STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 12/13/22 Census: 117 Sample: 24 + 2 closed records+14 =40 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow physician orders for blood pressure (BP) parameters according to standards of clinical practice for one of 24 residents reviewed (Resident #18). This deficient practice was evidenced by the following:	F 658	1.Residents affected by deficient practice: Resident # 18 was administered medication EX Order 26 § 4b1 when the medication should have been held. All licensed staff were educated by ADON on the facility policy and procedure on documentation of medication administration.	1/16/23

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

Electronically Signed | 01/06/2023

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1 Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 12/06/22 at 9:45 AM, the surveyor observed Resident #18 in bed watching television. The surveyor reviewed the medical records of Resident #18. Resident #18's Admission Record (Face sheet; an admission summary) revealed that the resident was admitted to the facility with diagnoses that included: EX Order 26 § 4b1 [redacted]	F 658	2.Identifying other residents who could be affected by the deficient practice: All residents have the potential to be affected from this practice. 3.Measures or systemic changes to ensure that the deficiencies will not recur: All licensed staff educated by DON/ADON/Designee on the facility policy and procedure on documentation of medication administration 4.Monitoring the continued effectiveness of the systemic change: DON/ADON/Designee will conduct random audits of all licensed staff on Medication Pass, Documenation of Medciation Adminstration weekly x 4 weeks then monthly x 3 months. Results of audit will be reviewed at the monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Completion date: 01/16/2023	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658		F 658		

Continued From page 2

EX Order 26 § 4b1

The Annual Comprehensive Minimum Data Set, an assessment tool used to facilitate the management of care, dated 12/02/22 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Or out of 15, indicating that the resident's EX Order 26 § 4b1

The December 2022 Order Summary Report (OSR) revealed an original physician order dated 11/17/22 and was updated on 11/29/22 for EX Order 26 § 4b1 to give one tablet (tab) by mouth three times daily every Tuesday, Thursday, Saturday, and Sunday for EX Order 26 § 4b1 to be given for EX Order 26 § 4b1

The December 2022 OSR also showed a physician order dated 11/29/22 for EX Order 26 § 4b1 give one tab by mouth two times a day on Monday, Wednesday, and Friday for EX Order 26 § 4b1

The above orders for EX Order 26 § 4b1 were transcribed to the November and December 2022 electronic Medication Administration Record (eMAR) and signed by the nurses as administered. The November and December 2022 eMAR revealed that the EX Order 26 § 4b1 was administered when the medication should have been held on:

11/18/22 at 9 AM the SBP was documented as 156
11/21/22 at 9 PM the SBP was documented as

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 3	F 658		

111
12/01/22 at 1 PM the SBP was documented as 116
12/04/22 at 9 AM the SBP was documented as 103
12/04/22 at 5 PM the SBP was documented as 109

A review of the eMAR revealed that this deficient practice was first noticed on 11/18/22. The medical records showed that there were three nurses administered the medications when the medication should have been held.

On 12/07/22 at 9:15 AM, the surveyor was unable to interview Licensed Practical Nurse#1 (LPN#1) because she called out sick.

On 12/07/22 at 11:00 AM, the surveyor left a message with LPN #2 who did not return the surveyor call.

On 12/07/22 at 12:00 PM, the surveyor interviewed a LPN #3 who stated that when the resident's SBP is above 100 the nurse must hold the [redacted]. The LPN reviewed the November and December 2022 eMARs with the surveyor and acknowledge that on five occasions in November and December 2022 that [redacted] was administered when it should have been held for Resident #18.

Furthermore, LPN#3 acknowledged that administering Resident #18's [redacted] when the resident's SBP was above 100 could have elevated the resident's SBP. LPN#3 further stated that there was no negative effect to the resident.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 4 A review of the facility's policy for Administering Medications that was dated 5/31/21 and was provided by the DON indicated the following: "3. Medications must be administered in accordance with the orders, including any required time frame ....8. The following information must be checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vitals signs, if necessary." On 12/08/22 at 01:40 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Assistant Director of Nursing (ADON). The surveyor presented his findings to the administration. The DON acknowledged that administering [redacted] when Resident #18's SBP was above 100 could have potentially elevated the resident's SBP. The DON stated that there was no negative effect to the resident. No further documentation was provided to the survey team to refute theses findings. NJAC 8:39-11.2(b)	F 658		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 5 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to routinely and accurately post the nurse staffing information on four of 10 days during the survey period in a place within the facility readily accessible to the residents and the visitors. This deficient practice was evidenced by the following:	F 732	1. Immediate Action Staffing was updated and posted. 2.) Identification of Others All residents are at potential risk if facility cannot provide sufficient staffing to address care needs. 3. Systemic Changes a.) The facility updated the policy for posting staffing sheets to include the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 6 On 11/28/22 at 8:48 AM, upon entry into the facility, the surveyor observed that the Nursing Home Staffing Report Form (NHSRF) that was posted in the reception area of the lobby showed a staffing report dated 11/28/22 with the census of 115 for Day Shift 7 AM - 3 PM. On that same date and time, the Licensed Nursing Home Administrator (LNHA) provided a copy of the facility's census in the presence of the Regional LNHA (RLNHA) and the Regional Director of Nursing (RDON). The provided copy of the facility's census showed 118 with one bed hold. The surveyor asked the facility management why the posted NHSRF in the reception area and the provided census copy did not match. The LNHA stated that she will get back to the surveyor. On 11/28/22 at 10:00 AM, during the Entrance Conference of the surveyor with the LNHA, DON, RDON, and RLNHA, the LNHA confirmed that the facility census was 117 with two bed hold. On Monday, 12/05/22 at 8:12 AM, the surveyor observed the NHSRF that was posted in the reception area of the facility lobby dated 12/02/22, three days prior on Friday, 12/02/22 with a census of 118 for the Day Shift 7 AM-3 PM, Evening Shift 3 PM-11 PM, and Night Shift 11 PM-7 AM. The 12/05/22 NHSRF was not posted for the day shift. On 12/05/22 at 8:13 AM, the surveyor interviewed the Receptionist regarding the posted NHSRF. The Receptionist informed the surveyor that she was not responsible for posting the NHSRF. She further stated that it was the Staffing Coordinator's responsibility to post the updated	F 732	weekends. b.) The staffing coordinator was educated on the process . c.) The facility will implement an audit that includes weekend auditing to ensure that the staffing sheets are posted according to the facility policy. The audit will be conducted on a weekly basis for three months. The audit will be conducted by the Director of Nursing or designee. 4.) Quality Assurance Results of the audits will be reported during the Quality Assurance and Performance Improvement (QAPI) meeting monthly for the next three months. Following three months, the committee will determine frequency and need. Completion date: 01/16/2023	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 7	F 732		

NHSRF during weekdays and the Nursing Supervisor's responsibility to post it during the weekends in the facility lobby.

On 12/07/22 at 10:58 AM, the surveyor copied and reviewed the posted 12/07/22 NHSRF in the reception area and showed that on the Day Shift the total number of patients (census) was 120. The surveyor reviewed the facility-provided schedule, revealed a conflicting resident census of 122 for 12/07/22 for the Day Shift.

On 12/07/22 at 11:05 AM, the surveyor interviewed the Staffing Coordinator (SC) who informed the surveyor that she was also a Certified Nursing Aide (CNA). The SC stated that her job responsibilities included creating the schedule of nurses and CNAs, entering information into the NHSRF, and posting the NHSRF in the facility lobby.

On that same date and time, the surveyor asked the SC why the census that was posted on 11/28/22 and 12/07/22 NHSRF did not match the actual census report for those days. In addition, the surveyor asked why on Monday, 12/05/22 there was still the Friday 12/02/22 staffing posted? The SC stated that it was "probably my mistake, I'm sorry." The SC further stated that on the days that she was not working, it will be the Nursing Supervisor's responsibility to post the correct and updated NHSRF.

At that time, the SC stated that she receives the census daily via email from admission, then she entered the information to the NHSRF, and post it in the lobby area.

Furthermore, the surveyor asked the SC who was

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 8 responsible for posting the updated and correct NHSRF this weekend, on 12/03/22 and 12/04/22. The SC stated that she worked on 12/03/22 and 12/04/22, then the surveyor asked the SC why the updated and correct NHSRF was not posted. The SC responded, "I cannot remember why." On 12/07/22 at 12:57 PM, the survey team met with the DON, LNHA, and RLNHA who were made aware of the above findings. A review of the facility's Posting of Nurse Staffing Information Policy and Procedure dated 11/22/22 that was provided by the LNHA showed that it was the facility's policy to post the nurse staffing information on a daily basis, to make nurse staffing information readily available in a readable format to residents and visitors at any given time. The procedure included that the SC will post the notice of nurse staffing daily, placed at the first-floor receptionist desk (lobby), and the notice will include the following information: facility name, current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses, Certified nurse aide, current resident census. On 12/12/22 at 02:44 PM, the survey team met with the LNHA, DON, and Regional LNHA. The facility management acknowledged the above findings and there was no further documentation was provided to the survey team to refute these findings. NJAC 8:39-41.2 (a)(b)(c)(1)	F 732		
F 836 SS=C	License/Comply w/ Fed/State/Locl Law/Prof Std	F 836		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 9 CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for	F 836	1. Immediate Action: a) Facility will submit proper 855 form and all other required paperwork	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 10 Medicare & Medicaid Services) and apply for a change in ownership upon 30 days of their sale in April 2022 in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76.....	F 836	2. Identification of Others: a.) This deficient practice did not cause harm to any of the residents or personnel in the facility. 3. Systemic Changes: a.) All staff was educated as to the correct legal name of the facility. The Administrator or designee will follow up with CMS regarding the change of facility name on a weekly basis x 6 months or until the name change of the facility has been approved by CMS. 4. Quality Assurance: a.) All findings will e reviewed with the quality assurance committee on a monthly basis. Completion Date: 01/16/2023	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 11	F 836		

(d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:
(1) Within 30 days -
(i) A change of ownership;
(ii) Any adverse legal action; or
(iii) A change in practice location.
(2) All other changes in enrollment must be reported within 90 days."

On 11/28/22 at 8:48 AM, upon arrival of the surveyors to the facility, the surveyor observed a stone mantel facility entrance sign that had a name that did not correspond with the CMS approved name and provider registered name. Covering that sign was a banner with another facility name indicating Springhills Post Acute Wayneview written on top of it indicating "Under New Management." The facility name indicating on the banner and was listed as Avalon Rehabilitation Care Center did not correspond with a CMS approved name change.

On 11/28/22 at 10:00 AM, during the Entrance Conference with the Licensed Nursing Home Administration (LNHA), Director of Nursing (DON), and the Regional LNHA (RLNHA), the surveyor asked the facility management why the signs outside the facility in the entrance of the parking lot showed two different facility names Springhills Post Acute Wayneview with a banner over that with a new name of Avalon Rehab & Care Center both of which do not match with the CMS approved name of Atrium Post Acute Care

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 12	F 836		

of Wayneview.

On that same date and time, the surveyor asked the facility management about the website which reflects that the CMS approved name of Atrium Post Acute Care of Wayneview reflects it was "permanently closed."

At that same time, the RLNHA stated that the facility transitioned to a new facility name and new management of Avalon Rehabilitation & Care Center since 4/25/22 and that the facility had been using the new company's name and logo. She further stated that the other name Springhills Post Acute Wayneview was changed from the current license name for unspecified number of years, and then under the new management of Avalon Rehabilitation & Care Center.

On 12/07/22 at 12:57 PM, the survey team met with the DON, LNHA, and RLNHA and were made aware of the above findings.

On 12/08/22 at 01:16 PM, the surveyor reviewed documents and the facility's policies that were provided by the LNHA and showed that the facility name and logo that were used were not according to the facility's licensed name and CMS approved name/change of ownership approval.

On 12/12/22 at 8:46 AM, the surveyor notified the LNHA that the team was requesting any and all communication with CMS, including the CMS-855 form (application for change of ownership) submitted to the CMS for a change of ownership. The LNHA stated that she will get back to the surveyor.

On 12/12/22 at 01:34 PM, the RLNHA and the

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 13 LNHA both stated to the surveyor that they will follow up again with the corporate office about communications with the CMS Medicare Administrative Contractor (MAC). On 12/12/22 at 01:52 PM, the RLNHA informed the surveyor that the application for a change in ownership was not submitted according to their Corporate Representative (CR) who was responsible for applying for the change of name and other facility's licensing because the CR thought "form 855 was only to be submitted once closing happened" and the facility did not receive the final approval from NJDOH (New Jersey Department of Health). A review of the facility license that was issued by the New Jersey Department of Health Division of Certificate of Need and Licensing with an issue date of 3/4/22 and an expiration date of 2/28/23. The NJDOH issued the license for the facility name of Atrium Post Acute Care of Wayneview, not Springhills or Avalon Rehab & Care Center. On 12/12/22 at 02:44 PM, the survey team met with the LNHA, RLNHA, and the DON and no further documentation was provided to the survey team to refute these findings. NJAC 8:39-5.1 (a)	F 836		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14	F 880		

development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to perform handwashing appropriately for two of five staff (agency Certified Nursing Aide (aCNA) and Supply Clerk/CNA) observed during incontinence care in accordance with the Centers for Disease Control and Prevention (CDC) guidelines for infection control and facility policy. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines, Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 01/18/2021	F 880	It is the policy of this facility to accurately and safely provide infection prevention and control, including the provision of establishing and maintaining an infection control program designed to provide a safe , sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This facility considers hand hygiene the primary means to prevent and control the spread of infections. 1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: On 12/5/22 at 6:27am, the surveyor	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Immediately after glove removal." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds." On 12/05/22 at 6:27 AM, the surveyor observed an aCNA in front of room 205 with a supply cart of linens, towels, and incontinence pads. The aCNA informed the surveyor that she was an agency nursing aide that had been working in the facility "for two weeks now," worked the 11 PM-7 AM night shift last night, and was about to perform morning care for the two residents in the room. Upon entry inside the resident's room, the aCNA immediately went inside the bathroom and washed both hands with water. The aCNA did not apply soap and proceeded to wash her hands for five seconds and then dried both hands with the use of clean paper towels. Then, the aCNA took a new pair of gloves. At that time, the surveyor asked the aCNA if she was done with hand hygiene and the aCNA stated "yes, I did wash my hands when I came out of the other room but my hands were sticky that is why I just washed them now with water. Why? You want me to see me wash my hands again?"	F 880	observed the CNA in front of room 205 with a supply cart of linens, towels, incontinence pad. The CNA informed the surveyor that she was an agency nursing aide that had been working in the facility for two weeks now worked 11pm □ 7am night shift last night and was about about to perform morning care for the two residents in the room. Upon entry inside the resident's room, the CNA immediately went inside the bathroom and washed both hands with water On 12/5/22 at 6:55am, the surveyor observed the Supply Clerk/CNA enter a resident's room and donned applied a new pair of gloves without performing hand hygiene. POC: After conducting the root cause analysis to this problem, we found the need to conduct a mandatory in-service/competency and ensure a systematic approach in the following areas: " Prevent , detect, investigate, and control infections in the facility " Train where and how to find and use pertinent procedures and equipment related to infection control " Train and in-service on the importance of hand hygiene in preventing the transmission of healthcare associated infections. " Use of gloves does not replace hand washing / hand hygiene. " Use of equipment and supplies necessary for hand hygiene " Proper handwashing technique	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17 At that same time, the aCNA then turned on the faucet, without wetting both hands with water. The aCNA lathered her hands with soap, then washed off the soap under the stream of running water, and dried hands with clean paper towels. During an interview of the surveyor with the aCNA regarding hand washing, the aCNA stated that no hand hygiene education and competency was provided to her by the facility since she started two weeks ago. She further stated that she knew how to wash her hands from her other job. The surveyor then asked the aCNA why she did not wet her hands prior to applying soap and the aCNA responded: "this is how we do handwashing in my other job, we do not need to wet our hands first." On 12/05/22 at 6:40 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN) immediately of the above concern. The IPN informed the surveyor that she worked last night during the 11 PM-7 AM nigh shift as the Nursing Supervisor because she was on-call. The IPN stated that as per facility protocol, she believed that the aCNA should have been educated and provided a competency for hand hygiene and PPE (personal protective equipment) use. The surveyor then asked the IPN why the aCNA had not received education or a competency on hand hygiene, the IPN replied, "I have to find out." On that same date and time, the IPN stated that the aCNA should have wet her hands first before applying soap and performed handwashing with soap and water before applying gloves or PPE. Immediately, the IPN went to room 205 and	F 880	2.The procedure for implementing the acceptable POC for the specific deficiency cited: " Administrator/DON/ADON and Infection Control Preventionist developed the following process and procedure to assure compliance with Infection Control and prevention, proper handwashing/hand hygiene. " ADON/Designee conducted a mandatory Infection Control Prevention and Management In service with all nursing personnel on 12/05/22. " All nursing staff was instructed on infection control policies and procedures paying particular attention to hand washing /hand hygiene. 3.The monitoring procedure to ensure that the POC is effective and that the specific deficiency remains corrected and/or in compliance with the regulations. " DON, ADON/IP/Designee will monitor 20 nursing staff/personnel weekly for compliance with hand washing/hand hygiene for a period of 4 weeks. Thereafter, DON/ADON/IP/Designee will monitor 20 nursing staff/personnel every other week for compliance with proper handwashing/ hand hygiene for a period of 4 weeks. " Any employees not following facility policy relating infection control prevention and management and handwashing/hand hygiene will have disciplinary actions taken on an individual basis " ADON/IP/Designee will document the audit results and report findings monthly during the facility's Quality Assurance and	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18 spoke to the aCNA. On 12/05/22 at 6:55 AM, the surveyor observed the Supply Clerk/CNA (SC/CNA) enter a resident's room and donned (applied) a new pair of gloves without performing hand hygiene. On that same date and time, the surveyor asked the SC/CNA for an interview and he immediately removed gloves and performed handwashing inside the resident's bathroom. The surveyor observed the SC/CNA perform handwashing under the stream of running water for 10 seconds, applied soap to both hands which immediately washed off the soap, dried both hands with clean paper towels, and left the resident's room. During an interview with the surveyor, the SC/CNA stated that the Assistant Director of Nursing (ADON) provided him an education and competency with regard to hand hygiene. He further stated that it was appropriate for him to lather his hands with soap under the stream of running water at the same time and to apply soap immediately rinse under water. Furthermore, he stated that he should wash his hands before applying a new pair of gloves. At that time, the Registered Nurse (RN) in the nursing station informed the supply clerk that he should lather his hands with soap outside the stream of running water. On 12/05/22 at 7:13 AM, the surveyor interviewed the IPN in the presence of another surveyor. The surveyor discussed the findings of the hand hygiene breaches with the IPN. The IPN stated that after speaking with the aCNA about the	F 880	Performance Improvement (QAPI) meeting. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance. 4.The title of the person responsible for implementing the acceptable POC Administrator Director Of Nursing Assistant Director of Nursing Infection Control Preventionist Registered Nurses Licensed Practical Nurses Completion date: 01/16/2023	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19	F 880		

above concerns, the aCNA acknowledged that she did not wet her hands before applying soap because she was following the hand hygiene procedure from another job.

At this time, the surveyor notified the IPN that both the aCNA and the SP/CNA did not use ABHR (alcohol base hand rub) during hand hygiene observations.

On 12/05/22 at 9:06 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and were made aware of the above findings.

On 12/07/22 at 11:37 AM, the LNHA provided the surveyor a copy of the Competency Validation for PPE, Competency Skills Checklist signed/dated on 11/23/22 (this did not correspond with the aCNA's interview on 12/05/22 in which the aCNA told the surveyor she had not had a competency). The surveyor inquired with the LNHA regarding that discrepancy. The LNHA replied that the competency date should have been dated 12/05/22, and not 11/23/22. She acknowledged that there was no education and competencies done to aCNA by the facility until the surveyor's inquiry.

On 12/08/22 at 01:41 PM, the survey team met with the Regional LNHA (RLNHA), LNHA, and DON. The RLNHA acknowledged that the aCNA should have followed the appropriate hand hygiene guidelines to wet hands first before applying soap. The facility management acknowledged that the hand hygiene breaches included performing hand hygiene for less than the minimum of 20 seconds according to their facility policy, lathering hands under the stream of

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20	F 880		

running water, and hand hygiene not done after removal of PPE.

A review of the facility's Handwashing/Hand Hygiene Policy that was provided by the LNHA with the last update date of May 2021 included "Policy Interpretation and Implementation: ...2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.....9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.....Procedure: Washing Hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature.....2. Rinse hands thoroughly under running water. .....Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves...."

On 12/12/22 at 02:44 PM, the survey team met with the LNHA, RLNHA, and the DON and no further documentation was provided to the survey team to refute these findings.

NJAC 8:39-19.4 (a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061629	A. BUILDING: _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Part A: Based on interviews and a review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for 12 of 14-day shifts as mandated by the state of New Jersey. This deficient practice was identified and the findings were as follows: Reference: New Jersey Department of Health (DOH) 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,	S 560	1. All residents have the potential or at risk to be affected by this deficient practice due to the nature of deficiency. 2. The facility will utilize internal and external resources to increase recruitment of direct staff and to ensure the availability of other staffing resources (e.g. contracted staff) in the event of staffing shortage. 3. Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, facility will utilize staffing agencies to fill any open spots in the schedule. 4. The facility will add an additional	1/16/23

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

Electronically Signed | 01/06/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061629	A. BUILDING: _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 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 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 "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two weeks beginning 11/13/22 and ending 11/26/22 revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: -11/13/22 had 13 CNAs for 114 residents on the day shift, required 14 CNAs. -11/14/22 had 12 CNAs for 113 residents on the day shift, required 14 CNAs. -11/15/22 had 13 CNAs for 113 residents on the day shift, required 14 CNAs. -11/17/22 had 13 CNAs for 113 residents on the day shift, required 14 CNAs. -11/18/22 had 13 CNAs for 113 residents on the day shift, required 14 CNAs. -11/19/22 had 12 CNAs for 116 residents on the	S 560	weekend bonus pay to ensure the weekends are staffed appropriately. 5. For the next three months, the administrator/designee will review the projected staffing hours to ensure they are above state minimum. 6. Findings will be submitted for the three months to the monthly QAPI committee who will determine further interventions as needed. Completion Date: 01/16/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061629	A. BUILDING: _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2	S 560		

day shift, required 14 CNAs.
-11/20/22 had 12 CNAs for 116 residents on the day shift, required 14 CNAs.
-11/21/22 had 12 CNAs for 116 residents on the day shift, required 14 CNAs.
-11/23/22 had 13 CNAs for 116 residents on the day shift, required 14 CNAs.
-11/24/22 had 13 CNAs for 117 residents on the day shift, required 15 CNAs.
-11/25/22 had 13 CNAs for 117 residents on the day shift, required 15 CNAs.
-11/26/22 had 12 CNAs for 117 residents on the day shift, required 15 CNAs.

On 12/7/22 at 11:07 AM, the surveyor interviewed the Nursing Staffing Coordinator/Certified Nurse Aide (SC/CNA) in the presence of the survey team. The SC/CNA acknowledged staff shortages for day shifts weekdays and weekends. She informed the survey team that the nursing staff call-outs were "mostly" on weekends.

In a follow-up interview with the SC/CNA on 12/12/22 at 11:15 AM, she stated that she was familiar with the minimum staffing requirement for the day shift but could not speak about evening and night shifts and stated, "I will get back with you for that."

On that same date at 1:11 PM, the Licensed Nursing Home Administrator (LNHA) and the Regional LNHA(RLNHA) met with the survey team where they acknowledged the nursing staff shortages. Additionally, they informed the survey team that they identified "short staffing" on weekends.

A review of the facility's "Staffing Policy and Procedure" with a revision date of 11/16/22 reflected that the facility "maintains adequate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061629	A. BUILDING: _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 staffing on each shift to ensure that our resident's needs and services are met." On 12/12/22 at 2:44 PM, the survey team met with the facility LNHA, RLNHA, and Director of Nursing (DON) and there was no additional information provided. Part B: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to accurately represent the facility's licensed name to operate and provide service in compliance with all applicable State, and local laws, regulations, and codes to the facility's residents, resident representatives, staff and the general public. This deficient practice was evidenced by the following: On 11/28/22 at 8:48 AM, upon arrival of the surveyors to the facility, the surveyor observed a banner that indicated that the facility was under the new management of Avalon Rehabilitation & Care Center. On 11/28/22 at 10:00 AM, during the Entrance Conference of the surveyor with the LNHA, DON, and the RLNHA, the surveyor asked the facility management why the signs outside the facility in the entrance of the parking lot showed two different names of the facility, Springhills Post Acute Care Wayneview and Avalon Rehab & Care Center not according to the current license name. On that same date and time, the surveyor asked the facility management about the website which	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061629	A. BUILDING: _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 reflects that the state approved name of Atrium Post Acute Care of Wayneview reflects it was "permanently closed". At that same time, the RLNHA stated that the facility transitioned to a new facility name and new management since 4/25/22 and that the facility had been using the new company's name and logo. On 12/07/22 at 12:57 PM, the survey team met with the DON, LNHA, and RLNHA and were made aware of the above findings. On 12/08/22 at 01:16 PM, the surveyor reviewed documents and the facility's policies that were provided by the LNHA and showed that the facility name and logo that were used were not according to the facility's licensed name. A review of the facility license that was issued by the New Jersey Department of Health Division of Certificate of Need and Licensing with an issue date of 3/04/22 and an expiration date of 2/28/23. The NJDOH issued the license for the facility name of Atrium Post Acute Care of Wayneview, not Springhills or Avalon Rehab & Care Center. On 12/12/22 at 02:44 PM, the survey team met with the LNHA, RLNHA, and the DON and no additional further documentation was provided to the survey team to refute these findings.	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
315291 Y1	A. Building B. Wing Y2	3/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH 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 F0658	Correction	ID Prefix F0732	Correction	ID Prefix F0836	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.70(a)-(c)	Completed
LSC	01/16/2023	LSC	01/16/2023	LSC	01/16/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/16/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/13/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061629 (Y1)	A. Building B. Wing (Y2)	3/1/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH WAYNE, NJ 07470

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/16/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON
12/13/2022

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1990s with no current major renovations or noted additions. It is a two story building Type II protected construction. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 170 certified beds. At the time of the survey the census was 117. The 125 KW diesel generator does approximately 50% of the building. The building has 3 elevators The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, interview and	K 211	I. Immediate Action	1/16/23

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

Electronically Signed | 01/06/2023

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 1 documentation review on 12/12/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice occurred for 12 of 12 fire doors observed, and was evidenced by the following: At 09:45 AM, the MD was asked to provide the annual testing requirements for fire door assemblies in accordance with NFPA 80. The MD indicated that currently the facility did not have any documentation on fire door assemblies. The MD was not at the facility on 12/13/22, the Administrator was informed that the Maintenance Director would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	a.) An outside vendor was contacted to provide the necessary annual inspection of all the facility's fire doors. II. Identification of others a.) This deficient practice affects all residents and personnel in the facility due to the fact that it can potentially be a life safety issue should the fire doors malfunction in the event of a fire. The potential malfunction of the fire doors could result in the loss of life. III. Systemic Changes a.) An in-service was done with all maintenance staff to reiterate the importance of all fire doors of the facility being inspected annually, without being delinquent. c.) A monthly audit of facility required maintenance will be conducted by the maintenance director or designee for six months. b.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis. These finding will be provided to the quality assurance committee by the Maintenance Director or designee.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National	K 345		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 2 Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 12/12/22 and 12/13/22, in the presence of the Maintenance Director (MD) and Assistant Maintenance (AM) the facility failed to ensure a) smoke detection sensitivity testing was completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2., b), that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. The deficient practice was identified for 2 of 2 inspection reports and was evidenced by the following: A) On 12/13/22, at 11:10 AM, the surveyor reviewed all related fire alarm documentation from the fire alarm vendor. The report dated: 9/10/22 did not indicate that any smoke detection sensitivity reports were completed. The AM was not sure if this required 5-year report was completed. B-1) On 12/13/22, at 11:15 AM, the surveyor reviewed all fire alarm documentation from the fire alarm vendor. The report dated: 9/10/22 indicated: #1, 1- Smoke failed in the corridor by resident rooms 246/247. #2, Pull station by resident room 221 does not exist. #3, Could not test battery 12V7ah Dialer not	K 345	I. Immediate Action a.) The facility had the appropriate smoke detection sensitivity testing and reports completed by our servicing provider along with testing of the 12V7ah Dialer. b.) The facility has also replaced the faulty smoke detector in the corridor by resident rooms 246/247 and an additional smoke detector was installed in the area of the fire panel in the main lobby. c.) The facility will ensure the fire alarm inspection is performed semiannually. The facility has also obtained quotes for an updated fire alarm panel to be installed. d.) Remnant painters tape that was covering a smoke detector located outside resident room 120 was removed from the smoke detector. II. Identification of others a.) The deficient practices affect all residents and personnel in the facility due to the reasons listed below: 1.) The smoke detectors were not properly tested and maintained. Improper testing and maintenance of the smoke detectors in the facility could result in smoke detectors not working properly and malfunctioning in the presence of smoke and/or fire. 2.) An outdated fire alarm panel that	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 3 tested (NO ACCESS). The fire alarm reports dated: September 2022 and March 2021 indicated that the total number of smoke detectors, heat detectors and duct detectors did not tally together on the reports September 2022 report: 182- smokes 6- heat 9- ducts March 2021 report: 177- smokes 7-heat 8-duct B-2) On 12/13/22 at 10:10 AM, the surveyor reviewed all provided fire alarm inspection reports: dated September 2022 and March 2021 almost 18 months apart. The fire alarm inspection is required to be preformed semi annually. The facility fire alarm batteries are sealed-lead acid units and are to be tested semi-annually as per NFPA 70, 72. B-3) At 12/12/22 at 10:18 AM, the main fire alarm panel was observed to be not addressable, located in front of the receptionist desk. The fire alarm panel was an old style annunciator panel and did not have an indicator window to locate the activation point. The panel was located behind a closed wooden flat cabinet that did not have the required smoke detector in the area of the enclosed main old-style fire alarm annunciator cabinet as required by NFPA 70,72. On 12/12/22 during the observations the MD confirmed the main fire panel was old and needed to be upgraded.	K 345	lacks an indication window to locate the activation point could cause confusion in the event of an emergency. This confusion can potentially result in the loss of life. III. Systemic Changes a.) An in-service was done with all maintenance staff as to the importance of having smoke detectors properly inspected and maintained. b.) The importance of keeping the results of these inspections in the Life Safety inspection book was also reinforced. c.) The Administrator as well as the Maintenance Director will do weekly rounds to visually inspect all smoke detectors in the facility to ensure they are properly working. d.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 4 B-4) On 12/12/22 at 10:12 AM, the surveyor observed in the exit/egress corridor that the smoke detector was covered from activation with blue painters tape. The smoke detector was located outside resident room 120. The MD indicated at 10:15 AM, that the smoke detector was taped from activation, due to the installation of flooring in that unit of the building a few days ago. The MD was not at the facility on 12/13/22, the Administrator was informed that the Maintenance Director would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 5 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interviews from 12/12/22 to 12/13/22, in the presence of the Maintenance Director (MD) and Assistant Maintenance (AM), it was determined that the facility failed to maintain the sprinkler system by ensuring that a) ceiling was smoke resistant and fire rated, b) failed to maintain all parts of their automatic fire sprinkler system in optimal condition as evidenced by the following: in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. The deficient practice was evidenced for 1 of 2 overhangs and 3 of 4 inspection reports by the following: A) On 12/12/22 at 9:45 AM, the surveyor observed the front entrance attached overhang approximately 50' x 50', that no fire sprinkler protection was observed. The MD indicated new 2' x 2' ceiling tiles were just installed. The ceiling had approximately 10- 6" openings for lighting that was not installed at the time of the observation. The surveyor asked the MD to provide any type of fire resistant rating for the new 2' x 2' ceiling tiles installed, but no documents were provided by the LSC exit on 12/13/22.	K 353	I. Immediate Action a.) The facility has the proper documentation of the fire-resistant rating for the ceiling tiles in question. b.) The facility Administrator obtained the missing fire sprinkler quarterly inspection from the providing vendor and made certain that all reports were placed in the Life Safety inspection book. II. Identification of Others a.) The deficient practice affects all residents and personnel of the facility due to the improper keeping of fire-resistant rating and fire sprinkler inspection documentation. The fire-resistant rating of the ceiling tiles guarantees that the materials being used are safe and meet all NFPA standards. b.) Proper documentation of the fire sprinkler quarterly inspection shows that the facility's fire sprinkler system will work properly in an emergency. Without this acceptable documentation, there is no evidence that the facility and its fire sprinkler system comply with NFPA standards. III. Systemic Changes a.) An in-service was done with all	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 6 The MD stated and confirmed the findings above during the observation. B) On 12/13/22, the surveyor observed that no fire sprinkler quarterly inspections were in the Life Safety inspection book. The AM indicated that he and the Administrator would call the vendor for the reports. The reports were emailed to the surveyor after the 12/13/22 exit. Three (3) of the Four (4) quarterly reports required were emailed and dated: 8/15/22, 03/02/22 and 12/02/22. The third quarter report was missing. The most recent report/inspection dated 08/15/22 indicated that under #4 Annual Inspections g. internal inspection of the pipe performed in the last 5-years, was marked N/A. The AM, confirmed the above findings during the observations. The MD was not at the facility on 12/13/22, the Administrator was informed that the MD would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1.	K 353	maintenance staff to instill the importance of keeping the results of the fire sprinkler quarterly inspections in the Life Safety inspection book. b.) The Administrator as well as the Maintenance Director will inspect the Life Safety inspection book on a weekly basis. c.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers	K 355		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 7 Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/22 in the presence of the Maintenance Director (MD), it was determined that the facility failed to A) ensure that fire extinguishers were not blocked or obstructed for 1 of 1 kitchen ansul systems, in any way that would delay staff from activating the system in the event of an emergency and B) perform and document on the tag attached to the fire extinguisher a monthly visual examination for 3 of 19 fire extinguishers. This deficient practice was evidenced by the following: A) At 01:58 PM, the surveyor observed in the facility kitchen, that a drain pipe approximately 1" was installed next to the ansul activation conduit. The pipe was blocking the activation procedure for the ansul system. The MD confirmed the finding during the observation. B-1, At 01:58 PM, the surveyor observed in the main dining room, that the portable fire extinguisher was last inspected 06/01/22. B-2, At 2:05 PM, the surveyor observed in the exit/egress corridor that one fire extinguisher was last inspected 06/01/22. B-3, At 2:10 PM, the surveyor observed that the	K 355	I. Immediate Action a.) The obstruction blocking the kitchen ansul activation systems was moved. b.) Proper inspection of all portable fire extinguishers and kitchen ansul activation system has been initiated. II. Identification of Others a.) The deficient practice affects all residents and personnel of the facility because the kitchen ansul activation system could not be accessed immediately in the event of a fire. The kitchen staff would be delayed in activating the system in the event of an emergency which could result in injury and/or death. b.) Also, fire extinguishers and ansul activation systems may not appropriately work in an emergency because they have not been properly inspected. The use of a faulty fire extinguisher in the event of a fire or other emergency could result in injury and/or death. III. Systemic Changes a.) An in-service was done with all maintenance staff to educate them on the importance of the kitchen ansul activation system being free of all obstruction. b.) Additionally, a log of all portable fire extinguishers in the facility has been	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 8 main kitchen ansul system activation device, was provided with an inspection tag that did not have any monthly inspections logged on the tag. The Maintenance Director confirmed the findings, during the observations. The MD was not at the facility on 12/13/22, the Administrator was informed that the MD would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.2(e) NFPA 10, Standard for Portable Fire Extinguishers.19.3.5.12, NFPA 10	K 355	designed to ensure that every fire extinguisher in the facility is inspected monthly. c.) The Administrator and the Maintenance Director will round weekly to make certain that the kitchen ansul activation system is free of hindrance and that all fire extinguishers are appropriately inspected. d.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors	K 363		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 9 complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was further identified in 22 of 55 resident room doors observed and was evidenced by the following:	K 363	I. Immediate Action a.) The corridor room doors identified during the building tour were repaired to ensure that the resident room doors properly close and latch and have hardware in good working condition. II. Identification of Others a.) The deficient practice affects all residents and personnel of the facility because the corridor doors lacked the ability to resist the passage of smoke therefore improperly defending occupants in place from fire and smoke in the event of fire or other emergency.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 10 During the building tour from 9:15 AM to 2 PM, the surveyor, in the presence of the MD toured the facility and observed the following: Resident Room doors: # 107 bag hanging on door hardware # 108 loose hardware # 126 will not latch into frame # 129 loose hardware top 1/2" gap. 1/4 hole in door # 201 will not latch into frame # 204 loose hardware, will not latch # 207 warped top 1/2" gap # 213 will not latch into frame # 214 hardware issue # 220 warped 1/2 top gap # 221 warped 1/2 top gap # 229 will not latch # 230 warped top 1/4" gap # 235 warped top 1/4" gap # 239 Hardware will not latch # 240 hooks on door, will not latch # 242 warped on the bottom 1/2 gap # 244 door gets stuck into the frame # 249 loose hardware # 250 loose hardware # 252 warped top 1/2" gap # 253 warped top 1/2" gap At the time of observations, the surveyor interviewed the MD, who confirmed the above findings. The MD was not at the facility on 12/13/22, the Administrator was informed that the MD would provide his observations and notes from the building tour as the life safety code exit on	K 363	III. Systemic Changes a.) An in-service was done with all staff as to the importance of corridor doors closing and latching properly. A malfunction could result in the spread of smoke and/or fire to resident rooms. b.) The staff was educated to report any compromised doors to the maintenance department. c.) The Administrator and the Maintenance Director will round weekly to inspect all residents' rooms' doors. d.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 11 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, on 12/12/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide smoke barrier wall doors that completely closed to resist the passage of smoke, flame, or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1.	K 374	I. Immediate Action a.) The smoke door located near resident room 252 was repaired so that the magnetic hold-open device was properly fastened to the wall. b.) Additionally, the door was repaired to fully close and properly prevent the transfer of smoke fire and other poisonous gases from one smoke compartment to another.	1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 12 This deficient practice was observed for 1 of 8 sets of double smoke door sets observed and tested for closure and was evidenced by the following: At 11:18 AM, the surveyor observed that the floor #2 set of smoke doors by resident room 252, had the magnetic hold-open device not properly attached to the wall (falling off). The set of doors when released were observed to have a gap between the set of doors approximately 1/4 inch, This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire compromising the integrity of the smoke zone. An interview was conducted with the MD, during the observations, where he stated and confirmed that the smoke door magnetic hold-open must be properly installed, and smoke doors must fully close to resist the passage of smoke, flames, or gases during a fire. The MD was not at the facility on 12/13/22, the Administrator was informed that the MD would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.2(e)	K 374	II. Identification of Other a.) The deficient practice affects all residents and personnel of the facility due to the fact that it could be a life safety issue should the smoke door not maintain proper smoke and fire resistance. III. Systemic Changes a.) An in-service was done with all maintenance staff as to the importance of all smoke barrier wall doors maintaining proper fire and smoke resistance. b.) The Administrator as well as the Maintenance director will do weekly rounds to inspect the integrity of all magnetic hold-open devices and smoke barrier doors. c.) Completion date 01/16/2023. IV. Quality Assurance All findings will be reviewed with the quality assurance committee on a monthly basis.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall	K 521		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 13 comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure A), resident bathroom ventilation systems were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B and B), PTAC (Packaged Terminal Air Conditioners) were operating in optimal condition. This deficient practice was evidenced for 6 of 40 resident room bathrooms vents and 6 of 40 PTAC units by the following: A) On 12/12/22 during a tour of the building, the surveyor with the MD, toured the facility and observed that the ventilation in the following Resident Room bathrooms did not function: # 102, 201, 202, 208, 214, and 235 At the time of observations, the surveyor requested that the assistant Administrator confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation.	K 521	Immediate Action a.) The exhaust vents in the identified resident rooms were repaired. b.) Additionally, all affected PTAC units were cleaned immediately. A PTAC filter cleaning log book has been established. II. Identification of Others a.) The deficient practice has the potential to affect all residents and personnel of the facility due to the fact that there is not proper ventilation in rest rooms in the facility. b.) Also, resident PTAC units will not function properly if the PTAC units and their components are not regularly maintained. III. Systemic Changes a.) An in-service was done with all staff as to the importance of proper ventilation in the facility restrooms. b.) Facility staff were instructed to report any damaged bathroom vent to the maintenance department. c.) The Administrator as well as the Maintenance Director will inspect the PTAC filter cleaning log book on a weekly basis.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 14 At that time, the surveyor interviewed the MD, who confirmed that the exhaust vents in the above resident room bathrooms, were not functioning when tested. B) On 12/12/22 while touring the building with the MD it was observed that PTAC unit filters were clogged and dirty in the following resident rooms: # 103, 105, 112, 117, 122, and 203. The MD confirmed the findings during the observations. No policy and procedure on PTAC maintenance was provided and no PTAC filter cleaning schedule and or log was provided by the facility. The MD was not at the facility on 12/13/22, the Administrator was informed that the MD would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	d.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis.	
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and	K 531		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 531	Continued From page 15 Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that there was documented evidence that all existing elevators; having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes conformed with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key.19.5.3, 9.4.2, 9.4.3). This deficient practice was evidenced for 3 of 3 elevators by the following: On 12/12/22, the surveyor reviewed all current documentation dated: 11/23/22 from the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Unit Inspection report.	K 531	I. Immediate Action a.) Firefighter's Service will be operated on all elevators in the facility on a monthly basis. b.) Written record of the Firefighter's Monthly Service Log will be kept by the maintenance department. II. Identification of Others a.) The deficient practice has the potential to affect all residents and personnel of the facility due to the fact that the elevators in the facility may not operate properly for firefighters or other first responders in the event of an emergency. The delay in firefighters' response could result in injury and/or death of residents and personnel in the facility. III. Systemic Changes a.) An in-service was done with all maintenance staff as to the importance of	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 531	Continued From page 16 The report indicated that under B. Elevator Car and Counterweight #13 that the Firefighter Service PH-1 and PH-2 were found Unsatisfactory for device's 03-PASS #1 and 01-F3. At the time of survey the elevator #2 device was out of service, but at 09:48 AM, during the building tour, it was observed to not have an "out of service" sign on the device, to inform passengers. The MD provided documentation indicating from their elevator vendor that a proposal # 2212050 dated: 12/05/22 under Description: #1 Elevator: Trouble shoot phase 1 fire service to determine issue and any additional work needed #2 Elevator: Furnish and install a new phase 1 fire service keyswitch cover. #3 Elevator: Furnish and install a new phase 1 fire service keyswitch cover. An interview was conducted with the MD, during the record review. He confirmed there is no current firefighter's monthly service log for the entire year. The MD was not at the facility on 12/13/22, the Administrator was informed that the Maintenance Director would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3 & 9.4.3	K 531	proper servicing of the elevators in the facility for the use of firefighters in the event of an emergency as well as documentation of these inspections. b.) The Administrator as well as the Maintenance Director will inspect the Firefighter's Monthly Service Log on a monthly basis. c.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 531	Continued From page 17 Fire Fighters Emergency Operations: 9.4.3.2	K 531		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview on 12/13/22, in the presence of the facility's Assistant Maintenance (AM), it was determined that the facility failed to functionally test electrical receptacles in resident rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. Maintenance and testing 6.3.3.2 Receptacle Testing in Patient Care Rooms.	K 914	I. Immediate Action a.) Proper documentation for the annual electrical inspection by an outside vendor was obtained by the facility. II. Identification of Others a.) The deficient practice has the potential to affect all residents and personnel of the facility due to the fact that without proper documentation there is no confirmation	1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 18 This deficient practice was evidenced for all resident rooms by the following: Throughout a tour of the facility on 12/12/22, the surveyor and the facility's Maintenance Director (MD), observed that the resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The last annual electrical inspection by the facility vendor was dated: 10/28/22, indicated that there was no documentation for the annual inspection and itemized list of receptacle testing in patient care rooms. The prior electrical inspection by the facility vendor was dated: 10/28/21, reported "common area receptacle outlets were verified for compliance". The (new) AM indicated he was not sure about this issue. The MD was not at the facility on 12/13/22, the Administrator was informed that the MD would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.2(e) NFPA 99	K 914	that the electrical receptacles identified in the tour are in suitable working condition. Faulty receptacles could result in injury and even death of residents and/or facility staff. III. Systemic Change a.) An in-service was done with all maintenance staff regarding the importance of proper documentation of electrical receptacle inspections performed at the facility. c.) A monthly audit of all mandatory facility maintenance will be conducted by the Maintenance Director or designee for six months. b.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 916		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 916	Continued From page 19 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 12/12/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that the facility's emergency generator annunciator (one of one) was fully functional as evidenced by the following: At 11:20 AM, in the presence of the MD, the surveyor observed on floor-1, that the generator annunciator panel at the nurse station, by resident room 109 was observed to have one of 15 warning indicator lights on. The RA15 annunciator panel "common warning" light was activated. The MD was unsure what that "common warning" light indicated at the time of the observation. The MD was not at the facility on 12/13/22, the Administrator was informed that the MD would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22.	K 916	I. Immediate Action a.) The facility's emergency generator annunciator panel has been serviced and is in proper working order. II. Identification of Others a.) The deficient practice has the potential to affect all residents and personnel of the facility due to the fact that the emergency generator annunciator was not fully functional which could have resulted in an unnecessary loss of backup power to the facility during an emergency leading to further disorder. III. Systemic Changes a.) An in-service was done with all maintenance staff on the importance of assuring the facility's emergency generator annunciator panel is working correctly. b.) The Administrator as well as the Maintenance Director will visually inspect the emergency generator annunciator panel on a weekly basis to confirm that it is in quality working order.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 916	Continued From page 20 NJAC 8:39-31.2(e) Alarm Annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	K 916	c.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 21 the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility documents on 12/12/22 and 12/13/22, in the presence of the Maintenance Director (MD), and Assistant Maintenance (AM), it was determined that the facility failed to a.) certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems and b.) ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. c.) The facility monthly load test document did not provide any times indicating how long the monthly test was conducted as per NFPA 110. This deficient practice was evidenced for one-generator log provided by the MD by the following: A) On 12/13/22 at 9:30 AM, a review of the generator records for the previous twelve months did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the monthly load test document provided by the MD on 12/12/22, indicated no transfer time was being logged. An interview was conducted with the AM, during the document review on 12/13/22, he stated that	K 918	I. Immediate Action a.) The facility has implemented a new monthly testing of the emergency generator to ensure the equipment is capable of supplying service within 10 seconds in the event the primary power source to the facility fails. b.) The 10-second time frame will be recorded for all monthly testing. c.) The remote emergency shutoff switch to the generator was installed. d.) Additionally, the length of the monthly load test will also be documented. II. Identification of Others a.) The deficient practices can potentially affect all residents and personnel in the facility for the following reasons: 1.) There could be a delay in treatment of residents in the facility if the emergency generator does transfer power to the facility within the appropriate 10-second time frame, particularly those residents requiring oxygen. This delay in treatment could result in injury or death of a resident. Furthermore, the generator must be capable of operating for an extended period of time under load in the event that primary	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 22 he was unsure if the current monthly generator load test transfer times, were being documented on the log. B) On 12/13/22 at 11:40 AM, the surveyor and AM, observed that the facility's generator did have a remote shutoff. An interview was conducted during the observation with the AM, who confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation located (remote) of the enclosure housing the prime mover. The current manual stop station was located on the generator cabinet and not remote. The MD was not at the facility on 12/13/22, the Administrator was informed that the MD would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918	power to the facility is not restored in a timely manner. 2.) Should the generator be engulfed in flames or smoke condition while in operation, it cannot be shut off quickly because the shut off switch is not located remotely for easy access. III. Systemic Changes a.) An in-service was done with all maintenance staff on the importance of documenting how long it takes for the emergency generator to transfer power to the facility and to ensure the transfer occurs within the appropriate 10-second time frame. b.) All maintenance staff were educated on proper documentation of duration of the emergency generator monthly load test. c.) An additional in-service was provided to all maintenance staff on the importance of a remote emergency shut off switch to the emergency generator. d.) The switch will be tested on a monthly basis by the Maintenance Director as well as the Administrator to ensure its proper operating function. e.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 23 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/22, in the presence of the Maintenance Director (MD), the facility failed to prohibit the use of extension cords and power cords, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard.	K 920	I. Immediate Action a.) Power strips and extension cords were removed from the identified locations. II. Identification of Others a.) The deficient practices could affect all residents and personnel in the facility due to the fact that electrical power strips and extension cords could result in an electrical fire or electrical shock. III. Systemic Change a.) An in-service was done with all staff on	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 24 This deficient practice was identified in three of 14 offices, observed and was evidenced by the following: 1) At 10:42 AM, the surveyor and MD, observed in the floor-2 staffing office that a microwave oven and refrigerator were plugged into a multi-outlet power strip. The power strip was then plugged into the duplex wall outlet. 2) At 10:50 AM, the surveyor and MD, observed in resident room 122 that electronics were plugged into a resident grade extension cord. The electronics were then plugged into a duplex wall outlet. 3) At 01:18 PM, the surveyor and MD, observed in the Director of Nursing (DON) office that a microwave oven was plugged into a multi-outlet power strip. The power strip was then plugged into the duplex wall outlet. The findings were verified by the MD at the time of the observations, where he stated and confirmed that multi-outlet power strips was not to be used for high draw appliances in the facility. The MD was not at the facility on 12/13/22, the Administrator was informed that the MD would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.2(e)	K 920	the importance of not utilizing electrical power strips or extension cords in the facility. b.) If extension cords are used, it can only be temporarily and must be removed immediately upon completion of utilization. c.) Facility staff were instructed to report any use of electrical power strips and/or extension cords to the maintenance department immediately. d.) The Administrator as well as the Maintenance Director will round the facility on a weekly basis to ensure electrical power strips and extension cords are not being utilized in the facility. e.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the quality assurance committee on a monthly basis.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 25	K 921		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and documentation review on 12/12/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure	K 921	I. Immediate Action a.) All patient-care related electrical equipment has been tested and inspected to make certain the equipment meets all	1/16/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 26 that PCREE (patient care-related electrical equipment) were maintained in accordance with NFPA 99-testing and maintenance requirements PCREE as per NFPA 99-99:10.5.3 The deficient practice was evidenced for three of three PCREE area observations and was evidenced by the following: 1) On 12/12/22 at 11:08 AM, the surveyor observed in resident room 203 that a resident oxygen concentrator was enclosed on three-sides by a privacy curtain. The privacy curtain blocking the intake and exhaust, did not allow the concentrator to have clear access. 2) On 12/12/22 at 11:32 AM, the surveyor observed a resident electric wheel chair stored and charging in the exit/egress corridor. The electric wheel chair was observed to not have an inspection tag. 3) On 12/12/22 at 11:44 AM, the surveyor observed in the janitors closet/storage room, that patient care related electrical equipment (oxygen concentrators) were being stored. The PCREE equipment was stored not fully protected from dirt and dust as one of four concentrators were not protected in a plastic barrier/bag. The concentrators were stored by a janitors sink that was filled with stale dirty water. two of the four concentrators were last inspected in 2019. In an interview at 11:55 AM, the MD confirmed the findings above. The facility did not provide policies and procedures for inspection, testing and maintenance for patient care related electrical equipment, and inventory form was not available for review.	K 921	safety standards and is in reliable, proper working condition. b.) Patient-care related electrical equipment will also be stored in such a way as to protect the integrity and sterility of the equipment. II. Identification of Others a.) The deficient practices affect all residents and personnel in the facility due to the fact that a resident or staff member could be injured while operating faulty patient-care related electrical equipment. b.) Improper storage of such equipment could result in diminished integrity and therefore a negative outcome could result from the utilization of ill-functioning patient-care related electrical equipment. III. Systemic Changes a.) An in-service was done with all maintenance staff on the significance of properly inspecting, maintaining, and storing of patient-care related electrical equipment. b.) All staff were educated to report any malfunctioning patient-care related electrical equipment to the maintenance department immediately. c.) The Administrator as well as the Maintenance Director will round the facility on a weekly basis to make certain all patient-care related electrical equipment is appropriately inspected, maintained and stored. d.) Completion date 01/16/2023. IV. Quality Assurance a.) All findings will be reviewed with the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING **01** B. WING _____	C **12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	**2020 ROUTE 23 NORTH** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 27 The MD was not at the facility on 12/13/22, the Administrator was informed that the MD would provide his observations and notes from the building tour as the life safety code exit on 12/13/22. The facility was still providing documents from the Fire Sprinkler Vendor Quarterly Inspection reports after the Life Safety Code Exit Conference on 12/13/22. NJAC 8:39-31.2(e) NFPA 99-99:10.5.3	K 921	quality assurance committee on a monthly basis.	

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
315291 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM POST ACUTE CARE OF WAYNEVIEW	2020 ROUTE 23 NORTH 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	01/16/2023	LSC K0345	01/16/2023	LSC K0353	01/16/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	01/16/2023	LSC K0363	01/16/2023	LSC K0374	01/16/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	01/16/2023	LSC K0531	01/16/2023	LSC K0914	01/16/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0916	01/16/2023	LSC K0918	01/16/2023	LSC K0920	01/16/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0921	01/16/2023	LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/13/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO