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 _____	C 07/20/2023

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 COMPLAINT#: NJ164781 CENSUS: 149 SAMPLE SIZE: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. Based on interviews, medical records (MRs), and review of other pertinent facility documentation on 7/13/23, it was determined the facility failed to thoroughly investigate an alleged staff-to-resident physical abuse allegation involving the Certified Nursing Aide (CNA #1) and Resident #1. The facility also failed to ensure its policy titled "Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property" was consistently implemented; when, on 6/4/23 (time unknown), a visitor (Visitor #1) reported to the Licensed Practical Nurse/Unit Manager (LPN/UM) that CNA #1 hit Resident #1. The LPN/UM then reported the abuse allegation to the Registered Nurse/Evening Supervisor (RN/ES). At approximately 4:30 PM that same day, a second visitor (Visitor #2) reported to the RN/ES that Resident #1 [redacted] was [redacted] and someone might have hit the Resident's [redacted] or the Resident. The RN/ES interviewed the LPN/UM, LPN #1, and CNA #1. According to the RN/ES, she was not notified of the alleged	F 000		

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

Electronically Signed | 08/10/2023

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 _____	C 07/20/2023

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	Continued From page 1 physical abuse reported by Visitor #1. However, she started an investigation focusing on CNA #1 because she was the last person with Resident #1 in the dining room. The RN/ES confirmed that CNA #1 was not immediately suspended when she initiated an investigation because "it was not alarming at that time." During the investigation, the RN/ES reassigned CNA #1 to provide care to residents in another unit for the rest of the evening shift (3 PM-11 PM) without the CNA being monitored or supervised for approximately 6 hours. The facility's failure to immediately remove and/ or suspend CNA #1 until the outcome of the investigation and thoroughly investigate the allegations of abuse, per the facility's abuse policy, posed a likelihood of serious harm to the health and well-being of Resident #1 and potentially all other residents that CNA #1 provided care. This resulted in an Immediate Jeopardy (IJ) situation. This IJ was identified, and an IJ template was presented to the Administrator on 7/13/23 at 6:03 PM. The IJ began on 6/4/2023 and continued until 7/13/2023. The facility presented an acceptable removal plan which included initiating in-services for all staff on the facility's abuse policy. This was verified on-site on 7/20/23. The non-compliance remained on 7/14/23 for no actual harm, with the potential for more than minimal harm that is not an immediate jeopardy.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		8/11/23

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 _____	C 07/20/2023

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 609	Continued From page 2 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00164781 Based on interviews and a review of the medical records (MRs) and other facility documentation on 7/13/23, it was determined that the facility failed to immediately report an allegation of staff to resident physical abuse to the New Jersey Department of Health (NJDOH) and follow its policy titled; "Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property." This	F 609	What corrective action will be accomplished for those residents affected by the deficient practice? CNA#1 was suspended on [redacted] in accordance to the incident on [redacted] in compliance with the facility's Abuse, Neglect, Mistreatment and Misappropriation policy and procedure. The center called the NJDOH and 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 _____	C 07/20/2023

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 609	Continued From page 3 deficient practice was identified for 1 of 5 residents (Resident #1) and was evidenced by the following: According to the Admission Record, Resident #1 was admitted to the facility on [redacted] with diagnoses that included but were not limited to; [redacted], and [redacted]. A Minimum Data Set (MDS), an assessment tool, dated [redacted] 3, revealed the Resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated [redacted], and the Resident required assistance with activities of daily living (ADLs). A review of the Order Summary Report (OSR) included a Physician Order (PO) initiated on [redacted] for [redacted] care to the [redacted] and [redacted] to [redacted] and [redacted] shift. A review of the Care Plan (CP) dated [redacted] indicated that Resident #1 had [redacted] Interventions included but were not limited to [redacted] consult, explaining all procedures before starting and allowing to [redacted], attempting non-pharmacological approaches including [redacted] n, and developing more appropriate methods of [redacted]. A review of nursing progress notes (NPN) dated 6/4/23 at 2:49 pm revealed Resident #1 was [redacted], and [redacted]. Redirection [was] ineffective. The	F 609	Ombudsman office to report the 6/4/2023 incident on 7/13/2023. Resident #1 was evaluated by the nursing supervisor on 6/4/2023, No visible signs of new injury nor pain. CNA #1 was educated on Abuse, Neglect, Mistreatment and Misappropriation policy and procedure on 6/5/2023. DON and Supervisor (E.S.) were educated on Abuse, Neglect, Mistreatment and Misappropriation policy and procedure for 6/4/2023 incident to ensure any allegation of abuse is being followed, specifically on removing the staff/employee from the staff to resident abuse, in accordance to the policy of Abuse, Neglect, Mistreatment and Misappropriation. --- How the facility will identify other residents having the potential to be affected by the 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 [redacted] had [redacted] t and [redacted] assessment on [redacted]. No visible signs of injury nor signs of pain and all residents denied abuse or had no signs of abuse.	

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 _____	C 07/20/2023

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 609	Continued From page 4 responsible party (RP) was notified. Further review of the NPN, a late entry dated [redacted] at 2:20 pm, revealed Resident #1 was noted with [redacted] in the [redacted]. The physician and RP were notified. A review of the "Investigational Summary" dated [redacted] (timeline of events unknown) signed by the DON, revealed on [redacted], under the description of the event, she received a call from the supervisor [RN/ES] that Visitor #1 made an accusation that CNA #1 hit a resident. The investigation findings indicated an investigation was conducted, and the statement was immediately collected. The supervisor was told to make sure not to assign CNA #1 to the alleged Resident. The investigation findings revealed that statements from all staff present at the time of the alleged abuse denied witnessing the alleged incident. CNA #1 denied the allegation. According to CNA #1 interview, she was redirecting Resident #1 due to behavior when a family member (Visitor #1) saw the [redacted] s and assumed CNA #1 hit the Resident (Resident #1). Visitor #1, who made the allegation, stated they did not witness the alleged incident but referred to another (Visitor #2) who was also a witness. Visitor #2 denied witnessing the alleged abuse. The conclusion (time unknown) included that no substantial evidence substantiated the alleged abuse. A review of the typewritten witness statement dated 7/4/23, unsigned, prepared by the RN/ES, revealed on 6/4/23, around 4:30 pm, Visitor #1 asked her to check on [the] [redacted] unit because something was happening. The RN/ES indicated the [redacted] unit "was ok and nothing to report." The statement further showed that another visitor (Visitor #2) questioned if someone hit Resident	F 609	All remaining residents in the building had full body skin assessment and pain assessment on 7/13/2023 with no visible signs of injury nor signs of pain and all residents denied abuse or had no signs of abuse. ------- What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur? All direct care staff have been in-serviced/educated on the center's Abuse, Neglect, Mistreatment and Misappropriation policy and procedure on 7/13/2023. All non-direct care staff, department heads and the DON were educated on Abuse, Neglect, Mistreatment and Misappropriation policy and procedure. This education began on 7/13/2023 and was fully completed on 7/14/2023. Nurse Supervisor (E.S.) was educated in accordance to the 6/4/2023 incident on how the facility's Abuse, Neglect, Mistreatment and Misappropriation of resident policy and procedure is followed. Abuse, Neglect, Mistreatment and Misappropriation of resident policy and procedure, revised on August 11, 2023; staff was re-inserviced on the policy and procedure revision on August 11, 2023. ------	

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 _____	C 07/20/2023

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 609	Continued From page 5 #1 because there was [redacted] on the Resident's [redacted] According to the statement, the RN/ES assessed the Resident, and [redacted] were noted. The nurses (LPN #1 and LPN/UM) who were there stated Resident #1 was [redacted] and when CNA #1 went to assist the Resident, who "patient refused to have any contact, and the CNA came back to continue with her documentation without having skin contact with the resident." The DON told RN/ES to "collect everybody's statement for her to start an investigation." A review of a handwritten statement dated [redacted] signed by LPN/UM revealed, "On the day in question, I was working as a floor nurse; I did not see CNA #1 hit the resident (Resident #1)." A review of a handwritten statement dated 6/4/23 (untimed), unsigned, prepared by CNA #1 per DON, revealed that on [redacted] while in the dining room, Resident #1 was having an [redacted]. Visitor #1 and Visitor #2 were nearby, having a conversation. Another Visitor with Visitor #2 asked why Resident #1 was [redacted] CNA #1 responded that it was from a [redacted]. After that, while CNA #1 and LPN/UM were talking to Visitor #2, Visitor #1 alleged somebody hit Resident #1. CNA #1 replied, "No, Resident #1 always [redacted] ...he/she was not touched." According to CNA #1, during an interview on 7/24/23 at 11:06 am, she confirmed Visitor #1 alleged she hit Resident #1. Further review of the investigation summary and attached witness statements did not include documented evidence that CNA #1, LPN #1, Resident #1, and other residents assigned to CNA #1 were interviewed and/or submitted a	F 609	How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. What Q.A program will be put into place to monitor the continued effectiveness of the systemic change? The Director of Nursing, or Administrator (LNHA) will conduct a random audit of five (5) residents weekly for four consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated, and reported to the appropriate people. This is part of the Performance Improvement Project (PIP) included in the QAPI program; this was already initiated to ensure this is properly executed.	

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 _____	C 07/20/2023

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 609	Continued From page 6	F 609		

statement. LPN #1 was not employed at the facility during the survey.

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 [redacted] at about 4:30 pm: on 6[redacted] 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.

During an interview on 7/13/23 at 3:30 pm, the DON stated she completed the abuse allegation investigation summary dated[redacted] involving CNA #1 and Resident #1. The DON and the Administrator confirmed the alleged incident was not reported to the New Jersey Department of Health (NJDOH), and CNA #1 was not immediately suspended because it was determined within two hours of the allegation that there was no abuse. However, there was no documented evidence in the MRs, including witness statements and investigation summary, that a thorough investigation was completed within two hours after the physical abuse allegation. When the surveyor asked if the facility's policy on abuse to report to the NJDOH timely any abuse allegation and immediately remove and/or suspend team members accused of alleged abuse pending the investigation outcome was followed, the DON and Administrator refused to answer.

During an interview on 7/14/23 at 1:00 pm, the RN/ES stated she notified the Director of Nursing (DON) immediately of the allegation made by Visitor #2, and the DON instructed her to collect written statements.

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 _____	C 07/20/2023

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 609	Continued From page 7 During an interview on 7/14/23 at 3:00 pm, the Administrator stated she was unaware of the alleged incident until the next day. She stated the DON or Administrator is responsible for reporting and conducting a thorough investigation of an abuse allegation. During an interview on 7/20/23 at 9:45 am, the LPN/UM stated on [redacted] (time unknown), Visitor #1 alleged CNA #1 hit Resident #1, and she informed the RN/ES of the alleged abuse incident. During an interview on 7/24/23 at 11:06 am, CNA #1 stated on [redacted] (time unknown), while she was in the dining room trying to calm Resident #1, Visitor #1 alleged she hit Resident #1. The allegation was made in front of Visitor #2 and LPN/UM. CNA #1 was unable to recall if she informed the RN/ES of the alleged incident but stated that LPN/UM witnessed the allegation and spoke with the RN/ES. Review of facility policy updated on 5/2022, titled; "Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property" included but was not limited to; "It is the policy of (Center) that each Resident will be free from abuse ...include verbal, mental, sexual, or physical abuse ...No abuse or harm will be tolerated ... Reporting and Response Component: It is the policy of the [center] that abuse allegations ...are reported per Federal and State Law. The center will ensure that all alleged violations involving abuse, neglect ...are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the	F 609		

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 _____	C 07/20/2023

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 609	Continued From page 8 allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the center and the Department of Health to in accordance with State law through established procedures."	F 609		
F 610 SS=J	NJAC 8:39-9.4(f) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00164781 Based on interviews, medical records (MRs), and review of other pertinent facility documentation on 7/13/23, it was determined the facility failed to	F 610	What corrective action will be accomplished for those residents affected by the deficient practice? CNA#1 was suspended on 7/13/2023 in accordance to the incident on [redacted], in compliance with the facility's Abuse,	8/11/23

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 _____	C 07/20/2023

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 610	Continued From page 9 thoroughly investigate an alleged staff-to-resident physical abuse allegation involving the Certified Nursing Aide (CNA #1) and Resident #1. The facility also failed to ensure its policy titled "Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property" was consistently implemented; when, on [redacted] (time unknown), a visitor (Visitor #1) reported to the Licensed Practical Nurse/Unit Manager (LPN/UM) that CNA #1 hit Resident #1. The LPN/UM then reported the abuse allegation to the Registered Nurse/Evening Supervisor (RN/ES). At approximately 4:30 PM that same day, a second visitor (Visitor #2) reported to the RN/ES that Resident #1 [redacted] was [redacted], and someone might have hit the Resident's hand or the Resident. The RN/ES interviewed the LPN/UM, LPN #1, and CNA #1. According to the RN/ES, she was not notified of the alleged physical abuse reported by Visitor #1. However, she started an investigation focusing on CNA #1 because she was the last person with Resident #1 in the dining room. The RN/ES confirmed that CNA #1 was not immediately suspended when she initiated an investigation because "it was not alarming at that time." During the investigation, the RN/ES reassigned CNA #1 to provide care to residents in another unit for the rest of the evening shift (3 PM-11 PM) without the CNA being monitored or supervised for approximately 6 hours. The facility's failure to immediately remove and/ or suspend CNA #1 until the outcome of the investigation and thoroughly investigate the allegations of abuse, per the facility's abuse policy, posed a likelihood of serious harm to the health and well-being of Resident #1 and	F 610	Neglect, Mistreatment and Misappropriation policy and procedure. The center called the NJDOH and the Ombudsman office to report the [redacted] incident on 7/13/2023. Resident #1 was evaluated by the nursing supervisor on [redacted], No visible signs of new injury nor pain. CNA #1 was educated on Abuse, Neglect, Mistreatment and Misappropriation policy and procedure on 6/5/2023. DON and Supervisor (E.S.) were educated on Abuse, Neglect, Mistreatment and Misappropriation policy and procedure for [redacted] incident to ensure any allegation of abuse is being followed, specifically on removing the staff/employee from the staff to resident abuse, in accordance to the policy of Abuse, Neglect, Mistreatment and Misappropriation. --- How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by not following the Center's policies and procedures on Abuse, Neglect, Mistreatment and Missapropriation. All residents that resided on CNA #1	

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 _____	C 07/20/2023

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 610	Continued From page 10 potentially all other residents that CNA #1 provided care. This resulted in an Immediate Jeopardy (IJ) situation. This IJ was identified, and an IJ template was presented to the Administrator on 7/13/23 at 6:03 PM. The IJ began on 6/4/2023 and continued until 7/13/2023. The facility presented an acceptable removal plan which included initiating in-services for all staff on the facility's abuse policy. This was verified on-site on 7/20/23. The non-compliance remained on 7/14/23 for no actual harm, with the potential for more than minimal harm that is not an immediate jeopardy. This deficient practice was identified for 1 of 5 residents (Resident #1) and was evidenced by the following: According to the Admission Record, Resident #1 was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted] Review of the Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed the Resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated [redacted], and the Resident required assistance with activities of daily living (ADLs). A review of the Care Plan (CP) dated [redacted]2 indicated that Resident #1 had a behavior problem, including yelling out without provocation/cause. Interventions included but were not limited to [redacted] consult, explaining all procedures before starting and allowing to adjust to changes, attempting	F 610	assignment on [redacted] had [redacted] skin assessment and [redacted] assessment on 7/13/2023. No visible signs of injury nor signs of pain and all residents denied abuse or had no signs of abuse. All remaining residents in the building had full body skin assessment and pain assessment on 7/13/2023 with no visible signs of injury nor signs of pain and all residents denied abuse or had no signs of abuse. --- What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur? All direct care staff have been in-serviced/educated on the center's Abuse, Neglect, Mistreatment and Misappropriation policy and procedure on 7/13/2023. All non-direct care staff, department heads and the DON were educated on Abuse, Neglect, Mistreatment and Misappropriation policy and procedure. This education began on 7/13/2023 and was fully completed on 7/14/2023. Nurse Supervisor (E.S.) was educated in accordance to the 6/4/2023 incident on how the facility's Abuse, Neglect, Mistreatment and Misappropriation of resident policy and procedure is followed. Abuse, Neglect, Mistreatment and	

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 _____	C 07/20/2023

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 610	Continued From page 11 non-pharmacological approaches including [redacted] observation, and developing more appropriate methods of [redacted]. A review of the nursing progress notes (NPN) dated [redacted] at 2:49 PM revealed Resident #1 was [redacted] Redirection [was] ineffective. The responsible party (RP) was notified. Further review of the NPN, a late entry dated [redacted] at 2:20 PM, revealed Resident #1 was noted with [redacted] in the [redacted] The physician and the Resident's RP were notified. A review of the "Investigational Summary" dated 6/4/23 (timeline of events unknown) signed by the DON, revealed on [redacted] under the description of the event, she received a call from the supervisor [RN/ES] that Visitor #1 made an accusation that CNA #1 hit a resident. The investigation findings indicated an investigation was conducted, and the statement was immediately collected. The supervisor was told to make sure not to assign CNA #1 to the alleged Resident. The investigation findings revealed that statements from all staff present during the alleged abuse denied witnessing the incident. CNA #1 denied the allegation. According to CNA #1 interview, she was redirecting Resident #1 due to behavior when a family member (Visitor #1) saw the [redacted] on the [redacted] and assumed CNA #1 hit the Resident (Resident #1). Visitor #1, who made the allegation, stated they did not witness the alleged incident but referred to another (Visitor #2) who was also a witness. Visitor #2 denied witnessing the alleged abuse. The conclusion (time unknown) included that there was no substantial evidence to substantiate the alleged abuse.	F 610	Misappropriation of resident policy and procedure, revised on August 11, 2023; staff was re-inserviced on the policy and procedure revision on August 11, 2023. --- How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. What Q.A program will be put into place to monitor the continued effectiveness of the systemic change? The Director of Nursing, or Administrator (LNHA) will conduct a random audit of five (5) residents weekly for four consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated, and reported to the appropriate people. This is part of the Performance Improvement Project (PIP) included in the QAPI program; this was already initiated to ensure this is properly executed. The Administrator or Director of Social Worker will conduct a random audit of five (5) employees weekly for four consecutive weeks. These employees will be asked on the protocols of Abuse, Neglect, Mistreatment and Misappropriation policy and procedure. Any concerns during audits will be addressed immediately to ensure compliance with standards of care.	

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 _____	C 07/20/2023

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 610	Continued From page 12	F 610		

A review of a typewritten witness statement dated 7/4/23, unsigned, prepared by the RN/ES, revealed on [redacted], around 4:30 PM, Visitor #1 asked her to check on the West unit because something was happening. The RN/ES indicated the [redacted] unit "was ok and nothing to report." The statement further showed that another visitor (Visitor #2) questioned if someone hit Resident #1 because there was [redacted] on the Resident's [redacted] According to the statement, the RN/ES assessed the Resident, and no bruises or injuries were noted. The nurses (LPN #1 and LPN/UM) who were there stated Resident #1 was [redacted] and when CNA #1 went to assist the Resident, who "patient refused to have any contact, and the CNA came back to continue with her documentation without having skin contact with the resident." The DON told RN/ES to "collect everybody's statement for her to start an investigation."

A review of a handwritten statement dated [redacted] signed by the LPN/UM showed, "On the day in question, I was working as a floor nurse; I did not see CNA #1 hit the resident (Resident #1)."

A review of a handwritten statement dated 6/4/23 (untimed) and unsigned, prepared by CNA #1 per DON, revealed that on [redacted], while in the dining room, Resident #1 was having an [redacted] Visitor #1 and Visitor #2 were nearby, having a conversation. Another Visitor with Visitor #2 asked why Resident #1 was [redacted]. CNA #1 responded that it was from a [redacted]. After that, while CNA #1 and LPN/UM were talking to Visitor #2, Visitor #1 alleged somebody hit Resident #1. CNA #1 replied, "No, Resident #1 always outbursts like that ... he/she was not touched."

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 _____	C 07/20/2023

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 610	Continued From page 13	F 610		

According to CNA #1, during an interview on 7/24/23 at 11:06 AM, she confirmed Visitor #1 alleged that she hit Resident #1.

A review of CNA #1 "Detailed Hours," an employee timecard report, revealed CNA #1 worked the following hours: on 6/4/23 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.

During an interview on 7/13/23 at 12:15 PM and 7/20/23 at 9:45 AM, the LPN/UM stated on [redacted] (time unknown), Visitor #1 alleged CNA #1 hit Resident #1. She stated she informed the RN/ES of the alleged abuse incident.

During the first and second interviews on 7/13/23 at 2:40 PM, the RN/ES stated CNA #1 was not immediately suspended when she initiated an investigation because "it was not alarming at that time." During the investigation, CNA #1 was reassigned to care for residents in another unit for the rest of the evening shift (3 PM-11 PM). The RN/ES stated CNA #1 was not told to go home because there was no abuse, and staff did not witness it. RN/ES confirmed she only interviewed LPN #1 and LPN/UM. Additionally, the RN/ES stated she notified the Director of Nursing (DON) immediately of the allegation made by Visitor #2, and the DON instructed her to collect written statements. The DON did not instruct her to suspend CNA #1 but reassigned her to another unit. The RN/ES confirmed she was aware of the facility's policy on abuse which included immediately removing and/or suspending staff members accused of the alleged "abuse" pending the investigation outcome; however, she was unable to explain why it was

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 _____	C 07/20/2023

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 610	Continued From page 14	F 610		

not followed and stated, "I missed that part ...I misunderstood that part".

During an interview on 7/13/23 at 3:30 PM, the DON stated she completed the abuse allegation investigation summary dated 6/4/23 involving CNA #1 and Resident #1. The DON and the Administrator confirmed the alleged incident was not reported to the New Jersey Department of Health (NJDOH), and CNA #1 was not immediately suspended because it was determined within two hours of the allegation that there was no abuse. Therefore, CNA #1 was reassigned to another unit instead. However, there was no documented evidence in the MRs, including witness statements and investigation summary, that a thorough investigation was completed within two hours after the physical abuse allegation. The DON further stated all staff on the West unit were interviewed immediately after the allegation was made. Statements from these staff were all collected. However, the DON could not provide documented evidence that CNA #2, LPN #1, Resident #1, and other residents assigned to CNA #1 were interviewed or submitted witness statements. The Administrator confirmed that both visitors' statements were obtained the next day, on [redacted] when she was informed of the allegations.

During a second interview on 7/14/23 at 2:30 PM, the DON stated she couldn't speak to the investigation summary, they may be misused words, but the investigation findings were accurate. According to the DON, the RN/ES notified her about Visitor #1's allegation to check on the [redacted] unit, and within 2 hours, the RN/ES notified her again that the issue was about Resident #1's [redacted] The DON stated she was

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 _____	C 07/20/2023

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 610	Continued From page 15	F 610		

not aware of a second visitor allegation until the next day when she interviewed CNA #1. The DON acknowledged she failed to prepare an accurate investigation report but asserted the alleged incident was thoroughly investigated.

During an on 7/14/23 at 3:00 PM, the Administrator stated she was unaware of the alleged incident until the next day. She stated the DON or Administrator is responsible for reporting and conducting a thorough investigation of an abuse allegation. She added she could not speak for the investigation summary for [redacted] but confirmed she is the last person to review and approve each investigation summary.

During an interview on 7/20/23 at 10:00 AM, CNA #2, assigned to Resident #1 on [redacted] during the day shift (7 AM-3 PM), confirmed the RN/ES or the DON did not interview or ask her to write a witness statement.

During an interview on 7/24/23 at 11:06 AM, CNA #1 stated on [redacted] (time unknown), while she was in the dining room trying to calm Resident #1, Visitor #1 alleged she hit Resident #1. The allegation was made in front of Visitor #2 and LPN/UM. CNA #1 could not recall if she informed the RN/ES of the alleged incident but stated that LPN/UM witnessed the incident and spoke with the RN/ES.

During the survey, the surveyor attempted to interview Resident #1, but he/she refused to be interviewed.

Review of facility policy updated on 5/2022, titled; "Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property," included

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 _____	C 07/20/2023

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 610	Continued From page 16	F 610		

but was not limited to: "It is the policy of (Center) that each Resident will be free from abuse ...include verbal, mental, sexual, or physical abuse ...No abuse or harm will be tolerated ...
Investigation Components: It is the policy of this center that reports of abuse ...are promptly and thoroughly investigated.
Procedure: The center will immediately begin a thorough investigation of any reported incident and collect information that corroborates or disproves the incident.
a. When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel.
The investigation will include:
ii. Who was involved
iii What happened: a. Resident's statements, b. Resident's roommate statements, c. interviewing the alleged perpetrator, d. Involved team members and witness statements of [the] event: i. identifying and interviewing other team members and residents in the immediate area at the time of the incident who may have witnessed what occurred, ii. Interviewing team members who worked the previous shift ...
iv. Where did it happen?
v. How did it happen ...
x. Conclusion based upon findings.
Additional Investigation Protocols.
The Administrator or designee will inform the Resident and/ or his/her representative of the findings of the investigation and corrective action plan.
Protection Components: Immediately upon receiving a report of alleged abuse, the Administrator and or designee will coordinate [the] delivery of appropriate medical and/or psychosocial care and attention. Ensuring 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 _____	C 07/20/2023

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 610	Continued From page 17 safety and well-being of vulnerable individuals...The center will take necessary steps to protect residents ... a. Procedures must be in place to provide the Resident with a safe, protected environment during the investigation: i. The alleged perpetrator will immediately be removed, and the Resident will be protected. Team members accused of alleged abuse will be immediately removed from the center and will remain removed pending the results of a thorough investigation. (Decision of the extent of the immediate disciplinary action will be made by the Administrator or designee.), iv. Examine, assess, and interview the Resident and other residents potentially affected immediately ...Notify the physician. Reporting and Response Component: It is the policy of the [center] that abuse allegations ...are reported per Federal and State Law. The center will ensure that all alleged violations involving abuse, neglect ...are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the center and the Department of Health to in accordance with State law through established procedures." NJAC- 8:39-4.1 (a)5	F 610		

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 _____	C 07/20/2023

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	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: COMPLAINT # NJ00164781 Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was evidence by the following. shifts reviewed. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. 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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and	S 560	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 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	8/11/23

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 _____	C 07/20/2023

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 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 CNA and perform CNA duties. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 06/04/2023 and 06/17/2023 and 06/25/2023 to 07/07/2023, revealed the staffing to resident ratios did not meet the minimum requirement. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -06/04/2023 had 13 CNAs for 142 residents on the day shift, required 18 CNAs. -06/05/23 had 15 CNAs for 142 residents on the day shift, required 18 CNAs. -06/06/23 had 14 CNAs for 142 residents on the day shift, required 18 CNAs. -06/07/23 had 15 CNAs for 142 residents on the day shift, required 18 CNAs. -06/08/23 had 13 CNAs for 144 residents on the day shift, required 18 CNAs. -06/09/23 had 15 CNAs for 143 residents on the day shift, required 18 CNAs. -06/10/23 had 14 CNAs for 143 residents on the day shift, required 18 CNAs. -06/11/23 had 14 CNAs for 142 residents on the day shift, required 18 CNAs. -06/12/23 had 13 CNAs for 142 residents on the day shift, required 18 CNAs. -06/13/23 had 14 CNAs for 142 residents on the day shift, required 18 CNAs. -06/14/23 had 13 CNAs for 142 residents on the day shift, required 18 CNAs. -06/15/23 had 15 CNAs for 145 residents on the day shift, required 18 CNAs. -06/16/23 had 14 CNAs for 145 residents on	S 560	for their school to get their CNA license. The facility has contracted a CNA school to send new hires Nursing Assistants to get certified and once certified may start working in the facility. The Administrator or Director of Nursing will review daily staffing sheets weekly for four (4) consecutive weeks then monthly x six (6) months. Any significant concerns during audits will be addressed immediately to ensure compliance with the 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, i.e. What Q.A program will be put into place to monitor the continued effectiveness of the systemic change? The Administrator or Director of Nursing 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 _____	C 07/20/2023

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	S 560		

the day shift, required 18 CNAs.
-06/17/23 had 15 CNAs for 145 residents on the day shift, required 18 CNAs.

The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

-06/25/23 had 12 CNAs for 145 residents on the day shift, required 18 CNAs.
-06/26/23 had 12 CNAs for 144 residents on the day shift, required 18 CNAs.
-06/27/23 had 14 CNAs for 144 residents on the day shift, required 18 CNAs.
-06/28/23 had 13 CNAs for 144 residents on the day shift, required 18 CNAs.
-06/29/23 had 14 CNAs for 144 residents on the day shift, required 18 CNAs.
-06/30/23 had 14 CNAs for 144 residents on the day shift, required 18 CNAs.
-07/01/23 had 13 CNAs for 144 residents on the day shift, required 18 CNAs.

-07/02/23 had 13 CNAs for 143 residents on the day shift, required 18 CNAs.
-07/03/23 had 13 CNAs for 142 residents on the day shift, required 18 CNAs.
-07/04/23 had 13 CNAs for 141 residents on the day shift, required 18 CNAs.
-07/05/23 had 13 CNAs for 141 residents on the day shift, required 18 CNAs.
-07/06/23 had 13 CNAs for 141 residents on the day shift, required 18 CNAs.
-07/07/23 had 13 CNAs for 141 residents on the day shift, required 18 CNAs.
-07/08/23 had 14 CNAs for 147 residents on the day shift, required 18 CNAs.

During an interview with the surveyor on 7/20/23 at 12:39 PM, the Administrator stated she was aware they are not meeting the required

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 _____	C 07/20/2023

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 minimum direct care staff to resident ratios. She added, they continue to find solutions to meet the requirements. NJAC 8:39-5.1(a)	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315335 (Y1)	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 08/11/2023	ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 08/11/2023	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

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	
7/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO