STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey : 12/21/22 Census: 161 Sample Size: 35 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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		1/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/11/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not provide written notification of an emergency transfer to the resident, resident representative, and/or the Office of the Long-Term Care Ombudsman (LTCO) for 5 of 7 residents reviewed for Ex Order 26. 4B1, Residents #98, 86, 76, 69, 135. The findings are as follows:	F 623	What corrective action will be accomplished for those residents affected by the deficient practice: On 12/5/2022, surveyor reviewed residents #98, #86, #76, #69 and #135. Written notification of an emergency transfe Ex Order 26. 4B1 to resident or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 3 1.The surveyor reviewed Resident #98's medical record. The Census List indicated the resident was transferred out of the facility on Ex Order 26. 4B1. On 12/05/22 at 1:06 PM the surveyor interviewed the Social Worker (SW) regarding written notification of emergency transfer. The SW provided documentation indicating that the LTCO was notified. However, neither the resident nor the responsible party was notified of the reason for emergency transfer for the Ex Order 26. 4B1 transfer. On 12/05/22 at 12:51 PM the surveyor interviewed the Administrator. The Administrator confirmed neither the resident nor the responsible party was notified in writing of the reason for transfer. 2.The surveyor reviewed Resident #86's medical record. The Census List indicated the resident was transferred out of the facility on Ex Order 26. 4B1. On 12/05/22 at 1:06 PM the surveyor interviewed the Social Worker (SW) regarding written notification of emergency transfer. The SW stated neither the resident, the responsible party nor the LTCO was notified of the reason for emergency transfer for the Ex Order 26. 4B1 transfer. On 12/05/22 at 12:51 PM the surveyor interviewed the Administrator. The Administrator confirmed neither the resident, the responsible party or the LTCO was notified in writing of the reason for transfer. 3.The surveyor reviewed Resident #76's medical record. The Census List indicated the resident	F 623	responsible party were not completed. An in-service was immediately conducted to the social worker to ensure emergency transfer/Ex Order 26. 4B1 are completed timely. Residents #98, #86, #76, #69 and #135 notification of an emergency transfer were completed immediately and LTCO office were notified. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents/responsible party have the right to recieved written notification during an emergency transfer/Ex Order 26. 4B1. An audit was immediately conducted for the resident that had an emergency transfer/Ex Order 26. 4B1 for the last month (30 days) and all resident/responsible party was notified including LTCO office. No harm was done. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Adminsitrator/designee will conduct an in-service to all social service to ensure notification to the resident/responsible party and LTCO office are being notified timely. An ombudsman log will be updated and will be faxed to the ombudsman office every 3 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 623 Continued From page 4
was transferred out of the facility on Ex Order 26. 4B1.

On 12/05/22 at 1:06 PM the surveyor interviewed the Social Worker (SW) regarding written notification of emergency transfer. The SW was unable to provide written documentation indicating that the resident or the responsible party was notified in writing of the reason for emergency transfer on Ex Order 26. 4B1 transfer. The SW provided written documentation of the LTCO notification.

On 12/05/22 at 12:51 PM the surveyor interviewed the Administrator. The Administrator confirmed neither the resident or the responsible party was provided with written notification of the emergency transfer on Ex Order 26. 4B1.

4.The surveyor reviewed Resident #69's medical record. The Census List indicated the resident was transferred out of the facility on Ex Order 26. 4B1.

On 12/05/22 at 1:06 PM the surveyor interviewed the Social Worker (SW) regarding written notification of emergency transfer. The SW was unable to provide written documentation indicating that the resident or the responsible party or the LTCO was notified in writing of the reason for emergency transfer on Ex Order 26. 4B1 transfer.

On 12/05/22 at 12:51 PM the surveyor interviewed the Administrator. The Administrator confirmed the resident, the responsible party, and the LTCO weren't notified in writing of the reason for transfer.

5. The surveyor reviewed the medical record of

F 623

Social Worker/designee will monitor all emergency transfer/Ex Order 26. 4B1 daily and ensure a written notification notifying the resident/responsible party and LTCO office weekly x 4 then monthly x 6 months. An ombudsman log will be updated and will be faxed every 3 days.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?

Administrator/designee will do an audit to ensure notification to the resident/ responsible party and LTCO office are being notified timely weekly x 4 then monhtly x 6 months. Any concerns during audits will be addressed imemdiately to ensure compliance with standards of care.

Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (quality assurance performance improvement). Any concerns during audits will be addressed immediately to ensure complaince with standards of care. Monitoring will occur for 4 weeks and them monthly for 6 months unless any significant trends are identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 5 Resident # 135 which revealed that the resident was transferred to the hospital on Ex Order 26. 4B1 with a Ex Order 26. 4B1 and Ex Order 26. 4B1 . On 12/02/22 at 11:55 AM, the surveyor interviewed the Administrator. The Administrator confirmed neither the resident, the responsible party or the LTCO was notified in writing of the reason for transfer. On 12/2/22 the surveyor was provided with the 11/28/17 facility policy titled "Transfer and Discharge from the Center." Section C included the following verbiage. "Before the center will transfer or discharge a resident, the center will provide a written notice to the resident and resident representative in a manner and language in which is understood [sic]. The center will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman and identified state agencies per requirements." NJAC 8:39-5.3; 5.4	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on Ex Order 26. 4B1 , the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if	F 625		1/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 6 any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to provide residents and/or their representatives with the facility's notice of bed hold policy. This was found with for 5 of 7 residents reviewed for hospitalization, Residents #98, 86, 76, 69, and 135. The deficient practice was evidenced by the following: 1. The surveyor reviewed the medical record of Resident # 135 which revealed that the resident was transferred to the Ex Order 26. 4B1 on Ex Order 26. 4B1 with a Ex Order 26. 4B1 and Ex Order 26. 4B1 . On 12/02/22 at 11:55 AM, the surveyor interviewed the Administrator. The Administrator confirmed written notification of the bed hold	F 625	What corrective action will be accomplished for those residents affected by the deficient practice? On 12/5/2022, surveyor reviewed residents #98, #86, #76, #69, and #135. Bed Hold Notice upon transfer to resident or responsible party were not completed. An in-serviced was immediately conducted to the soical workers to ensure bed hold notice are completed upon transfer. Resident #98, #86, #76, #69, and #135 bed hold notice were completed immediately. How will the facility identify other residents having the potential to be affected by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 7 policy is not provided to residents or their representatives when transferred. 2. The surveyor reviewed Resident #98's medical record. The Census List indicated the resident was transferred out of the facility on Ex Order 26. 4B1. On 12/05/22 at 1:06 PM the surveyor interviewed the Social Worker (SW). The SW stated written notification of the facility bed hold policy was not provided to the resident or resident representative. On 12/05/22 at 12:51 PM the Administrator confirmed written notification of the bed hold policy is not provided to residents or their representatives when transferred. 3. The surveyor reviewed Resident #86's medical record. The Census List indicated the resident was transferred out of the facility on Ex Order 26. 4B1. On 12/05/22 at 1:06 PM the surveyor interviewed the SW who stated the written bed hold policy was not provided to the resident or their representative at the time of emergency transfer. On 12/05/22 at 12:51 PM the Administrator confirmed written notification of the bed hold policy is not provided to residents or their representatives when transferred. 4. The surveyor reviewed Resident #76's medical record. The Census List indicated the resident was transferred out of the facility on Ex Order 26. 4B1. On 12/05/22 at 1:06 PM the SW stated written notification of the bed hold policy is not provided	F 625	same deficient practice? All residents/responsible party have the right to recieved Ex Order 26. 4B1 notice upon transfer. An audit was immediately conducted for the residents that had a transfer for the last month and all resident/responsible party was notified. No harm was done. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Administrator/Designee will conduct an in-service to all social workers to ensure bed hold notice to the resident/responsible party are being notified upon transfer. Social worker/designee will monitor all transfers daily and a bed hold notice to the resident/responsible party are being done upon transfer . In addition, bed hold agreement and consent forms will be completed and mailed out to the resident/responsible party x 4 weeks then monthly x 6 months. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Administrator/designee will perform an audit on any resident transfer to ensure bed hold notice was provided to the resident/responsible party weekly x 4 weeks then monthly x 6 months. Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 8 to the resident or their representative upon transfer. On 12/05/22 at 12:51 PM the Administrator confirmed written notification of the bed hold policy is not provided upon transfer. 5. The surveyor reviewed Resident #69's medical record. The Census List indicated the resident was transferred out of the facility on Ex Order 26. 4B1. On 12/05/22 at 1:06 PM the SW stated written notification of the bed hold policy was not provided to the resident or their representative. On 12/05/22 at 12:51 PM the Administrator confirmed written notification of the bed hold policy is not provided to residents or their representatives when transferred. The surveyor reviewed the facility's Bed Hold and Return to Center Policy which revealed "Residents and their representative will be provided with bed hold and return information at admission and upon a hospital transfer or therapeutic leave." NJAC 8:39-5.3	F 625	concerns during audits will be addressed immediately to ensure complaince with standards of care. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure complaince with standards of care. Monitoring will occur for 4 weeks and then monthly for 6 months unless any significant trends are identified.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		1/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	**1120 ALPS ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 658 Continued From page 9

Based on observation, interview, and record review, it was determined that the facility failed to obtain a physician's order and maintain accountability for the use of a bed alarm to ensure it's use for Resident # 120. This was found with 1 of 31 residents reviewed for professional standards of practice.

Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities with in the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

The deficient practice was evidenced by the following:

Based on observation, interview, and record review, it was determined that the facility failed to monitor and maintain accountability for the use of a [Ex Order] [Ex.Order 26.4(] as an intervention to prevent [Ex Order] for Resident # 120. This was found with 1 of 31 residents reviewed for professional standards of practice.

Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states:

F 658

What corrective action will be accomplished for those residents affected by the deficient practice?

On 12/9/2022, surveyor observed residents 1 out 31 resident (resident #120) with no [Ex.Order 26.4(b)(1)]. Based on observation, interview and record, the facility has failed to monitor and maintain accountability for the use of [Ex.Order 26.4(b)(1)] as an intervention to prevent [Ex Order].
Assigned LPN was asked by the surveyor if Resident #120 has a [Ex Order] [Ex.Order 26.4(b)] and the LPN replied she was not sure if the resident has a [Ex.Order 26.4(b)(1)] as she did not see an order in EHR.

LPN assigned was immediately re-educated on how to determine if a resident requires a [Ex Order 26. 4B1] [Ex.Order 26.4(b)]

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents have the potential to be at risk related to this citation.

An adult was conducted on all residents with [Ex Order 26. 4B1] [Ex.Order 26.4(] as an intervention. All residents with a [Ex Order 26. 4B1] [Ex.Order 26.4(] were observed with appropriate [Ex Order 26. 4B1] [Ex.Order 26.4(] as an intervention. All nurses/CNAs are aware that resident requires [Ex Order 26. 4B1] [Ex.Order 26.4(b)] No harm was noted on 12/9/2022.

What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 658

Continued From page 10

"The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."

Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

The deficient practice was evidenced by the following:

On 12/09/22 at 8:59 am, the surveyor reviewed the hybrid [electronic and paper] medical record for Resident #120 which revealed the following:

According to the Admission Record, the resident was admitted with diagnoses that included Ex Order 26. 4B1 of the Ex Order 26. 4B1

The Significant Change Minimum Data Set

F 658

DON/Designee reviewed all resident with bed or chair interventions and added "check for placement and function" order for all resident with Ex Order 26. 4B1 Ex.Order 26.4(under TAR EHR following facility's policy and procedure.

ADON/Designee will conduct an in-service to all Nurses on adding "check placement and fucntion" order under TAR EHR for resident with Ex Order 26. 4B1 Ex.Order 26.4(intervention.

Unit Managers/Designee will be reviewing all residents with Ex Order 26. 4B1 Ex.Order 26.4(b to ensure an order for checking placement and function are put in placed or added in EHR weekly x 4 weeks, then monthly x 6 months. Any significant concerns during audits will be addressed immediately to ensure compliance with standards of care.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?

DON/Designee will be conducting audits by reviewing all resident with Ex Order 26. 4B1 Ex.Order 26.4(to ensure an order for placement and function are being addedd on EHR weekly x 4 weeks then monthly x 6 months unless any significant trends are identified.

Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meeting (Quality Assurance Performance Improvement). Any concerns during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 11 (MDS), an assessment tool dated Ex Order 26. 4B1, revealed that the facility performed a Brief Interview for Mental Status (BIMS) which indicated that the resident had a score of Ex Order 26. 4B1. The resident was assessed as having Ex Order 26. 4B1. A review of progress notes indicated the resident had a Ex.Order 26.4(b)(1) on Ex Order 26. 4B1 and Ex Order 26. 4B1. An Interdisciplinary Team (IDT) Committee Meeting note, dated Ex Order 26. 4B1, indicated that an intervention of a Ex Order Ex.Order 26.4(b) would be implemented. A review of care plans for Resident #120 included a care plan titled, "The resident is at risk for Ex Order". The care plan had an intervention that read, 'Ex Order 26. 4B1" for the resident, with an initiation date of Ex Order 26. 4B1. On 12/9/22 at 9:36 am, the surveyor observed the resident lying in bed resting. The resident was alert, verbally responsive to simple questions but was unable to state their name when asked. The resident was on a low air mattress and there was no Ex Order Ex.Order 26.4(observed. On 12/9/22 at 9:39 am, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to care for Resident #120 about Ex Ord prevention and interventions in place. The LPN stated the staff monitored the resident more often, used wedge cushion for their wheelchair if applicable, and Ex Order Ex.Order 26.4(b)(1 may be used for residents with high risk for Ex Order. The surveyor asked the LPN if Resident #120 had a Ex Order Ex.Order 26.4(b) intervention. The LPN replied that she was not sure if the resident had a Ex Order Ex.Order 26.4(in place. The surveyor accompanied the LPN to the resident's room, to check for a Ex Order Ex.Order 26.4(b The LPN did not find a Ex Order Ex.Order 26.4(for	F 658	audits will be addressed immediately to ensure complaince with standards of care. Monitoring will occur for 4 weeks and them monthly for 6 months unless any significant trends are identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 Resident #120. The LPN reviewed the EHR and stated there was no order for a Ex Order Ex.Order 26.4(. The LPN further stated the resident had not had a Ex Order since last occurrence and the resident had not tried to get out of bed on their own since their room change. On 12/9/22 at 9:49 am, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) asked about Ex Order prevention interventions for Resident #120. The RN/UM reviewed the care plan for Resident #120 in the EHR and stated interventions included anticipating the residents needs and a Ex Order Ex.Order 26.4(. The surveyor informed the RN/UM that the surveyor checked the resident's bedside with the LPN and there was no Ex Order Ex.Order 26.4(b found in use. The RN/UM stated it may have been misplaced, that the resident will remove and place somewhere else. The RN/UM stated she would get another Ex Order Ex.Order 26.4(for the resident. The surveyor asked the RN/UM if it was expected for there to be an order for the Ex Order Ex.Order 26.4(. The RN/UM stated that there was not usually an order for Ex Order Ex.Order 26.4(b)(and that it was found in the care plan. The surveyor asked the RN/UM how a nurse would know that a resident was to have a Ex Order Ex.Order 26.4(in place. The RN/UM stated that nurses were updated on resident interventions and care plans. On 12/9/22 at 10:08 am, the surveyor interviewed the LPN about how nurses would know that a resident was to have a Ex Order Ex.Order 26.4(b)(The LPN stated it was communicated in the 24 hours report. The LPN was asked if the nurses would document elsewhere that a resident was using a Ex Order Ex.Order 26.4(b The LPN stated in the Treatment Administration Record (TAR), the nurses would sign for every shift that a Ex Order Ex.Order 26.4(b is in place.	F 658		

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

PRINTED: 08/16/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 13	F 658		

The LPN acknowledged an order would need to be entered to document in the TAR.

12/9/22 at 1:57 pm, the surveyor interviewed the Director of Nursing (DON) about the resident's intervention of a Ex Order Ex.Order 26.4(b) not being in place and the accountability of resident using a Ex Order Ex.Order 26.4(b)(The DON was informed of the interview with the LPN and RN/UM. The DON stated Ex Order Ex.Order 26.4(interventions were documented in the care plans. The DON further stated it would not be found in the TAR and did not have to be written as an order. The DON stated the nurses were aware of residents who were Ex.Order 26.4(b)(1) or used a Ex Order Ex.Order 26.4(from the 24-hour reports between nurses. The DON stated she would re-educate the LPN on the facility's procedure. The DON stated the resident at times removed the Ex.Order 26.4(b)(1) and would provide nurses' progress notes.

On 12/12/22 at 9:45 am, the DON provided a nurse progress note from 11/8/22, that documented the resident removed their Ex Order Ex.Order 26.4(. The DON stated there were no other progress notes related to the resident's Ex Order Ex.Order 26.4(use. The DON acknowledged the nurses were expected to check the resident's Ex Order Ex.Order 26.4(b every shift and they would work on a process for the documentation of Ex Order Ex.Order 26.4(use.

The surveyor reviewed the facility's policy and procedure with a revised date of 12/12/22, titled "Falls-Clinical Protocol". Under Monitoring and Follow-Up, it read "2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.".

The surveyor also reviewed the facility's policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 14 and procedure with a revised date of 12/12/22, titled "Falls and Fall Risk, Managing". Under Monitoring Subsequent Falls and Fall Risk, it read "The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling." NJAC 8:39 - 27.1	F 658		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to assess a resident returning from the dialysis center for any complications. The deficient practice was observed for 1 of 3 residents (Resident # 141), reviewed for Ex Order 26. 4B1 care. The deficient practice was evidenced by the following: 1. On 11/30/22 at 12:11 pm, the surveyor observed Resident #141 lying in bed and the resident had a Ex Order 26. 4B1. The Ex Order 26. 4B1 delivered the oxygen to the resident via the Ex Order 26. 4B1. The resident had unclear speech related to their Ex Order 26. 4B1, but the resident was able to communicate with simple gestures.	F 698	What corrective action will be accomplished for those residents affected by the deficient practice? On 12/5/2022, the surveyor reviewed Dialysis Center Communication Report of resident #141 in the resident chart from November to December 2022. For 10 out of 15 Ex Order 26. 4B1 days, the post Ex Order 26. 4B1 section on the Ex Order 26. 4B1 Center Communication Report were not completed and tjere were no nurse's progress notes documented for the days upon resident's return to facility from Ex Order 26. 4B1 center. All nurses were in-serviced immediately on ensuring the completion of Ex Order 26. 4B1 Center Communication report upon	1/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 698

Continued From page 15

On 11/30/22 at 1:26 pm, the surveyor reviewed the electronic health record (EHR) of Resident #141 which revealed:

According to the Admission Record, Resident #141 was admitted with diagnoses that included Ex Order 26. 4B1, Ex Order 26. 4B1.

A physician's order, dated Ex Order 26. 4B1, indicated the resident received Ex Order 26. 4B1 every Tuesday, Thursday, and Saturday.

On 12/5/22 at 11:26 AM, the surveyor interviewed a Licensed Practical Nurse (LPN) who stated the resident goes to Ex Order 26. 4B1 on Tuesdays, Thursdays, and Saturdays via stretcher and with Ex Order 26. 4B1. The LPN stated Resident #141 had a Ex Order 26. 4B1 which was monitored for signs and symptoms of Ex Order 26. 4B1, and Ex Order 26. 4B1. The LPN showed the surveyor the Ex Order 26. 4B1 communication report form, titled "Ex Order 26. 4B1 Center Communication Report", that was found in the resident's chart. The LPN explained to the surveyor the first section was to be filled out by the facility nurse prior to the resident going to their Ex Order 26. 4B1 session. The first section would include up to date information on the resident's status, including access site assessment and vital signs. The second section was to be filled out by the Ex Order 26. 4B1 center nurse. It included for the Ex Order 26. 4B1 nurse to document the resident's pre and post Ex Order 26. 4B1 weights and vital signs, medications given to the resident and any pertinent information of the resident's condition. The last section of the form was to be filled out by

F 698

resident's return from Ex Order 26. 4B1 to the facility. And if in the event the Ex Order 26. 4B1 Center Communication report is not available upon resident's return, all nurses will document a proresgs note on their post-Ex Order 26. 4B1 assessment in EHR.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents have the right to receive services consistent with professional standards of practice.

An audit was immediately conducted on all Ex Order 26. 4B1 resident's Ex Order 26. 4B1 Center Communication Report and all reports were completed upon their return to the facility. There was no harm done noted on Ex Order 26. 4B1.

What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?

Assistance Director of Nursing/designee will in-service all Nurses to ensure all resident's Ex Order 26. 4B1 Center Communication Report are completed upon their return to the facility or a progress note will be written regarding their assessment if the report is not availble upon return. In additon, this will also be added during Nurse's orientation, emphasizing the importance of completing the post assessment.

Unit Manager/Designee will be reviewing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 16 the facility nurse upon the resident's return from the Ex Order 26. 4B1 center. The LPN stated that when the resident returned from Ex Order 26. 4B1 the vital signs, Ex Order 26. 4B1 access site and the resident's condition were assessed and documented on the "Ex Order 26. 4B1 Center Communication Report". The surveyor asked the LPN if there was anywhere else a nurse would document other than the Ex Order 26. 4B1 communication report. The LPN said that the nurses may sometimes write a progress note in the EHR. On 12/5/22 at 11:40 am, The surveyor interviewed the RN Unit Manager (RN/UM) about the nurses' responsibilities for the care of Ex Order 26. 4B1 residents and documentation. The RN/UM stated that the nurses were expected to fill out the appropriate sections on the 'Ex Order 26. 4B1 Center Communication Report" form and it should be completed upon the resident's return from Ex Order 26. 4B1. The surveyor reviewed the Ex Order 26. 4B1 communication forms located in the resident's chart with the RN/UM. The RN/UM acknowledged the post Ex Order 26. 4B1 section on several of the forms were not completed. The RN/UM stated she would review if progress notes were written by the nurses for those days. The surveyor reviewed the 'Ex Order 26. 4B1 Center Communication Report" forms in the resident's chart for November and December 2022. For 10 of 15 Ex Order 26. 4B1 days, the post Ex Order 26. 4B1 section on the Ex Order 26. 4B1 Center Communication Report were not completed and there were no nurses' progress note documented for those days upon the resident's return to facility from Ex Order 26. 4B1. On Ex Order 26. 4B1 at 11:00 am, the surveyor interviewed the Director of Nursing (DON) about the expectations and policy for nurses' documentation for residents receiving Ex Order 26. 4B1.	F 698	all resident's Ex Order 26. 4B1 center Communication Report weekly x 4 weeks then monthly x 6 months. Any concerns during audits will be addressed immediately to ensure complaince with standards of care. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? DON/Designee will conduct an audit on all resident's Ex Order 26. 4B1 center Communication report weekly x 4 weeks then monthly x 6 months. Any concerns during audits will be addressed immeidately to ensure compliance with standards of care. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (Quarterly Assurance Performance Improvement). any concerns during audits will be addressed immediately to ensure complaince with standards of care. Monitoring will occur for 4 weeks then monthly for 6 months unless any significant trends are identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING _____ B. WING _____	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 17 The DON stated that the nurses were to complete the Ex Order 26. 4B1 communication report form and if not able to, a progress note should be written in the EHR. The DON stated she followed up with the nurses who did not complete the post Ex Order 26. 4B1 section of the Ex Order 26. 4B1 communication form. The DON stated the nurses did assess the resident upon their return from Ex Order 26. 4B1 but did not fill out the Ex Order 26. 4B1 communication form. The DON further stated the nurses documented a late progress note entry after she spoke with them. On 12/7/22 at 1:41 pm, the surveyor informed the DON, Licensed Nursing Home Administrator (LNHA), and Assistant LNHA, about the concern of assessments not being documented for Resident #141 upon their return from Ex Order 26. 4B1. The DON acknowledged the post assessment on the Ex Order 26. 4B1 Communication Report should have been completed upon the resident's return to the facility. The DON further stated if it could be documented on the form, a progress note should have been written by the nurse. On 12/8/22 at 10:30 am, the surveyor reviewed the facility's policy and procedure with a revised date of Ex Order 26. 4B1, titled "End-Stage Renal Disease, Care of Resident with", provided by the. The policy did not address documentation by nurses for Ex Order 26. 4B1 residents. NJAC 8:39 - 27.1(a)	F 698		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must-	F 711		1/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 711	Continued From page 18 §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of Ex Order 26. 4B1 and Ex Order 26. 4B1 [redacted], which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to assure that the physician responsible for supervising the care of residents signed and dated monthly physician's orders. This deficient practice was observed for 18 of 32 residents (Resident # 81, 98, 86, 11, 5, 135, 136, 133, 120, 28, 73, 84, 9, 112, 59, 95, 12, and 66) reviewed and was evidenced by the following: 1. The surveyor reviewed the 9/2022, 10/2022, and 11/2022 Order Summary Reports for Resident #81 which revealed that the physician did not sign and date the monthly orders for these months. 2. The surveyor reviewed the 9/2022, 10/2022, and 11/2022 Order Summary Reports for Resident #98 which revealed that the physician did not sign and date the monthly orders for these months. 3. The surveyor reviewed the 9/2022, 10/2022, and 11/2022 Order Summary Reports for	F 711	What corrective action will be accomplished for those residents affected by the deficient practice? The surveyor reviewed resident's Order Summary for 9/2022, 10/2022, and 11/2022. Out of 32 residents reviewed, surveyor found 18 resident's Order Summary that the physcian did not sign and date the monthly orders for these months. A review of all resident's Order Summary was conducted; contacted all Physicians to either come in to sign or sign electronically as soon as possible. An in-service was conducted immeidately to all physician to ensure monthly Order summary are signed timely. How will the facility identify other residents having the potential to be affected by the same deficient practice?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 711	Continued From page 19 Resident #86 which revealed that the physician did not sign and date the monthly orders for these months. 4. The surveyor reviewed the 9/2022, 10/2022, and 11/2022 Order Summary Reports for Resident #11 which revealed that the physician did not sign and date the monthly orders for these months. 5. The surveyor reviewed the 9/2022, 10/2022, and 11/2022 Order Summary Reports for Resident #5 which revealed that the physician did not sign and date the monthly orders for these months. On 12/09/22 at 11:35 AM the unit Registered Nurse (RN #1) stated the doctor should sign the orders every month. She stated the doctors are called to remind them, but it is difficult to get them to come in. 6. The hybrid medical records of Resident #135 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for September 2022, October 2022, and November 2022. 7. The hybrid medical records of Resident #136 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2022. 8. The hybrid medical records of Resident #133 revealed the resident's physician had not hand signed or electronically signed the monthly	F 711	All residents has the potential to be at risk related to the citation. An audit was conducted on all resident Order Summary Report from 9/2022 to 11/2022, all Order Summary were signed electronically or physically by designated Physician on 12/12/2022. No harm was done. What measures will be put in place or systemic changes made to ensure that the deficient practive will not recur? Administrator/designee will in-srviced all physicians/MD to ensure Order summary are signed physically or electronically in a timely manner. Unit Manager/designee will be conducting a chart review on all residents according to their unit to ensure complaince with having Physicans signed Order Summary either physically or electronically weekly x 4 weeks then monthly x 6 months. Any concerns during audits will be addressed immeidately to ensure complaince with standards of care. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? DON/designee will be conducting a chart review on all resident according to their unit to ensure complaince with having Physicians signed Order summary are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 711 Continued From page 20

physician's orders for September 2022, October 2022, and November 2022.

9. The hybrid medical records of Resident #120 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for September 2022, October 2022, and November 2022.

10. The hybrid medical records of Resident #28 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2022, and September 2022. October 2022 monthly physician's orders not found in chart.

On 12/09/22 at 11:14 am, the surveyor interviewed Licensed Practical Nurse (LPN). about where the physicians sign the orders for residents. LPN stated the physicians may sign electronically or in the paper chart. LPN further stated the physicians signed monthly physician orders sheet in the paper chart.

On 12/09/22 at 11:20 am, the surveyor interviewed the RN/Unit Manager (RN/UM) about where the physician sign orders. The RN/UM stated the physicians signed monthly physician orders sheet in the paper chart. The surveyor reviewed Resident #136 chart with the RN/UM and acknowledged physician orders were not found signed. The surveyor informed the RN/UM there were several residents with physician order sheets not signed and Resident #28's October 2022 monthly physician's orders were not found in the chart. The RN/UM stated she would look for Resident #28 October 2022 physician orders sheet. The RN/UM further stated physicians are expected to sign their orders at least monthly.

F 711

completed timely weekly x 4 weeks then monhtly x 6 months. Any concerns during audits will be addressed immediately to ensure complaince with standards of care.

Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks them monhtly for 6 months unless any significant trends are identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ____ B. WING ____	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	**1120 ALPS ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 711	Continued From page 21	F 711		

11. Resident #73's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2022.

12. Resident #84's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2022.

13. Resident #9's hybrid medical record revealed the resident's physician had hand signed or electronically signed the monthly physician's orders for October, or November 2022.

14. Resident #112's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for September, October, or November 2022.

15. Resident #59's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for September, or October 2022.

16. Resident #95's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for September, October, or November 2022.

17. Resident #12's hybrid medical record revealed the resident's physician had not hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 711 Continued From page 22 F 711

signed or electronically signed the monthly physician's orders for September, October, or November 2022.

18. Resident #66's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2022.

On 12/9/22 at 11:02 AM, the surveyor asked the Unit Manager/Licensed Practical Nurse how the physicians signed their orders. She said very few signed electronic. Mostly all of them signed the paper Physician's Order Sheet (POS) that the facility printed out once a month. She explained that the 11 pm -7 am shift printed the orders out and put them in the charts for the physicians to sign monthly.

On 12/9/22 at 1:55 PM, the survey team spoke with the Administrator and the Director of Nursing (DON) about the concern with the physician's not signing orders for months. The DON stated "This is not an issue we were aware of. When I remind the physician's please check your orders they say yes they will." The DON confirmed that the nurses should make sure they have valid, signed orders.

On 12/12/22 at 12:15 PM the surveyor reviewed the facility's policy and procedure titled "Physician's Medication Orders/Consultant Physician's" Under "Policy Interpretation and Implementation" Number 2. read "All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such and order. The signing of orders shall be by signature."

NJAC-8:39 23.2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, b.) failed to sanitize and air-dry steam table pans and sheets pans in a manner to prevent microbial growth and c.) failed to maintain the kitchen equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 11/30/22 at 10:02 AM, in the presence of the Food Service Director the surveyor observed the following:	F 812	What corrective actions will be accomplished for those residents affected by the deficient practice? On 11/30/2022, the surveyor observed three dented cans that were in rotation. The surveyor has also observed seven sized steam table pans stacked with water between and nine sheet pans that were greasy to touch with water between them. In the food preparation, the surveyor has observed the can opener blade with black and white debris and paper stuck to the blade. The Dietary staff was immediately	1/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 812 Continued From page 24

1. In the dry storage area, the surveyor observed a random sampling of dented cans which were in rotation for use. The surveyor observed the following:
- One #10 sized cans of grape jelly with 1/4-inch sized dent on the upper lip,
- One #10 sized can of blueberry pie filling with 1-inch sized dent on the body of the cans,
-One #10 sized can of mandarin oranges with a 1/2-inch sized dent on the upper lip of the can.

2. In the food preparation area, on metal dishware drying shelving unit, the surveyor observed seven ½ sized steam table pans which were stacked with water between them, seven full sized steam table which were stacked with water between them, nine sheet pans which were greasy to the touch and stacked with water between them. The surveyor interviewed the Food Service Worker (FSW) who was responsible for washing the dishware and the FSW stated that he stacked the dishware because there was no space for dishware to be air dried.

3. In the food preparation area, the surveyor observed that the can opener blade was soiled with black and white colored debris and it had paper stuck to the blade as well.

On 11/30/22 at 11:35 AM, the surveyor discussed the above concerns with the Administrator and the Assistant Administrator.

The surveyor reviewed the facility's Dented Can policy which revealed "all cans must be inspected for dented imperfections and placed into designated dented can bin or discarded" and the

F 812 (Plan of Correction)

in-serviced on proper storage of foods (including but are not limited to canned food) to prevent food borne-illness, proper cleaning, sanitizing and air drying of kitchen equipment (including but are not limited to pan and can opener) to prevent food borne-illness.

The three dented cans were immediately removed from the rotation.

The seven sized steam table pans which were stacked with water between them were immediately removed and were sent back to the dishwasher to be cleaned, sanitized and dry appropriately.

The can opener were immediately send back to the dishwasher to be cleaned, sanitized and dry appropriately.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents has the potential to cause food borne illnesses related to this citation.

An audit was immediately conducted by the Food Service Director to ensure no other dented cans are in the rotation, proper sanitation and air drying of pans/sheet pans; and all other kitchen equipment such as can opener are maintained in a sanitary manner. No harm was identified.

What measures will be put in place or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	**1120 ALPS ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 25 Sanitization policy and procedure which revealed " all utensils, counter, shelves and equipment shall be kept clean" and "all equipment, food contact surfaces and utensils shall be washed to removed or completely loosen soil by using manual or mechanical means necessary." NJAC 8:39-17.2(g)	F 812	systemic changes made to ensure that the deficient practice will not recur? Administrator/designee will conduct an in-service to the Food service diretor and staff to include safe food storage, proper washing and drying of pans, and maintaining kitchen equipemnt in a sanitary manner. The Food Service Director will monitor safe food storage, proper washing and drying of pans, and maintaining cleanliness of can opener/kitchen equipement daily. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Administrator/designee will perform an audit on safe food storage, proper washing and drying of pans and maintaining kitchen equipemnt in a sanitary manner weekly x 4 weeks them monthly x 6 months. Any concerns during audits will be addressed immediately to ensure compliance with professional standards for food service safety. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meetings (Quarterly Assurance Performance Improvement). Any cocnerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks then monthly for 6 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING ____ B. WING ____	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	**1120 ALPS ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 26	F 812	unless significant trands are identified.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	**1120 ALPS ROAD WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
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 the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	S 560	What corrective action will be accomplished for those residents affected by the deficient practice? A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 11/13/22 and 11/20/22 revealed the facility was deficient in CNA staffing for resident on 14 of 14 day shifts. The staffing coordinator was educated on the required minimum direct care staff to	1/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE 01/11/23

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 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 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.	S 560	resident ratios as mandated by the state of New Jersey. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by the facility failing to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. What measures will be put in place or systemic changes made to esnure that the deficient practice will not recur? The facility will continue to post job openings on job sites to promote CNA openings. The facility is offering sign on bonus and referral bonus. The facility will continue to hire Nursing Assistant and pay for their school to get their CNA license. The facility has contracted a CNA school to send new hire Nursing Assistants to get certified and once certified may start working in the facility. The Administrator/designee will review daily staffing sheets weekly x 4 weeks then monhtly x 6 months. Any significant concerns during audits will be addressed immediately to ensure compliance with staff to resident ratio as mandated by the state of New Jersey. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061601	A. BUILDING: ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 (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 ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 11/13/22 and 11/20/22 revealed the following: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -11/13/22 had 13 CNAs for 160 residents on the day shift, required 20 CNAs. -11/14/22 had 18 CNAs for 159 residents on the day shift, required 20 CNAs. -11/15/22 had 18 CNAs for 159 residents on the day shift, required 20 CNAs. -11/16/22 had 15 CNAs for 159 residents on the day shift, required 20 CNAs. -11/17/22 had 14 CNAs for 159 residents on the day shift, required 20 CNAs.	S 560	The Administrator/designee will review any findings of these audits and present them quarterly with the QAPI committee for evaluation and future recommendations. Any concerns during the audits will be addressed immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061601	A. BUILDING: ______ B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 -11/18/22 had 14 CNAs for 159 residents on the day shift, required 20 CNAs. -11/19/22 had 15 CNAs for 162 residents on the day shift, required 20 CNAs. -11/20/22 had 15 CNAs for 161 residents on the day shift, required 20 CNAs. -11/21/22 had 15 CNAs for 157 residents on the day shift, required 20 CNAs. -11/22/22 had 16 CNAs for 156 residents on the day shift, required 19 CNAs. -11/23/22 had 17 CNAs for 156 residents on the day shift, required 19 CNAs. -11/24/22 had 16 CNAs for 156 residents on the day shift, required 19 CNAs. -11/25/22 had 15 CNAs for 156 residents on the day shift, required 19 CNAs. -11/26/22 had 18 CNAs for 159 residents on the day shift, required 20 CNAs. On 12/12/22 at 12:15 p.m., the surveyor informed the Director of Nursing, Licensed Nursing Home Administrator (LNHA), and Assistant LNHA of the staffing ratio concerns.	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 A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315335		2/23/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

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 F0623 Reg. # 483.15(c)(3)-(6)(8) LSC	Correction Completed 01/30/2023	ID Prefix F0625 Reg. # 483.15(d)(1)(2) LSC	Correction Completed 01/30/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 01/30/2023
ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 01/30/2023	ID Prefix F0711 Reg. # 483.30(b)(1)-(3) LSC	Correction Completed 01/30/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 01/30/2023
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

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 12/21/2022	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061601 Y1	A. Building B. Wing Y2	2/23/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

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 01/30/2023	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	ID Prefix Reg. # LSC	Correction Completed
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 12/21/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING **01** B. WING	**12/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	**1120 ALPS ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 12/21/22. The facility was found to be in compliance with 42 CFR 483.73.	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 12/21/22 and 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 Post Acute Care of Wayne is one building that was built in 1998. It is composed of Type II protected construction. The facility is divided into 9-smoke zones. The generator does approximately 50 % of the building as per the Maintenance Director. The current occupied beds are 159 of 209.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced	K 211		1/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/11/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING 01 B. WING	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 1 by: Based on observation and interview, the facility failed to ensure any door, passage, or stairway that is neither an exit nor a way of exit access and is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: "NO EXIT" in accordance with NFPA 101 Life Safety Code (2012 Edition) 7.10.8.3.1. This deficient practice had the potential to affect 73 residents. Findings include: An observation on 12/21/22 at 1:00 PM revealed the double door leading to the Terrace, located on the Third Floor, was not a designated exit, could likely be mistaken for an exit, and was not identified by a sign that read "NO EXIT". During an interview at the time of the observation, the Maintenance Director confirmed the double door to the Terrace was not a designated exit and did not have a sign that read "NO EXIT". NJAC 8:39-31.1(c), 31.2(e)	K 211	What corrective action will be accomplished for those residents affected by the deficient practice? On 12/21/2022, surveyor did not observed "no exit" sign on the double door leading to the terrace located on the third floor. The Maintenance Director ordered the "no exit" sign immediately to be placed on the double leading to the terrace on the third floor. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be at risk related to this citation. A comprehensive building inspection was conducted by the Maintenance Director, no exit area where identified and labeled accordingly. No harm was done. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Maintenance Director/designee will assessed all passages or non-exit areas labled accordingly and cannot be mistaken as a means of egress. In addition, this will be added to the weekly maintenance preventative checklist. How will the facility monitor its corrective actions to ensure that the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING 01 B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2	K 211	practice is being corrected and will not recur? Administrator/Designee will review weekly maintenance preventative checklist weekly x 4 weeks then monthly x 6 weeks. Any concerns during audits will be addressed immediately to ensure comliance with life safety code. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meeting (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks then monthly for 6 months unless any significant trends are identified.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure smoke detection sensitivity was completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. This deficient	K 345	What corrective action will be accomplished for those residents affected by the deficient practice? On 12/21/2022, surveyor has observed	2/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING 01 B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 3 practice had the potential to affect 159 residents. Findings include: An observation of the facility smoke detectors on 12/21/22 from 12:15 PM to 2:40 PM revealed smoke detectors located in the corridors and other concealed areas throughout the building. A review of the facility's "State Inspection Logbook" and fire alarm "Inspection and Testing Form(s)" dated 03/23/22 and 09/06/22 revealed no reference to a smoke detection sensitivity test. During an interview with the Maintenance Director on 12/21/22 at 11:00 AM, the Maintenance Director stated he contacted the contracted fire alarm company and requested the report. The fire alarm company confirmed to him that a smoke detector sensitivity report had not been completed and one was scheduled. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	smoke detection sensitivity was not completed on the smoke facility detectors. The Maintenance Director was in-serviced to review the policy and revised to include smoke detection sensitivity testing to be done yearly. The smoke detection sensitivity testing was completed by an outside vendor on 2/13/2023 How will the facility identify other residents having the potential to be affected by the same deficient practice? All resident have the potential to be at risk related to this citation. Administrator/Maintenance Director immediately revised the policy on smoke to detection sensitivity to be done yearly. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Maintenance Director/designee will contact a third-party contractor to conduct an official asssessment of smoke detection sensitivity on smoke detector for the entire facility to ensure compliance. In addition, this will be added to weekly maintenance preventative checklist. A completed contract with an outside vendor was secuered to conduct smoke detection sensitivity testing annually to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING 01 B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 4	K 345	ensure compliance. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Administrator/Designee will review weekly maintenance preventative checklist weekly x 4 weeks then monthly x 6 weeks. Any concerns during audits will be addressed immediately to ensure comliance with life safety code. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meeting (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks then monthly for 6 months unless any significant trends are identified.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K 372		1/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING **01** B. WING ______	**12/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	**1120 ALPS ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 5 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke. This deficient practice had the potential to affect all 159 residents. Findings include: An observation on 12/21/22 at 12:33 PM revealed the smoke barrier, located adjacent to Room 309, had a bundle of ½ inch conduit penetrating an unsealed opening and was not protected by a system or material capable of restricting the transfer of smoke. An observation on 12/21/22 at 1:05 PM revealed the smoke barrier, located adjacent to Room 230, had a ½ inch conduit penetrating a one-inch diameter unsealed opening. An observation on 12/21/22 at 1:11 PM revealed the smoke barrier, located adjacent to Room 119, had one red wire and one blue wire penetrating a one-inch diameter unsealed opening. During an interview at the time of each observation, the Director of Maintenance confirmed the penetrations in the smoke barrier were not protected. NJAC 8:39-31.1(c), 31.2(e)	K 372	What corrective action will be accomplished for those residents affected by the deficient practice? On 12/21/2022, surveyor has observed smoke barriers located adjacent to room 309, 230, and 119 had unsealed openings. The Maintenance Director was in-service to ensure all rooms are smoke barriers are sealed. How will the facility identify other residents having the potential to be affected by the same deficient practice? All facility have the potential to be at risk related to this citation. The Maintenance Director immediately sealed the areas by rooms 309, 230, and 119. No harm was done. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Maintenance Director/designee will conduct an audit on all rooms and fire doors in each floor to ensure penetration of smoke barriers are protected by restricting the transfer of smoke. In addition, this will be added to weekly maintenance preventative checklist.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING 01 B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 6	K 372	How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Administrator/Designee will review weekly maintenance preventative checklist weekly x 4 weeks then monthly x 6 weeks. Any concerns during audits will be addressed immediately to ensure compliance with life safety code. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meeting (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks then monthly for 6 months unless any significant trends are identified.	
K 918 SS=F	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	K 918		2/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING **01** B. WING ______	**12/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	**1120 ALPS ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 7 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 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 observation, interview and document review, the facility failed to ensure the Emergency Power Supply (EPS) was equipped with a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the EPS where so installed, or elsewhere on the premises where the prime mover is located outside the building in accordance with NFPA 110 Emergency and Standby Systems (2010 Edition) 5.6.5.6. This deficient practice had the potential to affect 159 residents. Findings include: A review of the facility's documents titled, "State	K 918	What corrective action will be accomplished for those residents affected by the deficient practice? On 12/21/2022, surveyor observed there was no remote manual stop station installed for the EPS on the premises where the prime mover was located outside the building. The Maintenance Director was in-service to contact a third party to assess the EPS for proper installation of remote manual stop station. On 2/23/2023 a third party contractor fixed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING 01 B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	**1120 ALPS ROAD** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 8 Inspection Log-book" and "Generator Inspection Reports" revealed the EPS was serviced and inspected on 02/17/21, 05/21/21, 08/09/21, 02/14/22, 05/26/22, and 11/23/22; however, a remote manual stop station had not been installed. An observation at 2:20 PM on 12/21/22 revealed there was not a remote manual stop station installed for the EPS on the premises where the prime mover was located outside of the building. At the time of the observation of the EPS, the Maintenance Director confirmed the EPS did not have a remote manual stop station. NJAC 8:39-31.1(c) NFPA 99, 110	K 918	the remote manual stop. How will the facility identify other residents having the potential to be affected by the same deficient practice? The residents has the potential to be at risk related to this citation. The Maintenance Director immediately contacted a third-party to assess EPS for proper installation of remote manual stop station. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Maintenance Director/designee will ensure a remote manual stop station will be installed by a third party. In addition, this will be audited for function and will be added to weekly maintenance preventative checklist. The Maintenance Director/designee will conduct a weekly 30-minute test on the generator and 60-minute monthly test run to ensure the generator functions properly. This will be included on the weekly maintenance preventative checklist. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Administrator/Designee will review weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. BUILDING 01 B. WING ______	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 9	K 918	maintenance preventative checklist weekly x 4 weeks then monthly x 6 weeks. Any concerns during audits will be addressed immediately to ensure comliance with life safety code. Outcomes of the audits will be reported to the Quarterly (every 3 months) QAPI meeting (Quality Assurance Performance Improvement). Any concerns during audits will be addressed immediately to ensure compliance with standards of care. Monitoring will occur for 4 weeks then monthly for 6 months unless any significant trends are identified.	

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)
315335	A. Building 01 - MAIN BUILDING 01 B. Wing	2/23/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNE	1120 ALPS ROAD WAYNE, NJ 07470

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 Reg. # NFPA 101 LSC K0211	Correction Completed 01/30/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 02/13/2023	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 01/30/2023
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 02/23/2023	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	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	
12/21/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO