #12 and #32 have been revised and submitted. 2. All residents who reside in the facility	8/20/21

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F 641	Continued From page 7 Minimum Data Set (MDS), for 2 of 13 residents reviewed for MDS accuracy (Resident #12 and #32). The evidence was as follows: 1. The surveyor reviewed the medical record for Resident #32. A review of the Face Sheet (an admission summary) reflected that the resident was [NJ Exec. Order 26:4] admitted to the facility with diagnoses which included [NJ Exec. Order 26:4.b.1] A review of the Admission Nursing Assessment dated [NJ Exec. Order] reflected that the resident had minimal [NJ Exec. Order 26:4.b.1] with the use of a [NJ Exec. Order 26 4.b.1], and used [NJ Exec. Order 26:4.b.1] A review of the resident's individualized care plan effective [NJ Exec. Order 26:4] reflected that the resident was [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order 26:4.b.1]. Interventions included to apply the [NJ Exec. Order 26 4.b.1] during the waking hours. A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec. Order 26:] reflected that the resident had a brief interview for mental status (BIMS) score of [NJ Exec] out of 15, indicating that the resident had a [NJ Exec. Order 26:4.b.1] cognition. The MDS further revealed that the resident had [NJ Exec. Order 26:4.b.1] abilities ("no difficulty in [NJ Exec. Order 26:4.b.1] and no [NJ Exec. Order 26 4.b.1] or [NJ Exec. Order 26:4.b.1] was used when completing the assessment. (This did not accurately correspond with what was documented in the resident's medical record).	F 641	are at risk for this practice. 3. The MDS coordinator responsible for the error was educated on the importance of interviewing staff when completing the MDS. The DON and MDS coordinator will review and audit all MDS's prior to submission weekly to ensure accuracy of the assessments for six (6) months. 4. The results of the audits will be reported in teh quarterly QAPI meeting for six (6) months.	

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F 641	Continued From page 8 On 8/3/21 at 10:09 AM, the surveyor observed Resident #32 sitting in a [NJ Exec. Order 26 4.b.1] with a blanket around his/her shoulders. The resident was in the small day room in attendance for a religious presentation/activity. The surveyor observed that the resident was not [NJ Exec. Order 26:4.b.1] or other [NJ Exec. Order 26:4.b.1]. On 8/5/21 at 8:35 AM, the surveyor observed Resident #32 sitting in his/her private room wearing sunglasses. The TV was on, and the surveyor observed that the resident was not wearing any [NJ Exec. Order 26 4.b.1] The surveyor had to speak in a moderately loud tone of voice for the resident to [NJ Exec. Ord] with some repeated messaging, but the surveyor was able to interview Resident #32. The resident stated that he/she had [NJ Exec. Order 26:] but they went missing at the facility about a week ago. He/She stated that if the facility cannot find the [NJ Exec. Order 26 4.b.1] he/she would need a [NJ Exec. O] On the same day on 8/5/21 at 9:50 AM, the surveyor interviewed the resident's assigned Certified Nursing Aide (CNA) who stated that the resident had always had [NJ Exec. Order 26 4.b.1] since admission due to his/her difficulty [NJ Exec. Order 26:4.] but that she had been off of work for the last week and when she returned a few days ago, the [NJ Exec. Order 26 4.b.1] had been missing and that they were still searching for them. At 9:04 AM, the surveyor interviewed the LPN who stated that the resident lost [NJ Exec. Order 26 4.b.1] a few days ago and that they were still looking for them. She confirmed that the resident was [NJ Exec. Order 26:4.b.1] but that she could still communicate with the resident.	F 641		

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At 10:57 AM, the surveyor interviewed the Charge Nurse who confirmed that the resident had [NJ Exec. Order 26 4.b.1] to her knowledge. She stated that the MDS Coordinator was responsible for the assessing the resident and entering the data accurately into the MDS.

At approximately 11:00 AM, the surveyor interviewed the MDS Coordinator who stated that she had been out on leave and recently returned. She stated that she did not complete the MDS assessment dated [NJ Exec. Order 26:], but that it was her fill-in replacement that assessed the resident. She further stated that if the resident had [NJ Exec. Order 26:] [redacted] documented since admission in the medical record, then the MDS should have reflected that the resident's NJ Exec. Order 26:4.b.1. She stated that she would look into it further.

On 8/9/21 at 9:54 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team and the facility administration including the Licensed Nursing Home Administrator (LNHA). The DON stated that the resident's [NJ Exec. Order 26 4.b.1] were found as they accidentally got sent down with the laundry service. The DON further stated that the admission MDS assessment dated [NJ Exec. Order 26:] was inaccurate for the [NJ Exec. Order 26:4.] and was revised to reflect the resident's could NJ Exec. Order 26:4.b.1 [redacted]. The DON acknowledged that the inaccurate MDS could impact care, but confirmed that despite the accuracy error the resident still had a care plan for the application and use of the [NJ Exec. Order 26 4.b.1]. She stated that there were no adverse outcomes associated with the inaccurate MDS assessment.

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A review of the Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI) Manual updated 10/2019 included instructions to [NJ Exec. Order 26:4.b.1] Instructions included to "Ask the resident if he or she owns a [NJ Exec. Order 26:4.b.1] and, if so, whether it is at the nursing home...Check the medical record for evidence that the resident had a [NJ Exec. Order 26:4.b.1] in place when [NJ Exec. Order 26:4.b.1] was recorded...code 'No' if the resident did not use a [NJ Exec. Order 26:4.b.1]) for the 7-day [NJ Exec. Order 26:4.b.1] assessment coded."

2. During the initial tour of the facility on 8/2/21 at 11:38 AM, the surveyor observed Resident #12 in the small day room. The resident was seated in a [NJ Exec. Order 26 4.b.1] in the corner of the room and did not verbally respond when addressed by the surveyor. Resident #12 appeared calm and in no distress.

On 8/2/21 at 1:43 PM, the Director of Nursing (DON) stated to the survey team that Resident #12 had a [NJ Exec. Order 26:4.b.1] that was facility-acquired. The DON did not indicate the stage of the [NJ Exec. Order 26:4.b.1]

On 8/3/21 at 10:41 AM, the surveyor observed Resident #12 seated in a [NJ Exec. Order 26 4.b.1] in the large dining/activity room. The surveyor observed that Resident #12 was wearing [NJ Exec. Order 26 4.b.1] on [NJ Exec. Order 26:4.b.1]. The resident had kicked his/her soft slippers onto the floor. Through the [NJ Exec. Order 26:4.b.1], the surveyor observed a [NJ Exec. Order 26:4.b.1] on the underside of the [NJ Exec. Order 26:4.b.1], just below the [NJ Exec. Order] The resident's [NJ Exec. Order 26 4.b.1] had extra padding on both [NJ Exec. Order 26:4.b.1]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11 The surveyor reviewed the medical record for Resident #12. A review of the Face Sheet reflected that Resident #12 had diagnoses that included NJ Exec. Order 26:4.b.1 [redacted] A review of an initial NJ Exec. Order 26 Consultant evaluation dated 2/3/21 reflected that the Nurse Practitioner (NP) evaluated a new NJ Exec. Order [redacted] to the residents NJ Exec. Order 26 4.b.1 of the NJ Exec. Order 26:4.b [redacted] that measured NJ Exec. Order 26 [redacted] which was intact without evidence of NJ Exec. Order 26:4.b.1 The NP noted that the NJ Exec. Order 26 was an NJ Exec. Order 26:4.b.1 [redacted] The surveyor reviewed the progress notes in the electronic medical record which reflected that Resident #12 had been receiving NJ Exec. Order 26 4.b.1 to the NJ Exec. Order 26:4.b.1 through at least 6/30/21. A review of the most recent quarterly Minimum Data Set dated 6/11/21 reflected that Resident #12 was NJ Exec. Order 26:4.b.1 for completing a brief interview for mental status score, but the staff assessed the resident's NJ Exec. Order 26:4.b [redacted] as having a NJ Exec. Order 26:4.b.1 [redacted] and a	F 641		

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	315515	A. BUILDING _____ B. WING _____	08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 12	F 641		

NJ Exec. Order 26:4.b.1.

Further, Section M of the MDS summarized skin conditions and revealed that Resident #12 had [redacted]. This section also indicated that the resident had NJ Exec. Order 26:4.b.1 on the [redacted] and NJ Exec. Order 26:4.b.1 and was not receiving any NJ Exec. Order 26:4.b.1. (This did not accurately correspond with the resident's current NJ Exec. Order 26:4.b.1 at the time of the MDS assessment).

Further review of the medical record revealed that Resident #12 was NJ Exec. Order 26 4.b.1 from [redacted] The New Jersey Universal Transfer Form (UTF) that was prepared by a Licensed Practical Nurse (LPN) from the facility dated 7/21/21 indicated that Resident #12 had a [redacted] on the [redacted] when he/she was NJ Exec. Order 26 4.b.1 to the [redacted]

A review of most recent [redacted] Consultant evaluated dated 8/3/21 reflected that the resident had a NJ Exec. Order 26:4.b.1 to the [redacted] beneath the [redacted] that was [redacted] and measured NJ Exec. Order 26:4.b.1

On 8/4/21 at 10:50 AM, the surveyor interviewed the MDS Coordinator, who explained that she was not working at the facility from March 2021 until the last week in July. During this leave, she was temporarily replaced by a per diem employee. The MDS Coordinator stated that she was working on the current MDS for Resident #12 which included that the resident had a [redacted]

When the surveyor showed the MDS Coordinator

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	315515	A. BUILDING _____ B. WING _____	08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

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F 641	Continued From page 13	F 641		

the 6/11/21 quarterly MDS assessment and asked if she would have expected section M to include the presence of an NJ Exec. Order 26:4.b.1 she replied, "Yes." She acknowledged that if the resident was receiving NJ Exec. Order 26:4.b.1 to the NJ Exec. Order 26 on the NJ Exec. Or during the time of the assessment, it should have been reflected in the MDS assessment accurately.

On 8/9/21 at 8:42 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to care for Resident #12. The LPN acknowledged that the resident has had the NJ Exec. Order 26 to the NJ Exec. Or for a little while but that it was almost NJ Exec. Order 26:4

On 8/9/21 at 8:47 AM, the surveyor observed Resident #12 sitting in a NJ Exec. Order 26 4.b.1 being fed breakfast by the Certified Nursing Aide (CNA). The resident was wearing cushioned shoes and NJ Exec. Order 26:4.b.1 .

At 08:50 AM, the surveyor interviewed the resident's assigned CNA who stated that the resident was NJ Exec. Order 26 4.b.1 but could sometimes let him know what he/she wanted by head nodding. The CNA confirmed that the resident had a NJ Exec. Order 26 to the NJ Exec. Order 26:4.b.1 . He stated that he believed that the NJ Exec. Order 26 was healing. He confirmed that the resident always had NJ Exec. Order 26 to the NJ Exec. Order 26 4.b.1 which the NJ Exec. Order 26:4.b.1 helped to alleviate.

On 8/9/21 at 9:36 AM, the surveyor interviewed the DON in the presence of the survey team and the facility's administration including the LNHA. The DON stated that the facility did not conduct a formal investigation into the cause of the NJ Exec. Order 26:4.b.1 . She stated that according to a

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	315515	A. BUILDING _____ B. WING _____	08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

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F 641	Continued From page 14 NJ Exec. Order 26:4.b.1 timeline she was providing, the resident had a NJ Exec. Order 26:4.b.1 performed on 2/2/21 and there was NJ Exec. Order 26:4.b.1, but the next day on 2/3/21 during morning care, the CNA observed NJ Exec. Order 26:4.b.1 when applying the NJ Exec. Order 26:4.b.1 and reported it. She added that all potential areas of NJ Exec. Order 26:4.b.1 were discontinued including a NJ Exec. Order 26:4.b.1 on the bed, NJ Exec. Order 26:4.b.1 and the shoes. The DON confirmed that the NJ Exec. Order 26:4.b.1 to the NJ Exec. Order 26:4.b.1 region returned on 5/19/21 with a NJ Exec. Order 26:4.b.1 area with NJ Exec. Order 26:4.b.1 on 5/19/21 and acknowledged that it should have been accurately documented in the MDS dated 6/11/21. She confirmed that the NJ Exec. Order 26:4.b.1 opened and was a NJ Exec. Order 26:4.b.1 but that it was almost NJ Exec. Order 26:4.b.1 She stated that there were no adverse outcomes as a result of the inaccurate MDS assessment. A review of the CMS MDS RAI Manual updated 10/2019 instructed to assess the resident's NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1. It included to, "Review the medical record, including NJ Exec. Order 26:4.b.1 flow sheets or other NJ Exec. Order 26:4.b.1 forms, nurses ' notes, and NJ Exec. Order 26:4.b.1 assessments...Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident. Examine the resident and determine whether any NJ Exec. Order 26:4.b.1 present. Assess key areas for NJ Exec. Order 26:4.b.1 development (e.g., NJ Exec. Order 26:4.b.1 . Also assess NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 that is NJ Exec. Order 26:4.b.1 or subjected to NJ Exec. Order 26:4.b.1 If a resident with NJ Exec. Order 26:4.b.1 has an NJ Exec. Order 26:4.b.1 on the NJ Exec. Order 26:4.b.1 the 7-day	F 641		

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F 641	Continued From page 15 look-back period, code 0 and proceed... to code the [NJ Exec. Orde] as a [NJ Exec. Order 26:4.b.1]..." NJAC 8:39-11.1	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031304	A. BUILDING: _____ B. WING _____	08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

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S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 3 of 42 shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse	S 560	The facility has identified that all residents residing in the healthcare community can be impacted by the deficient practice of not meeting mandatory staffing levels throughout each day. Nurse manager and scheduler will review census to staff ratio's for compliance with mandatory staffing regulations prior to the start of each shift. As noted in this survey, it was determined by the surveyor that this deficient practice occurred during three (3) of the forty-two shifts reviewed. This deficient practice has the potential to affect all residents residing on the healthcare unit. As per facility policy, protocols for securing adequate staff include, contacting available staff to come to work when a shift void exists, offering incentive pay to work, contacting a staffing agency or asking staff currently on duty to work additional hours to cover the open shift. The facility has contracted with a number of staffing agencies to assist with maintaining the mandatory staffing levels which will further ensure to protect other residents in similar situations. Facility records support that on these three referenced shifts when a deficient staffing practice occurred, staffing records	8/31/21

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/25/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... On 8/2/21 at 12:09 PM, during surveyor interview, a resident that requested to remain anonymous stated that the facility was did not have enough healthcare staff. The resident stated that there was one night shift [11PM-7AM] in the last week	S 560	support instances where an LPN, RN, Occupational therapist, OTR or nurse manager provides support with clinical tasks involving activities of daily living. The facility continues its efforts to recruit staff in various ways, which include offering sign-on and recruitment bonus. Efforts to recruit also include advertising in various venues announcing open positions with competitive wage opportunities. The facility will monitor staffing levels closely to ensure mandatory staffing levels and report status of compliance at monthly/quarterly QAPI meetings.	

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S 560	Continued From page 2	S 560		

that he/she had to wait for a hour and a half for a CNA to answer their call bell so he/she could be toileted.

A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of July 18, 2021 and July 25, 2021 revealed the following:

The facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs to resident ratio during the 7:00 AM - 3:00 PM day shift on 7/22/21, 7/25/21 and 7/31/21.

On 8/5/21 at 12:45 PM, the surveyor discussed the staffing ratio concerns with the Licensed Nursing Home Administrator and the Director of Nursing who stated they were aware of the staffing ratio criteria, and they were trying to meet the criteria but sometimes it was difficult when staff would call out. They also stated that they were attempting to hire new CNAs and offer other incentives.

A review of the facility provided document titled, "Summary Assessment Report," updated October 20, 2020, included the following:

Under Staffing Plan ...Evaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff is available to meet each resident's needs ...Direct care staff ...All Certified Nursing Assistants with the following ratio at minimal ...7-3 [shift](1:8) [CNA:resident]

A review of the facility provided policy titled, "Skilled Nursing Facility Staffing (New Jersey)" with a revised date of 10/23/2020 included the

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S 560	Continued From page 3 following: Policy: Our facility provides adequate staffing to meet needed care and services for our resident population. Procedure: 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met ...3. [The Facility] will make judicious efforts to enforce the minimum caregiver-to-resident ratios and follow all the other staffing guidelines and specifics as outlined on NJ Act S2712. A review of the facility provided policy titled, "Abuse (Elder Abuse)" with a revised date of 4/1/2020, included the following: 3. Policies and Procedures that are in place to Prevent Abuse ... E. The Administrator/DON/Assisted Living Coordinator/CALA or designee will ensure adequate staffing to meet the needs of elders.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315515	A. Building B. Wing	9/24/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 08/20/2021	ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 08/20/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
8/9/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
031304		9/24/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/31/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/9/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315515	A. BUILDING **01** B. WING _____	**08/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	**40 RIVERSIDE AVENUE** **RED BANK, NJ 07701**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/02/21,was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Atrium at Navasink Harbor is 2 floors of a 12 story building that was built in 2013, It is composed of Type I fire resistant construction. The facility is divided into 6- smoke zones. The generator does approximately 90 % of the building.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used,	K 222		8/10/21

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/25/2021

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	315515	A. BUILDING **01** B. WING _____	**08/09/2021**

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ATRIUM AT NAVESINK HARBOR, THE	**40 RIVERSIDE AVENUE** **RED BANK, NJ 07701**

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K 222	Continued From page 1 only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4	K 222		

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	315515	A. BUILDING **01** B. WING _____	**08/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	**40 RIVERSIDE AVENUE** **RED BANK, NJ 07701**

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K 222	Continued From page 2 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/2/21 in the presence of Maintenance Director, it was determined that the facility failed to ensure that the delayed egress feature on three (3) of 3 exit discharge doors did not exceed 15 seconds and failed to provide signs that correctly identified this feature. This deficient practice was evidenced by the following: During a tour of the facility, beginning at 11:30 AM on 08/02/21, the surveyor and the Maintenance Director, observed that the floor-2 exit discharge doors (3 of 3) were provided with a delayed egress feature to push and hold the door to release in a non-fire emergency. Each door was provided with a sign stating the door would release in 30 seconds, in excess of the 15 second maximum allowable by the Code. An interview was conducted with the Maintenance Director who stated that the 3 egress doors on floor 2 were given approval by the Local fire inspector, and that they could continue with the current 30-second delayed egress device, but could not provide any documentation indicating that statement.	K 222	On August 2, 2021, upon notification of this deficient condition, the Director of Facilities placed a service call to ADT Commercial for assistance for this equipment system to be adjusted. The vendor's technician arrived to the facility on August 3, 2021 and confirmed that the delayed egress lock for the deficient area was changed from 30 to 15 seconds. All delayed egress doors were tested by the technician for proper operation following the change. The corrective action was accomplished for the surveyed residents found to be affected by this deficient practice. The facility has identified that all residents on this floor were impacted by this deficient practice because these specific exit doors would be used by all residents on this floor in the event of an evacuation emergency event. To ensure adequate operation and delayed egress compliance, the maintenance department will continue to monitor, test and log inspections of all delayed exit doors twice weekly. The	

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K 222	Continued From page 3 The Administrator was notified of the findings at the Life Safety Code exit conference on 8/2/21. NJAC 8:39-31.2(e)	K 222	maintenance director will report progress and continued compliance at monthly QA meeting and review accumulative results accordingly at quarterly QA meetings.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/2/21, it was determined that the facility failed provide a battery backup emergency light above the emergency generator's transfer switch and ensure emergency lighting worked when tested. This deficient practice was evidenced by the following: 1. During a tour of the building on 8/2/21, in the presence of the Maintenance Director at approximately 1:25 PM, the surveyor observed that the River Level 1 Boiler room where the emergency generator transfer switch is located was not equipped with a backup battery emergency light. This finding was confirmed by the Maintenance Director in an interview during the observation. 2. During a tour of the building, in the presence of the Maintenance Director at approximately 1:35 PM, the surveyor observed the Emergency Light #79 in the Generator #2 transfer room, that provided emergency power to floors 2 and 3,	K 291	On August 2, 2021, upon notification of this deficient condition, the Director of Facilities placed a service call to Navesink Electric for assistance with the malfunctioning emergency back-up light in the Generator #2 transfer room. On August 3, 2021, the emergency LED light in this area was replaced by the electrician. Also, the electrician ordered a new emergency back-up light in the River Level 1 boiler room where the emergency generator transfer switch is located. Once delivered, the back-up battery operated LED light and fixture were installed on August 20, 2021. The corrective action was accomplished for the surveyed residents found to be affected by this deficient practice. The facility has identified that all residents residing in the community were impacted by this deficient practice because the emergency back-up lighting required in these areas was necessary to ensure	8/20/21

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K 291	Continued From page 4 when tested by the Maintenance Director did not work, the emergency light was attempted a few times by the Maintenance Director and would still would not activate the light. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference on 8/2/21. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	operational stability, overall safety and access of the work area. To ensure functional operation of the emergency lighting, the maintenance department staff has numbered all emergency battery operated lighting fixtures in the community. This staff will continue to monitor, test and log inspections monthly of all emergency battery operated lighting fixtures. The maintenance director will report progress and continued compliance at monthly QA meeting and review accumulative results accordingly at quarterly QA meetings.	
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	K 531		8/20/21

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K 531	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 8/2/21, the facility failed to ensure that 3 of 3 elevators were inspected and tested monthly in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3, 9.4.6 and 9.4.6.2, ASME A17-1 Safety Code for Elevators and Escalators 2004 Edition Section 8.11.1.3 and Table N. The deficient practice was evidenced by the following: On 8/2/21 during a record review of documents at approximately 10:00 AM, revealed there was no record that Firefighter's Monthly Service Test on the elevator was performed and documented monthly. The surveyor interviewed the Maintenance Director at that time who indicated that the monthly Firefighter's Service test was not currently being conducted and documented on a log. The Administrator was notified of the findings at the Life Safety Code exit conference on 8/2/21, who was unable to provide documented evidence that the elevators were inspected at the time of surveyor inquiry. NJAC 8:39-31.2(e) Firefighter's Service Requirements of ASME/ANSI A17.3	K 531	On August 2, 2021, upon notification of this deficient condition, the Director of facilities placed a service call to Jersey Elevator for instructional assistance about the Firefighters Monthly Service Test required for elevators #1 and #2 located in the high rise building of the community. The facility has identified that the surveyed residents residing in the healthcare community were impacted by this deficient condition. Both elevators need to respond to the first floor upon activation by the fire department in the event of fire/smoke emergency response/evacuation event. It was determined that these two elevators provide service to all residents in the community and are required to operative and respond to the first floor during an emergency event for all residents. To ensure the functional operational response to the first floor of the community during such an emergency, the maintenance department has been inserviced and have implemented the Phase I & Phase II Monthly Test of elevators #1 and #2. The maintenance department staff will continue to test and log the Phase #1 & #2 inspections monthly for these two elevators in accordance with the Firefighters Service Testing for the high rise building in the community. The maintenance director will report	

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K 531	Continued From page 6	K 531	progress and continued compliance at monthly QA meeting and review accumulative results accordingly at quarterly QA meetings.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918		8/10/21

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K 918	Continued From page 7 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 8/2/21, in the presence of the Maintenance Director, it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10- second time frame in accordance with NFPA 99 for emergency electrical generator systems. and the facility did not log dates for required monthly load test requirements. This deficient practice was evidenced in 11 of 12 transfer times and 3 of 12 months with no documented load test dates by the following: A review of the generator records for the previous 12 months revealed that there was no documented certification that the generator would start and transfer power to the building within 10 seconds, when the load test was conducted on the following dates: 07/27/21 transfer time 4-seconds 06/00/21 no load test date 05/25/21 04/20/21 03/23/21 02/00/21 no load test date 01/19/21 12/00/20 no load test date 11/24/20 10/13/20 09/15/20 08/18/20	K 918	The Director of Facilities has reviewed the NFPA 110 requirements for the maintenance and testing of the emergency generator and transfer switches and inserviced his staff to ensure compliance with required documentation specific to logging transfer time and ensuring compliance time for transfer withing the 10 second time frame. He has determined that correct operation and testing of this equipment is necessary to ensure the safety of residents surveyed. It was also determined that all residents in the community are impacted by this deficient practice because the successful testing and operation of the generator assures the safety of the residents during an interruption of the facility's source of utility power. Facility documentation will ensure generator sets are inspected weekly, exercised under load for thirty (30) minutes twelve (12) times annually within twenty (20) to forty (40) day intervals and exercised once every thirty-six (36) months for four (4) continuous hours. The Director and his staff will document scheduled tests under load conditions that will include a complete simulated cold start and automatic or manual transfer of all EES loads. These documented tests will certify the time needed by the generator to transfer power to the building	

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K 918	Continued From page 8 The Maintenance Director confirmed there was no transfer time data on 11 of 12 load tests conducted and confirmed 9 of 12 months did not have load test dates documented on the current log provided. The Administrator was informed of the finding at the Life Safety Code exit conference on 08/02/21. NJAC 8:39-31.2(e), 31.2(g) NFPA 99	K 918	will be within the required ten (10) second time frame in accordance with NFPA 99 for emergency electrical generator systems. The maintenance director will report progress and continued compliance at monthly QA meetings and review accumulative results accordingly at quarterly QA meetings.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room,	K 923		8/10/21

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K 923	Continued From page 9 where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/2/21 in the presence of the Maintenance Director, it was determined that the facility failed to prohibit combustible storage within 5-feet of quantities of Oxygen exceeding 300 cubic feet in accordance with NFPA 99. This deficient practice was evidenced by the following: On 8/2/21 at 1:00 PM, the surveyor and the Maintenace Director observed that there were 31 full and empty E-tanks of compressed oxygen stored in the floor 2 oxygen storage room, across from resident room 206. The surveyor observed that there was stored combustible material within 5 feet of the tanks, including a combustible cardboard box stored on the full Oxygen storage cart. These 13 tanks exceeded the 300 cubic foot threshold requiring a minimum of 5 feet separation between oxygen storage and combustible material. In an interview, at that time, the facility's Maintenance Director was not aware of the	K 923	Upon notification of this deficient condition, the Director of Facilities initiated corrective action in cooperation with the nursing staff to comply with this deficient practice. This initiative will ensure the absence of all combustible storage within five (5) feet of quantities of oxygen exceeding three-hundred (300) feet in accordance with NFPA 99. The facility has identified that all surveyed residents on this floor were impacted by this deficient practice due to the proximity of the non-compliant storage area and the resident rooms and hallway. The facility has identified that all residents residing in this floor were impacted by this deficient practice because the areas of non-compliance could negatively impact them in the event of a combustible event. The Director of Facilities and nurse management staff worked together to consolidate all 02 equipment in a separate area away from all combustible materials.	

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K 923	Continued From page 10 limitations of oxygen storage tanks and combustible storage requirements. The Administrator was informed of the surveyor's findings at the Life Safety Code exit conference on 8/2/21. NJAC 8:39-31.2(e) NFPA 99	K 923	Staff was inserviced on the required absence of combustible materials and storage areas will be monitored to ensure continued compliance with NFPA 99. The maintenance director will report progress and continued compliance at monthly QA meeting and review accumulative results accordingly at quarterly QA meetings.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315515 Y1	A. Building 01 - MAIN (2ND AND 3RD FLOORS) B. Wing Y2	9/24/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT NAVESINK HARBOR, THE	40 RIVERSIDE AVENUE RED BANK, NJ 07701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	08/10/2021	LSC K0291	08/20/2021	LSC K0531	08/20/2021
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	08/10/2021	LSC K0923	08/10/2021	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/9/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO