DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> </u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	COMF	E SURVEY PLETED
		315335	B. WING				C 120/2022
NAME OF PI	ROVIDER OR SUPPLIER	010000		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 07	/20/2023
				11	120 ALPS ROAD		
	OST ACUTE CARE OF V	VAYNE		W	/AYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	COMPLAINT#: NJ16	64781					
	CENSUS: 149						
	SAMPLE SIZE: 5						
	42 CFR PART 483, S	DT IN SUBSTANTIAL THE REQUIREMENTS OF SUBPART B, FOR LONG TIES BASED ON THIS					
	review of other pertin 7/13/23, it was detern thoroughly investigate physical abuse allega Nursing Aide (CNA# facility also failed to e "Abuse, Neglect, Mist Misappropriation of R consistently implement unknown), a visitor (N Licensed Practical Nu- that CNA #1 hit Resid	treatment, and tesident Property" was nted; when, on 6/4/23 (time /isitor #1) reported to the urse/Unit Manager (LPN/UM) tent #1. The LPN/UM then legation to the Registered					
	second visitor (Visitor that Resident #1 someone might have the Resident. The RN	I/ES interviewed the d CNA #1. According to the					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	E		TITLE		(X6) DATE
Electroni	cally Signed						08/10/2023

Electronically Signed

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/23/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		045005					С
	ROVIDER OR SUPPLIER	315335	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	07/	20/2023
NAME OF FI	CONDER OR SOFFLIER				120 ALPS ROAD		
ATRIUM P	OST ACUTE CARE OF W	VAYNE		W	/AYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000 F 609 SS=D	she started an investi because she was the #1 in the dining room. CNA #1 was not imme she initiated an invest alarming at that time.' the RN/ES reassigned residents in another u evening shift (3 PM-1 being monitored or su 6 hours. The facility's failure to or suspend CNA #1 u investigation and thor allegations of abuse, policy, posed a likelih health and well-being potentially all other re provided care. This re Jeopardy (IJ) situation This IJ was identified, presented to the Adm PM. The IJ began on until 7/13/2023. The fa acceptable removal p in-services for all staff policy. This was verifi non-compliance rema actual harm, with the minimal harm that is r Reporting of Alleged V CFR(s): 483.12(b)(5)(ed by Visitor #1. However, gation focusing on CNA #1 last person with Resident . The RN/ES confirmed that ediately suspended when tigation because "it was not " During the investigation, d CNA #1 to provide care to unit for the rest of the 1 PM) without the CNA upervised for approximately b immediately remove and/ intil the outcome of the oughly investigate the per the facility's abuse ood of serious harm to the of Resident #1 and sidents that CNA #1 esulted in an Immediate n. and an IJ template was inistrator on 7/13/23 at 6:03 6/4/2023 and continued acility presented an lan which included initiating f on the facility's abuse ed on-site on 7/20/23. The ined on 7/14/23 for no potential for more than not an immediate jeopardy. Violations		509			8/11/23

Facility ID: NJ61601

If continuation sheet Page 2 of 18

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/23/2023 // APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		LETED
		315335	B. WING _				C 20/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				11	20 ALPS ROAD		
ATRIUM P	OST ACUTE CARE OF W	AYNE		W	/AYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 609	Continued From page must: §483.12(c)(1) Ensure involving abuse, negle mistreatment, includir source and misapprop are reported immedia hours after the allegat that cause the allegat serious bodily injury, of the events that cause abuse and do not result the administrator of the officials (including to the adult protective service for jurisdiction in long- accordance with State procedures. §483.12(c)(4) Report investigations to the ad designated represents accordance with State Survey Agency, withir incident, and if the alle appropriate corrective This REQUIREMENT by: Complaint#: NJ00164 Based on interviews a records (MRs) and otherations of the service the service of the service of the service accordance with states accordance with states accordance with states accordance with states accordance of the service of the service accordance with states accordance with states	that all alleged violations ect, exploitation or ing injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and es where state law provides term care facilities) in a law through established the results of all administrator or his or her ative and to other officials in a law, including to the State in 5 working days of the eged violation is verified a action must be taken. is not met as evidenced		609		ïed	
	to resident physical al Department of Health policy titled; "Abuse, N	report an allegation of staff buse to the New Jersey (NJDOH) and follow its Neglect, Mistreatment, and			compliance with the facility's Abuse, Neglect, Mistreatment and Misappropriation policy and procedure.		
	ivisappropriation of R	esident Property." This			The center called the NJDOH and the		

Facility ID: NJ61601

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315335	B. WING		C 07/20/2023
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	
ATRIUM P	OST ACUTE CARE OF W	/AYNE		1120 ALPS ROAD WAYNE, NJ 07470	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 609	deficient practice was residents (Resident # the following: According to the Adm was admitted to the fa diagnoses that include , and A Minimum Data Set dated 3, reveal Interview for Mental S which indicated required assistance w (ADLs). A review of the Order included a Physician for care to sh A review of the Care F indicated that Residen In were not limited to all procedures before , att non-pharmacological M review of nursing pr 6/4/23 at 2:49 pm rev	identified for 1 of 5 1) and was evidenced by ission Record, Resident #1 acility on with ed but were not limited to; (MDS), an assessment tool, ed the Resident had a Brief itatus (BIMS) score of, and the Resident vith activities of daily living Summary Report (OSR) Order (PO) initiated on a to the and 	F 60	 9 Ombudsman office to report the 6/4/2 incident on 7/13/2023. Resident #1 was evaluated by the nur supervisor on 6/4/2023, No visible sig of new injury nor pain. CNA #1 was educated on Abuse, Neg Mistreatment and Misappropriation por and procedure on 6/5/2023. DON and Supervisor (E.S.) were educated on Abuse, Neglect, Mistreatment and Misappropriation por and procedure for 6/4/2023 incident to ensure any allegation of abuse is beir followed, specifically on removing the staff/employee from the staff to reside abuse, in accordance to the policy of Abuse, Neglect, Mistreatment and Misappropriation. How the facility will identify other reside having the potential to be affected by same deficient practice? All residents have the potential to be affected by non-compliance of reporting an alleged violation. All residents that resided on CNA #1 assignment on the facility assessment on the facility is a sessessment on the staff of the	rsing ns glect, blicy bl

Event ID: JL5V11

Facility ID: NJ61601

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE (CONSTRUCTION	OMB N (X3) DAT	E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		CON	IPLETED	
						С		
		315335	B. WING			07	7/20/2023	
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE			
ATRIUM P	OST ACUTE CARE OF V	VAYNE	1120 ALPS ROAD WAYNE, NJ 07470					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	3E	(X5) COMPLETIO DATE	
F 609	Continued From page	م <u>م</u>	E	609				
1 000		P) was notified. Further		09	All remaining residents in the building	had		
	review of the NPN, a				full body skin assessment and pain	nau		
	2:20 pm, revealed Re			assessment on 7/13/2023 with no visil	ble			
				signs of injury nor signs of pain and al	I			
	The physician and RI	P were notified.			residents denied abuse or had no sigr	ns of		
					abuse.			
		stigational Summary" dated						
		ents unknown) signed by the , under the description of						
		ed a call from the supervisor			What measures will be put into place o	or		
		¹ 1 made an accusation that			systemic changes will be made to ens			
		t. The investigation findings			that the deficient practice will not recu			
		ation was conducted, and the						
	statement was immed				All direct care staff have been			
	-	o make sure not to assign			in-serviced/educated on the center's			
		d Resident. The investigation t statements from all staff			Abuse, Neglect, Mistreatment and Misappropriation policy and procedure	on		
	present at the time of	f the alleged abuse denied d incident. CNA #1 denied			7/13/2023.	, 011		
		ding to CNA #1 interview,			All non-direct care staff, department			
	-	Resident #1 due to behavior			heads and the DON were educated or	ו		
		er (Visitor #1) saw the			Abuse, Neglect, Mistreatment and			
		med CNA #1 hit the			Misappropriation policy and procedure			
		1). Visitor #1, who made the			This education began on 7/13/2023 ar	nd		
		y did not witness the alleged to another (Visitor #2) who			was fully completed on 7/14/2023.			
		/isitor #2 denied witnessing			Nurse Supervisor (E.S.) was educated	l in		
	the alleged abuse. The	-			accordance to the 6/4/2023 incident of			
		at no substantial evidence			how the facility's Abuse, Neglect,			
	substantiated the alle	eged abuse.			Mistreatment and Misappropriation of			
					resident policy and procedure is follow	/ed.		
		ritten witness statement			Abuna Naglaat Mistractment and			
		ed, prepared by the RN/ES, round 4:30 pm, Visitor #1			Abuse, Neglect, Mistreatment and Misappropriation of resident policy and	4		
		n [the] unit because			procedure, revised on August 11, 2023			
		ening. The RN/ES indicated			staff was re-inserviced on the policy a			
		k and nothing to report." The			procedure revision on August 11, 2023			
	statement further sho	wed that another visitor						
	(Visitor #2) questione	ed if someone hit Resident						

Facility ID: NJ61601

If continuation sheet Page 5 of 18

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				-			C
		315335	B. WING			07/	20/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ATRIUM P	OST ACUTE CARE OF W	VAYNE			120 ALPS ROAD		
				v	NAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page #1 because there was According to th assessed the Resider were noted. The nurs who were there stated and when CNA #1 we who "patient refused f CNA came back to co documentation without the resident." The DC everybody's statement investigation." A review of a handwri signed by LPN/UM re question, I was workin see CNA #1 hit the re A review of a handwri (untimed), unsigned, DON, revealed that our room, Resident #1 was #1 and Visitor #2 were conversation. Anothe asked why Resident # responded that it was while CNA #1 and LP	e 5 a statement, the RN/ES e statement, the RN/ES e statement, the RN/ES es (LPN #1 and LPN/UM) d Resident #1 was ent to assist the Resident, to have any contact, and the portinue with her at having skin contact with DN told RN/ES to "collect at for her to start an tten statement dated wealed, "On the day in ng as a floor nurse; I did not isident (Resident #1)." tten statement dated 6/4/23 prepared by CNA #1 per nd the dining as having an r Visitor with Visitor #2 #1 was CNA #1		609	DEFICIENCY)	ve ut five ve sed iries nd	
	According to CNA #1, 7/24/23 at 11:06 am, alleged she hit Reside Further review of the attached witness state documented evidence Resident #1, and othe	e/she was not touched." , during an interview on she confirmed Visitor #1					

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	-					FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMP	LETED
		TH AND HUMAN SERVICES OMB NO. 05 PORMAR SERVICES OMB NO. 05 PORMAR SO ADD SERVICE SO ADD SERVICE SO ADD SERVICES OF THE ADDRESS. CITY. STATE, ZIP CODE 120 ALPS ROAD WAYNE NO TO DEFICIENCIES PROVIDERS PLAN OF CORRECTIVE ADDRESS. CITY. STATE, ZIP CODE 120 ALPS ROAD WAYNE, NJ 07470 PROVIDERS PLAN OF CORRECTIVE ADDRESS. CITY. STATE, ZIP CODE 120 ALPS ROAD WAYNE, NJ 07470 PROVIDERS PLAN OF CORRECTIVE ADDRESS. CITY. STATE, ZIP CODE 120 ALPS ROAD WAYNE, NJ 07470 PROVIDERS PLAN OF CORRECTIVE ADDRESS. CITY. STATE, ZIP CODE 120 ALPS ROAD WAYNE, NJ 07470 PROVIDERS PLAN OF CORRECTIVE ADDRESS. CITY. STATE, ZIP CODE 120 ALPS ROAD WAYNE, NJ 07470 PROVIDERS PLAN OF CORRECTIVE ADDRESS. CITY. STATE, ZIP CODE 120 ALPS ROAD WAYNE, NJ 07470 PROVIDERS PLAN OF CORRECTIVE ADDRESS. CITY. STATE, ZIP CODE 120 ALPS ROAD WAYNE, NJ 07470 PROVIDERS PLAN OF CORRECTIVE ADDRESS. PROVIDERS PLAN OF CORRECTION ADDRESS. PROVIDERS PLAN OF CORRECTIVE ADDRE	C 20/2023				
Image: NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ATRIUM POST ACUTE CARE OF WAYNE STREET ADDRESS, CITY, STATE, ZIP CODE (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 CORRI (EACH ODRECTIVE ACTION S) F 609 Continued From page 6 statement. LPN #1 was not employed at the facility during the survey. F 609 A review of CNA #1 "Detailed Hours," an employee timecard report, revealed CNA #1 worked the following hours after an allegation of abuse was made on at about 4:30 pm: on d from 6:18 am to 9:01 pm, 6/5/23 from 6:29 am to 2:30 pm, 6/6/23 from 7:30 am to 3:57 pm, and 6/7/23 from 7:37 am to 10:13 pm. F 609 During an interview on 7/13/23 at 3:30 pm, the DON stated she completed the abuse allegation L							
ATRIUM P	OST ACUTE CARE OF W	VAYNE					
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 609	statement. LPN #1 wa facility during the surv A review of CNA #1 "I employee timecard re- worked the following I abuse was made on 6 from 6:18 am to am to 2:30 pm, 6/6/23 and 6/7/23 from 7:37 During an interview of DON stated she comp investigation summar CNA #1 and Resident Administrator confirm not reported to the Ne Health (NJDOH), and immediately suspend determined within two there was no abuse. I documented evidence witness statements at that a thorough invest within two hours after allegation. When the facility's policy on abu timely any abuse alleg remove and/or suspen of alleged abuse pend outcome was followed Administrator refused During an interview of RN/ES stated she not (DON) immediately of	as not employed at the vey. Detailed Hours," an eport, revealed CNA #1 hours after an allegation of at about 4:30 pm: on o 9:01 pm, 6/5/23 from 6:29 3 from 7:30 am to 3:57 pm, am to 10:13 pm. n 7/13/23 at 3:30 pm, the bleted the abuse allegation y dated with involving t #1. The DON and the ed the alleged incident was ew Jersey Department of CNA #1 was not ed because it was o hours of the allegation that However, there was no e in the MRs, including nd investigation summary, tigation was completed the physical abuse surveyor asked if the use to report to the NJDOH gation and immediately nd team members accused ding the investigation d, the DON and	F	609			

Facility ID: NJ61601

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315335	B. WING			RRECTION (X5) I SHOULD BE COMPLETION	
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ATRIUM P	OST ACUTE CARE OF W	/AYNE			1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION
F 609	Administrator stated s alleged incident until the DON or Administrator and conducting a thore abuse allegation. During an interview of LPN/UM stated on #1 alleged CNA #1 his informed the RN/ES of incident. During an interview of #1 stated on the RN/ES of incident. During an interview of #1 stated on the RN/ES of allegation was made LPN/UM. CNA #1 was informed the RN/ES of stated that LPN/UM with spoke with the RN/ES Review of facility police "Abuse, Neglect, Mist Misappropriation of R but was not limited to that each Resident wi include verbal, men abuseNo abuse or Reporting and Respon policy of the [center] to reported per Federal a will ensure that all alle abuse, neglectare in not later than 2 hours if the events that cause	n 7/14/23 at 3:00 pm, the she was unaware of the the next day. She stated the is responsible for reporting rough investigation of an n 7/20/23 at 9:45 am, the (time unknown), Visitor t Resident #1, and she of the alleged abuse n 7/24/23 at 11:06 am, CNA ime unknown), while she n trying to calm Resident she hit Resident #1. The in front of Visitor #2 and s unable to recall if she of the alleged incident but vitnessed the allegation and S. cy updated on 5/2022, titled; reatment, and esident Property" included s, "It is the policy of (Center) II be free from abuse tal, sexual, or physical harm will be tolerated nse Component: It is the hat abuse allegationsare and State Law. The center eged violations involving reported immediately, but after the allegation is made, se the allegation involve ious bodily injury, or no later	F	609			

Facility ID: NJ61601

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		315335	B. WING		C 07/20/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ATRIUM P	OST ACUTE CARE OF V	VAYNE		120 ALPS ROAD VAYNE, NJ 07470			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 609	in serious bodily injur center and the Depar	lve abuse and do not result y, to the Administrator of the	F 609				
	CFR(s): 483.12(c)(2) §483.12(c) In respons	Correct Alleged Violation -(4) se to allegations of abuse, or mistreatment, the facility	F 610		8/11/23		
	violations are thoroug §483.12(c)(3) Preven	t further potential abuse, or mistreatment while the					
	designated represent accordance with Stat Survey Agency, withi incident, and if the all appropriate corrective This REQUIREMENT by:	administrator or his or her ative and to other officials in e law, including to the State n 5 working days of the leged violation is verified e action must be taken.					
	Complaint#: NJ0016	4781		What corrective action will be accomplished for those residents affect by the deficient practice?	ted		
	review of other pertin	medical records (MRs), and ent facility documentation on nined the facility failed to		CNA#1 was suspended on 7/13/2023 i accordance to the incident on compliance with the facility's Abuse,	in , in		

Facility ID: NJ61601

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB I	NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	. ,	TE SURVEY MPLETED
		315335	B. WING _			C)7/20/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		11/20/2020
ATRIUM P	OST ACUTE CARE OF V	VAYNE		1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE GIENCY)	(X5) COMPLETIO DATE
F 610	Continued From page	e 9	F	510		
	thoroughly investigate physical abuse allega	e an alleged staff-to-resident ation involving the Certified 1) and Resident #1. The		Neglect, Mistreatment a Misappropriation policy		
	facility also failed to e "Abuse, Neglect, Mis	ensure its policy titled treatment, and Resident Property" was		The center called the N Ombudsman office to re incident on 7/13/2023.		
	unknown), a visitor (Licensed Practical Nu that CNA #1 hit Resid	/isitor #1) reported to the urse/Unit Manager (LPN/UM) dent #1. The LPN/UM then llegation to the Registered		Resident #1 was evalua supervisor on supervisor of new injury nor pain.	ated by the nursing , No visible signs	
	Nurse/Evening Super At approximately 4:30	rvisor (RN/ES). D PM that same day, a		CNA #1 was educated Mistreatment and Misa and procedure on 6/5/2	ppropriation policy	
	that Resident #1 someone might have the Resident. The RN	hit the Resident's hand or I/ES interviewed the		DON and Supervisor (E educated on Abuse, Ne Mistreatment and Misa	eglect, ppropriation policy	
	RN/ES, she was not physical abuse report	d CNA #1. According to the notified of the alleged ted by Visitor #1. However, igation focusing on CNA #1		and procedure for ensure any allegation of followed, specifically or staff/employee from the	of abuse is being n removing the	
	because she was the #1 in the dining room CNA #1 was not imm	e last person with Resident . The RN/ES confirmed that ediately suspended when tigation because "it was not		abuse, in accordance to Abuse, Neglect, Mistrea Misappropriation.	o the policy of	
	alarming at that time. the RN/ES reassigne residents in another u	" During the investigation, d CNA #1 to provide care to unit for the rest of the		 How the facility will ider	•	
		1 PM) without the CNA upervised for approximately		having the potential to l same deficient practice	?	
	or suspend CNA #1 ι	o immediately remove and/ Intil the outcome of the roughly investigate the		All residents have the p affected by not following policies and procedures Neglect, Mistreatment a	g the Center's s on Abuse,	
	allegations of abuse, policy, posed a likelih	per the facility's abuse nood of serious harm to the of Resident #1 and		All residents that reside		

Facility ID: NJ61601

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CENTER STATEMENT (AND PLAN OF	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315335	· /	NG	CONSTRUCTION	(FORM OMB NO X3) DATE S COMPL	.ETED
ATRIUM P	OST ACUTE CARE OF W	/AYNE			I20 ALPS ROAD IAYNE, NJ 07470			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	E	(X5) COMPLETION DATE
F 610	Jeopardy (IJ) situation This IJ was identified, presented to the Adm PM. The IJ began on until 7/13/2023. The fa acceptable removal p in-services for all staff policy. This was verifie non-compliance rema actual harm, with the minimal harm that is r This deficient practice residents (Resident # the following: According to the Adm was admitted to the fa diagnoses that include Review of the Minimu assessment tool, date Resident had a Brief I (BIMS) score of and the Resident with activities of daily A review of the Care F indicated that Resider problem, including yel provocation/cause. In were not limited to	sidents that CNA #1 sulted in an Immediate n. and an IJ template was inistrator on 7/13/23 at 6:03 6/4/2023 and continued acility presented an lan which included initiating on the facility's abuse ed on-site on 7/20/23. The ined on 7/14/23 for no potential for more than not an immediate jeopardy. was identified for 1 of 5 1) and was evidenced by ission Record, Resident #1 acility on with ed but were not limited to m Data Set (MDS), an ed the revealed the nterview for Mental Status , which indicated for sident required assistance living (ADLs). Plan (CP) dated for 2 at #1 had a behavior ling out without terventions included but for an and allowing to	F	610	assignment on had assessment and assessment and assessment and assessment of pain and all residents of abuse or had no signs of abuse. All remaining residents in the b full body skin assessment and assessment on 7/13/2023 with signs of injury nor signs of pain residents denied abuse or had abuse. What measures will be put into systemic changes will be made that the deficient practice will no systemic changes will be made that the deficient practice will no All direct care staff have been in-serviced/educated on the ce Abuse, Neglect, Mistreatment a Misappropriation policy and pro 7/13/2023. All non-direct care staff, depart heads and the DON were educ Abuse, Neglect, Mistreatment a Misappropriation policy and pro This education began on 7/13/2023. Nurse Supervisor (E.S.) was en accordance to the 6/4/2023 inconduction the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse, Neglect Abuse, Neglect Mistreatment and Misappropriation policy and procedure in the facility's Abuse Abu	ent on injury nor denied e. ouilding ha pain no visible n and all no signs o place or e to ensur iot recur? enter's and ocedure of tment cated on and ocedure. 2023 and 023. ducated in cident on ct, ation of is followed	e n	

Facility ID: NJ61601

If continuation sheet Page 11 of 18

		MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	LETED
		315335	B. WING		07/	C 20/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		20/2023
				120 ALPS ROAD		
ATRIUM F	OST ACUTE CARE OF V	VAYNE		NAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 610	Continued From page	s 11	F 610			
FOID	non-pharmacological observation, and deve methods of A review of the nursin dated at 2:49 F was Redirector responsible party (RF review of the NPN, a 2:20 PM, revealed Re The physician and the notified. A review of the "Invest 6/4/23 (timeline of eve DON, revealed on the event, she receive [RN/ES] that Visitor # CNA #1 hit a resident indicated an investiga statement was immed supervisor was told to CNA #1 to the alleged findings revealed that present during the alleged witnessing the incider allegation. According was redirecting Resid	approaches including eloping more appropriate ag progress notes (NPN) PM revealed Resident #1 on [was] ineffective. The P) was notified. Further late entry dated at esident #1 was noted with in the set of the set of the entry dated at esident #1 was noted with entry dated at esident #1 was noted with at esident #1 was noted with at entry dated at esident #1 was noted with at esident at esident's RP were at a call from the supervisor at made an accusation that the investigation findings at on was conducted, and the diately collected. The o make sure not to assign d Resident. The investigation t statements from all staff	F 610	Misappropriation of resident polic procedure, revised on August 11, staff was re-inserviced on the polic procedure revision on August 11, How will the facility monitor its con actions to ensure that the deficier practice is being corrected and wi recur, i.e. What Q.A program will into place to monitor the continue effectiveness of the systemic cha The Director of Nursing, or Admir (LNHA) will conduct a random au (5) residents weekly for four cons weeks. These residents will be a and interviewed to ensure that an are identified, properly investigate reported to the appropriate people part of the Performance Improver Project (PIP) included in the QAP program; this was already initiated ensure this is properly executed. The Administrator or Director of S Worker will conduct a random aud (5) employees weekly for four cor weeks. These employees will be a the protocols of Abuse, Neglect,	2023; cy and 2023. rrective at ll not be put d nge? istrator dit of five ecutive ssessed y injuries ed, and e. This is nent I d to ocial dit of five nsecutive	
	Resident (Resident # allegation, stated they incident but referred t			Mistreatment and Misappropriatic and procedure. Any concerns dur audits will be addressed immedia ensure compliance with standards	ing tely to	

Facility ID: NJ61601

If continuation sheet Page 12 of 18

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
		315335	B. WING				C 20/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	OST ACUTE CARE OF W	VAYNE			1120 ALPS ROAD		
_					WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	9 12	F	610	0		
	7/4/23, unsigned, pre- revealed on asked her to check or something was happed the unit "was ok statement further sho (Visitor #2) questione #1 because there was According to th assessed the Resider were noted. The nurs who were there stated and when CNA #1 we who "patient refused f CNA came back to co documentation without the resident." The DC everybody's statemer investigation." A review of a handwri signed by the LPN/UN question, I was workin see CNA #1 hit the re A review of a handwri (untimed) and unsign DON, revealed that on room, Resident #1 wa #1 and Visitor #2 wer conversation. Anothe asked why Resident # responded that it was while CNA #1 and LP #2, Visitor #1 alleged CNA #1 replied, "No,	ten statement dated M showed, "On the day in ng as a floor nurse; I did not sident (Resident #1)."					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315335	B. WING				C 20/2023
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
					1120 ALPS ROAD		
ATRIUM P	OST ACUTE CARE OF W	AYNE		1	WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	According to CNA #1, 7/24/23 at 11:06 AM, alleged that she hit R A review of CNA #1 "I employee timecard re worked the following I AM to 9:01 PM, 6/5/2 6/6/23 from 7:30 AM f 7:37 AM to 10:13 PM During an interview of 7/20/23 at 9:45 AM, tf (time unknown), Visite Resident #1. She state of the alleged abuse i During the first and se at 2:40 PM, the RN/E immediately suspend investigation because time." During the inve reassigned to care for for the rest of the eve The RN/ES stated CN home because there not witness it. RN/ES interviewed LPN #1 a the RN/ES stated she Nursing (DON) immer made by Visitor #2, a to collect written state instruct her to suspen her to another unit. Th was aware of the facil included immediately suspending staff men "abuse" pending the i	during an interview on she confirmed Visitor #1 esident #1. Detailed Hours," an eport, revealed CNA #1 hours: on 6/4/23 from 6:18 3 from 6:29 AM to 2:30 PM, to 3:57 PM, and 6/7/23 from In 7/13/23 at 12:15 PM and he LPN/UM stated on the LPN/UM stated on the LPN/UM stated on the LPN/UM stated on the she informed the RN/ES ncident. econd interviews on 7/13/23 S stated CNA #1 was not ed when she initiated an e "it was not alarming at that stigation, CNA #1 was residents in another unit ning shift (3 PM-11 PM). JA #1 was not told to go was no abuse, and staff did confirmed she only nd LPN/UM. Additionally, e notified the Director of diately of the allegation nd the DON instructed her ements. The DON did not d CNA #1 but reassigned he RN/ES confirmed she lity's policy on abuse which	F	610			

Facility ID: NJ61601

If continuation sheet Page 14 of 18

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/23/2023 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		315335	B. WING		C 07/20/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
ATRIUM P	POST ACUTE CARE OF V	VAYNE		1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 610	not followed and state misunderstood that p During an interview of DON stated she com investigation summat CNA #1 and Residen Administrator confirm not reported to the Ne Health (NJDOH), and immediately suspend determined within two there was no abuse. reassigned to anothe there was no docume including witness stat summary, that a thory completed within two abuse allegation. The on the West unit were after the allegation withese staff were all co could not provide doo #2, LPN #1, Residen assigned to CNA #1 submitted witness stat confirmed that both v obtained the next day informed of the allegation words, but the investi accurate. According f notified her about Vis on the mater about Vis on the mater about vis	ed, "I missed that partI part". on 7/13/23 at 3:30 PM, the pleted the abuse allegation ry dated 6/4/23 involving t #1. The DON and the ned the alleged incident was ew Jersey Department of d CNA #1 was not led because it was to hours of the allegation that Therefore, CNA #1 was or hours of the allegation that Therefore, CNA #1 was rr unit instead. However, ented evidence in the MRs, tements and investigation ough investigation was hours after the physical e DON further stated all staff e interviewed immediately as made. Statements from collected. However, the DON cumented evidence that CNA t #1, and other residents were interviewed or atements. The Administrator risitors' statements were y, on when she was ations.	F 610			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315335	B. WING				C 20/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ATRIUM P	OST ACUTE CARE OF W	/AYNE			1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	not aware of a second next day when she im DON acknowledged s accurate investigation alleged incident was t During an on 7/14/23 Administrator stated s alleged incident until t DON or Administrator and conducting a thor abuse allegation. She for the investigation s confirmed she is the I approve each investig During an interview of #2, assigned to Resid day shift (7 AM-3 PM) the DON did not inter witness statement. During an interview of #1 stated on Second (t was in the dining roor #1, Visitor #1 alleged allegation was made LPN/UM. CNA #1 cou the RN/ES of the alleg LPN/UM witnessed th the RN/ES. During the survey, the interview Resident #1 interviewed. Review of facility polic "Abuse, Neglect, Mist	d visitor allegation until the terviewed CNA #1. The she failed to prepare an a report but asserted the thoroughly investigated. at 3:00 PM, the she was unaware of the the next day. She stated the is responsible for reporting rough investigation of an e added she could not speak ummary for but ast person to review and gation summary. n 7/20/23 at 10:00 AM, CNA lent #1 on but during the b, confirmed the RN/ES or view or ask her to write a n 7/24/23 at 11:06 AM, CNA ime unknown), while she n trying to calm Resident she hit Resident #1. The in front of Visitor #2 and ald not recall if she informed ged incident but stated that he incident and spoke with e surveyor attempted to , but he/she refused to be	F	610			

Facility ID: NJ61601

If continuation sheet Page 16 of 18

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/23/2023 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMP	SURVEY PLETED
		315335	B. WING				C 20/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1120 ALPS ROAD		
ATRIUM P	OST ACUTE CARE OF W	VAYNE			WAYNE, NJ 07470		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IY	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	٩F	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
F 610	Continued From page	2 16	F	610	0		
				010	0		
		: "It is the policy of (Center)					
	that each Resident wi						
		tal, sexual, or physical					
		harm will be tolerated					
		nents: It is the policy of this					
		abuseare promptly and					
	thoroughly investigate						
		r will immediately begin a					
		n of any reported incident					
	and collect informatio						
	disproves the incident						
		or suspected incident of					
		e Administrator or designee					
	-	cident with the assistance of					
	appropriate personne						
	The investigation will	include:					
	ii. Who was involved						
		Resident's statements, b.					
		statements, c. interviewing					
	the alleged perpetrate						
		s statements of [the] event: i.					
		ewing other team members					
		nmediate area at the time of					
	the incident who may						
		ing team members who					
	worked the previous s						
	iv. Where did it happe	en?					
	v. How did it happen .						
	x. Conclusion based u	upon findings.					
	Additional Investigation						
		designee will inform the					
	Resident and/ or his/h	ner representative of the					
	findings of the investig	gation and corrective action					
	plan.						
	Protection Componen	nts: Immediately upon					
	receiving a report of a						
		designee will coordinate					
	[the] delivery of appro	-					
		d attention. Ensuring the					

Facility ID: NJ61601

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STATEMENT	OF DEFICIENCIES - CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY IPLETED
				i		С
		315335	B. WING		0	7/20/2023
	ROVIDER OR SUPPLIER	VAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 ALPS ROAD WAYNE, NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 610	safety and well-being individualsThe cent to protect residents a. Procedures must b Resident with a safe, during the investigation will immediately be re- will be protected. Tea alleged abuse will be the center and will re- results of a thorough the extent of the imm be made by the Admi Examine, assess, and other residents poten Notify the physician Reporting and Respo- policy of the [center] to reported per Federal will ensure that all alle abuse, neglectare not later than 2 hours if the events that caus abuse or result in ser than 24 hours if the e allegation do not invo in serious bodily injur- center and the Depar	of vulnerable er will take necessary steps be in place to provide the protected environment on: i. The alleged perpetrator emoved, and the Resident immediately removed from main removed pending the investigation. (Decision of ediate disciplinary action will instrator or designee.), iv. d interview the Resident and tially affected immediately n. onse Component: It is the that abuse allegationsare and State Law. The center eged violations involving reported immediately, but after the allegation is made, se the allegation involve ious bodily injury, or no later vents that cause the slve abuse and do not result y, to the Administrator of the tment of Health to in e law through established	F 61	0		

Event ID: JL5V11

Facility ID: NJ61601

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
		061601	B. WING	B. WING				
	ROVIDER OR SUPPLIER	1120 /	TADDRESS, CITY, ST ALPS ROAD IE, NJ 07470	ATE, ZIP CODE	07/20/2023			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE			
S 560		ory Access to Care comply with applicable local laws, rules, and	S 560		8/11/23			
	by: COMPLAINT # NJ0 Based on interviews facility documentation facility failed to main direct care staff to real as mandated by the deficient practice was shifts reviewed. Reference: New Jen (NJDOH) memo, da with N.J.S.A. (New 30:13-18, new minin nursing homes," inc Governor signed int codified at N.J.S.A.	s, and review of pertinent on, it was determined that the ntain the required minimum esident ratios for the day shift e State of New Jersey. This as evidence by the following. rsey Department of Health ted 01/28/2021, "Compliance Jersey Statutes Annotated) mum staffing requirements for licated the New Jersey to law P.L. 2020 c 112, 30:13-18 (the Act), which		What corrective action will be accomplished for those residents affected by the deficient practice? The staffing coordinator was educated on the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. How the facility will 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				
	nursing homes. The effective on 02/01/2 One Certified Nurse residents for the day One direct care staf residents for the eve fewer than half of al CNAs, and each dir	Aide (CNA) to every eight y shift. f member to every 10 ening shift, provided that no I staff members shall be ect staff member shall be s a CNA and shall perform		required direct care staff to resident ratio as mandated by the state of New jersey. What measures will be put into place or systemic changes will be made to ensure 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				

Electronically Signed

08/10/23

JL5V11

If continuation sheet 1 of 4

	ey Department of Hea				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		061601	B. WING		C 07/20/2023
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE. ZIP CODE	0112012020
		1120 AL	PS ROAD	,	
	OST ACUTE CARE OF V	WAYNE WAYNE,	NJ 07470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
S 560	Continued From page	e 1	S 560		
3.500	One direct care staff residents for the night direct care staff mem CNA and perform CN A review of the "Nurse by the facility for the 06/17/2023 and $06/2revealed the staffingmeet the minimum resultThe facility was deficeresidents on 14 of 14-06/04/2023$ had 14 the day shift, required -06/06/23 had 14 the day shift, required -06/07/23 had 14 the day shift, required -06/08/23 had 15 the day shift, required -06/09/23 had 15 the day shift, required -06/10/23 had 14 the day shift, required -06/11/23 had 14 the day shift, required -06/13/23 had 14 the day shift, required -06/14/23 had 13 the day shift, required -06/14/23 had 14	member to every 14 It shift, provided that each Iber shall sign in to work as a IA duties. The Staffing Report" completed weeks of 06/04/2023 and 5/2023 to 07/07/2023, to resident ratios did not equirement. The in CNA staffing for 4 day shifts as follows: 1 13 CNAs for 142 residents tired 18 CNAs. 5 CNAs for 142 residents on d 18 CNAs. 5 CNAs for 143 residents on d 18 CNAs. 4 CNAs for 142 residents on d 18 CNAs. 5 CNAs for 142 residents on d 18 CNAs. 4 CNAs for 142 residents on d 18 CNAs. 5 CNAs for 1		for their school to get their CNA licens The facility has contracted a CNA school to send new hires Nursing Assistants of get certified and once certified may sta- working in the facility. The Administrator or Director of Nursin will review daily staffing sheets weekly four (4) consecutive weeks then month six (6) months. Any significant concern during audits will be addressed immediately to ensure compliance with staff to resident ratio as mandated by state of New Jersey.	bol co art ng r for hly x hs h the the ve t ut o ng s and ng
	the day shift, required -06/16/23 had 14	d 18 CNAs. 4 CNAs for 145 residents on			

JL5V11

STATEMEN	Sey Department of Hea T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVE COMPLETED C			
		061601	B. WING			07/20/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE				
ATRIUM P	POST ACUTE CARE OF V	νδννέ	PS ROAD NJ 07470					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN(FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
S 560	Continued From page	e 2	S 560					
	the day shift, required -06/17/23 had 15 the day shift, required	5 CNAs for 145 residents on						
	-	ient in CNA staffing for day shifts as follows:						
	the day shift, required -06/26/23 had 12	2 CNAs for 144 residents on						
	the day shift, required	4 CNAs for 144 residents on						
	the day shift, required	d 18 CNAs. 4 CNAs for 144 residents on						
	-06/30/23 had 14 the day shift, required	4 CNAs for 144 residents on						
	the day shift, required							
	the day shift, required							
	the day shift, required -07/04/23 had 13	3 CNAs for 141 residents on						
	the day shift, required -07/05/23 had 13 the day shift, required	3 CNAs for 141 residents on						
	the day shift, required	3 CNAs for 141 residents on 1 18 CNAs. 3 CNAs for 141 residents on						
	the day shift, required	d 18 CNAs. 4 CNAs for 147 residents on						
	During an interview w	vith the surveyor on 7/20/23 ninistrator stated she was						
	aware they are not m							

JL5V11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED			
		061601	B. WING		07	C 07/20/2023		
	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE					
	OST ACUTE CARE OF V	1120 AL	PS ROAD					
		WAYNE,	NJ 07470					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE		
S 560	Continued From page	e 3	S 560					
		staff to resident ratios. She to find solutions to meet the						
	NJAC 8:39-5.1(a)							

JL5V11

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF RE	VISIT
	A. Building			
315335 _{Y1}	B. Wing	Y2	8/24/2023	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 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).

ITEN	и	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0609 483.12(b)(5)(i)(A) (1)(4)	(B)(c) (B)(c) (B)(c) (Completed (08/11/2023)	ID Prefix Reg. # LSC	F0610 483.12(c)(2)-(4)	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
REVIEWEL STATE AG REVIEWEL CMS RO		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR	I	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 7/20/2023			CK FOR ANY UNCORREC DRRECTED DEFICIENCI				в 🗌 NO	