STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. Building B. Wing	10/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Post Acute Care of Wayne	1120 Alps Road Wayne, NJ 07470

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Based on observation, interview, and facility documentation review, it was determined that the facility failed to ensure the resident's right to be treated with dignity and respect. This deficient practice was identified for 2 of 25 residents observed; Resident #49 and #58. This deficient practice was evidenced by the following: 1. On 10/5/20 at 10:40 AM, the surveyor, observed Resident #49 in bed with their head and neck leaning to the left side. The alert resident greeted the surveyor, speaking in a low voice with slurred speech, and informed the surveyor that they had Parkinson's disease and had no neck muscle control. The surveyor reviewed the Admission Record indicating that Resident # 49 was admitted to the facility with diagnoses, including Parkinson's Disease, Muscle Weakness, Depression, and Dysphagia (difficulty swallowing). A review of the Quarterly Minimum Data Set (MDS), an assessment tool, indicated a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which reflected that the resident had moderately impaired cognition. On 10/5/20 at 11:05 AM, the surveyor observed Certified Nursing Assistant (CNA) #1 enter Resident #49's room without knocking or obtaining permission before entering the room. When the surveyor questioned CNA#1, she responded that she was delivering ice water and was not the resident's assigned CNA. On that same day at 11:06 AM, CNA #2 entered Resident #49's room without knocking or obtaining permission before entering the room. When the surveyor questioned CNA #2, she responded that she was assigned to Resident 49's care. On that same day at 12:33 PM, during an interview, the surveyor asked CNA #2 if her routine practice was to enter resident rooms without first knocking. CNA #2 stated that she usually knocks on the door and should have knocked on Resident #49's door before entering. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/20 at 11:53 AM, the surveyor interviewed CNA #1, who acknowledged that she should not enter resident rooms without knocking first, and that she should have knocked before she entered Resident #49's room. On 10/9/20 at 9:15 AM, the surveyor observed Resident # 49's door open. The surveyor knocked on the door, and CNA #3 told the surveyor to come in. The surveyor observed Resident #49 seated on the toilet in the bathroom with the door wide open. At that time, the surveyor asked CNA #3 why she had not closed Resident #49's bathroom door to ensure privacy. CNA #3 stated that she provided morning hygiene care for Resident #49 and left the bathroom to obtain powder. CNA #3 further acknowledged that she should have provided privacy by closing both the bathroom door and the resident's room door. 2. On 10/05/20 at 11:47 AM, the surveyor observed Resident #58 lying in bed. Resident #58 greeted the surveyor and agreed to an interview. After obtaining the resident's permission, the surveyor closed the door and began the interview. At that time, CNA#2 opened Resident #58's door without first knocking and said, wrong room. CNA#2 then left the room, closing the door behind her. Resident #58 stated that sometimes staff enter the room without knocking and further said, it's rude. The surveyor reviewed the Admission Record indicating that Resident #58 was admitted to the facility with diagnoses that included Osteoarthritis of Right Shoulder, Status Post Right Shoulder Replacement Surgery, and Hypertension. The surveyor reviewed the Annual Minimum Data Set (MDS), an assessment tool, that reflected a Brief Interview for Mental Status (BIMS) score of 14, indicating that Resident #58 was cognitively intact, alert, and oriented. On 10/5/20 at 12:33 PM, during an interview, the surveyor asked CNA #2 if her routine practice was to enter resident rooms without first knocking. CNA#2 stated that she usually knocked before entering and acknowledged that she should have knocked on Resident #58's door before entering. On 10/14/20 at 1:31 PM, the surveyor discussed the above observations and concerns with the Administrator, Director of Nursing (DON), and Regional Nurse. No further documentation was provided. On 10/15/20 at 11:46 AM, the surveyor and Team Coordinator spoke with the Administrator and DON via a phone conference call at the facility's request. The DON stated that residents' [room] doors should be closed when hygiene and personal care were being rendered. N.J.A.C. 27.1 (a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 36419 Based on observation, interview, and record review, it was determined that the facility failed to accommodate the needs of a resident (dependent on staff) to utilize their call bell system for assistance. This deficient practice was identified for 1 of 25 residents reviewed; Resident #49, and was evidenced by the following: On 10/5/20 at 10:40 AM, the surveyor observed Resident #49 in bed with their head and neck leaning to the left side. The alert resident greeted the surveyor, stated that they had Parkinson's disease, and had no neck muscle control. Resident #49 stated that they wanted to get out of bed, but the Certified Nursing Assistant (CNA) had not yet come to assist. The surveyor asked the resident if they were able to use the call bell to obtain assistance. The resident replied that they were unable to reach it and gestured toward the call system. The surveyor observed that the call bell was inaccessible to Resident #49 as it was wedged behind the bed that was pushed against the wall. The surveyor reviewed the resident's Admission Record that indicated Resident #49 was admitted to the facility with diagnoses that included but were not limited to Parkinson's Disease, Muscle Weakness, Depression, and Dysphagia (difficulty swallowing). A review of the 4/26/20 Part C of the Quarterly Minimum Data Set (MDS), an assessment tool, Brief interview for Mental Status (BIMS) documented a score of 9 out of 15, indicating that the resident had moderate cognitive impairment. The 4/26/20 MDS also assessed Resident #49 as requiring extensive assistance from staff for transfers and that the resident was occasionally incontinent of bowel and bladder. On 10/5/20 at 11:06 AM, the surveyor observed the CNA enter Resident #49's room. The CNA assisted the resident out of bed to a standing position and stated, you're very wet. The surveyor asked the CNA if she had provided incontinence care for the resident that morning. The CNA replied, no, the resident will usually call when they need to be changed. The surveyor asked how the resident would typically call for assistance. CNA #1 replied that the resident uses the call bell. The resident then stated, I can't reach the call bell. The CNA did not acknowledge or respond to the resident's statement and assisted Resident #49 into the bathroom and provided morning care. On 10/5/20 at 12:33 PM, the surveyor and the CNA entered Resident #49's room to find that the call bell was still wedged behind Resident #49's bed frame and would be inaccessible to the resident. The CNA stated she did not check to ensure that Resident #49's call bell was within their reach at any time that morning, and further stated, I just assumed she could reach it; I should have checked. On 10/9/20 at 2:15 PM, the surveyor discussed the above observations and concerns with the Administrator, Director of Nursing, and Regional Nurse. No further documentation was provided. N.J.A.C. 8:39-27.1 (a)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 36419 Based on observation, interview, and record review, it was determined that the facility failed to respect the resident's right to mail delivery privacy. This deficient practice was identified for 1 of 25 residents reviewed; Resident #58, and was evidenced by the following. On 10/5/20 at 11:47 AM, the surveyor observed Resident #58 lying in bed. Resident #58 greeted the surveyor, and after obtaining the resident's permission, agreed to be interviewed. At that time, Resident #58 told the surveyor that the facility Social Worker (SW) delivered a letter that was opened on 10/2/20. The resident explained that it was a letter from a law firm suing for monies owed to the facility. Resident #58 further stated that it was upsetting that someone would have the nerve to open mail addressed to the resident. The resident showed the surveyor the letter that was clearly addressed to Resident #58. The surveyor reviewed the Admission Record that indicated Resident #58 was admitted to the facility with diagnoses that included Osteoarthritis of right shoulder, s/p right shoulder replacement surgery, and hypertension. The surveyor reviewed the Annual Minimum Data Set (MDS), an assessment tool that reflected a Brief Interview for Mental Status (BIMS) score of 14, indicating that Resident #58 was cognitively intact. On 10/6/20 at 1:15 PM, the surveyor interviewed Resident #58, who stated that they had spoken to the Business Office Manager (BOM) yesterday in the late afternoon. The BOM informed the resident that she had opened the letter by mistake. The resident mentioned that the letter came inside another large envelope addressed to him/her. The resident showed the envelope to the BOM, which was addressed to the resident, stamped and postmarked September 30, 2020. The resident stated that the BOM then apologized for opening the resident's mail. On 10/7/20 at 11:10 AM, the surveyor asked the administrator to meet with the BOM. The administrator replied that the BOM would be in the following day and that she was aware of the issue. On 10/8/20 at 11:01 AM, the surveyor met with the BOM. During the interview, the BOM stated that the resident's open letter came inside another envelope and that she thought it was addressed to her and mistakenly opened it. The BOM further noted that in the late afternoon on 10/2/20, she was running late and asked the SW to hand-deliver the opened piece of mail to Resident #58, without any explanation as to why the letter was opened. The BOM acknowledged that on 10/2/20, she should have delivered the letter to Resident #58 with an explanation as to why the letter was mistakenly opened. On 10/8/20 at 11:35 AM, the surveyor met with the SW, who explained that the activities staff generally deliver mail to residents. On Friday, 10/2/20, the BOM asked her to do her a favor and hand-deliver the envelope to Resident #58. The SW further stated that the BOM did not tell her that she had mistakenly opened the resident's letter nor informed her to speak to Resident #58 about it. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/20 at 11:56 AM, the surveyor met with the Administrator, who stated that she was not certain how she first became aware of the open mail being delivered, and noted that she thought the resident called her Monday, 10/5/20. The Administrator further stated that the resident informed her that she didn't understand what the letter was about in the phone call. On 10/8/20 at 12:30 PM, Resident #58 informed the surveyor that the phone call to the Administrator was made on Monday 10/5/20 in the morning before the resident had informed the surveyor about the opened letter. Resident #58 further stated that he/she told the administrator that receiving the opened private letter on Friday 10/2/20, made the resident very upset. The resident said that the Administrator suggested speaking to the SW about it. On 10/9/20 at 2:15 PM, the surveyor discussed the above observations and concerns with the Administrator, Director of Nursing (DON), and Regional Nurse. On 10/15/20 at 11:46 AM, the surveyor and Team Coordinator met with the Administrator and DON at the facility's request. The Administrator stated that she now remembered that the resident had called her Monday morning before 9:30 AM. She noted that she did not recall the resident mentioning the mail being opened. The Administrator stated that she asked both the SW and BOM to go to Resident #58's room to discuss the nature of the letter. The surveyor asked the Administrator why she had sent both the BOM and SW to Resident #58's room if she wasn't aware of the concern. The administrator did not answer that question. The administrator then stated, maybe the [BOM] should have waited until Monday and delivered the opened letter herself. The surveyor requested the facility Policy and Procedure for mail delivery to residents. The facility provided no further information. N.J.A.C. 8:39-4.1 (a) 16, 19

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31656 Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of nursing practice by not following a physician's order for 2 of 28 residents reviewed; Resident #6 and #49. This deficient practice was evidenced by the following: 1. On 10/9/20 at 10:20 AM, the surveyor observed Resident #6 seated on the bed in the resident's room. The resident smiled and responded to the surveyor's greeting in Spanish. On 10/9/20 at 11:00 AM, the surveyor reviewed the records for Resident #6 who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included but were no limited to End-Stage Renal Disease, Respiratory Failure Diastolic (Congestive) Heart Disease, Acute Respiratory Failure and Dependence on Renal Dialysis. On 10/13/20 at 11 AM, the surveyor reviewed the September and October 2020 Electronic Medication Administration Record (EMAR) for Resident #6, which revealed an order dated 6/29/20 and discontinued on 10/4/20 for Midodrine HCl Tablet 5 mg daily before meals for hypotension (Low Blood Pressure) hold if greater than 130. This Physician's order was documented to be administered at 7:00 AM, 11:30 AM, and 5:00 PM. A review of the October 2020 EMAR, revealed a 10/5/20 Physician order change to Midodrine HCl 5 mg two times a day every Monday, Wednesday, and Friday for hypotension hold for Systolic Blood Pressure (SBP) greater than 130 before meals. The surveyor reviewed the September and October 2020 EMAR that revealed documentation that the nurses administered the Midodrine HCL 5 mg to Resident #6, on numerous occasions when the SBP was greater than 130. The Midodrine was administered to Resident #6 on 9/4 at 11:30 AM with the SBP at 135, 9/10 at 5:00 PM with the SBP at 138, 9/16 at 11:30 AM with the SBP at 135, 9/27 at 7:00 AM with the SBP at 132, 10/2 at 11:30 AM with the SBP at 149, 10/3 at 5:00 PM with the SBP at 156, 10/7 at 11:30 AM with the SBP at 140, and 10/9 at 11:30 AM with the SBP at 137; There were no adverse consequences noted after receiving the medication against parameters. On 10/14/20 at 12:00 PM, the surveyor interviewed a Medication Nurse responsible for administering Midodrine to Resident #6, who stated that Midodrine is administered to Resident #6 if the SBP is less than 130 and held when the SBP is more than 130. 2. On 10/9/20 at 12:30 PM, the surveyor observed Resident #49 seated in a wheelchair, head leaning to the left side, eating lunch in the common area. The resident was approachable, responding quietly to the surveyor. On 10/14/20, the surveyor reviewed the records belonging to Resident #49, who was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis that included but were not limited to Parkinson's Disease, Muscle Weakness, and Major Depressive Disease. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/20, the surveyor reviewed Resident #49's October EMAR, which revealed an order dated 8/1/19 for Midodrine HCl Tablet 10 MG orally once daily for hypotension hold for SBP Greater than 130. This Physician's order was documented to be administered at 9:00 AM. The surveyor reviewed the October 2020 EMAR that revealed documentation that the nurses held administration of the Midodrine HCL 10 mg to Resident #49 on numerous occasions when the SBP was less than 130. The Midodrine was held and not administered to Resident #49 on 10/3 at 9:00 AM with the SBP at 130 and 10/14 at 9:00 AM with the SBP at 125. There were no adverse consequences noted after receiving the medication against parameters. On 10/13/20 at 2:20 PM and again on 10/14/20 at 2:30 PM, the irregularity associated the administration of Midodrine to Resident #6 and Resident #49 was discussed with the facility Director of Nursing (DON) and the Administrator. The (DON) and the Administrator could not provide any further information as to why the parameters set by the Physician's order were not accurately followed by the facility nursing staff. NJAC 8:39-27.1(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Based on observation, interview, and record review, it was determined that the facility failed to provide the necessary services to maintain adequate grooming for a resident who was dependent on the staff for activities of daily living. This deficient practice was observed for 1 of 25 residents reviewed; Resident #32, and was evidenced by the following: On 10/01/20 at 1:07 PM, the surveyor observed Resident #32 lying in bed. Resident #32's was observed having long hair and a thick, long beard. The resident told the surveyor that they had asked the Unit Manager (UM) for a shave over a week ago. Resident #32 stated that the UM informed the resident that he had someone who would do it, but the UM never followed through. The surveyor reviewed the Admission Record that indicated Resident #32 was admitted to the facility with diagnoses which included: hypertension, dementia without behavioral disturbances, and gastrostomy status. The surveyor reviewed the Quarterly Minimum Data Set (MDS), an assessment tool that reflected Resident #32 had a Brief Interview for Mental Status (BIMS) of 10, indicating the resident had a moderate cognitive impairment. The MDS further assessed that Resident #32 required extensive staff assistance for personal hygiene, including combing hair, brushing teeth, and shaving. On 10/6/20 at 11:41 AM, the surveyor observed the resident still with long, disheveled facial hair and in need of grooming. The resident informed the surveyor that there were several requests to several staff members to be shaved and to have their haircut. Resident #32 added that staff had not made any attempt to shave or have the resident's hair cut. On 10/7/20 at 11:40 AM, the surveyor observed that Resident #32's hair was cut, and facial hair was groomed but still had facial whiskers. The resident informed the surveyor that they wanted a close shave but that the staff member told the resident that she did not have a razor. On 10/7/20 at 11:44 AM, the Unit Manager (UM) stated that he had no recollection of Resident #32 asking for a shave/haircut. The UM said that it was the Certified Nursing Assistant's (CNA) responsibility to shave residents. The UM further stated that he had noticed that Resident #32 was very scruffy yesterday, and he told the CNA on the 3-11 PM shift to shave the resident. The UM stated that male residents should be shaved regularly if it is their preference and was unsure why the resident had not been shaved. On 10/7/20 at 11:55 AM, during an interview with the Assistant Director Of Nursing (ADON), she stated that she had noticed yesterday that Resident #32's facial hair was scruffy and needed tending to, so she cut only the beard off as she was concerned about using a razor on the resident's face. The ADON further stated that someone should have noticed, as she had, that the resident needed a shave. On 10/7/20 at 12:18 PM, the surveyor observed the UM shaving resident #32. The surveyor asked the resident if he ever grew his hair long or wore a beard or mustache before coming to the facility. The Resident replied, oh, no, never. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/20 at 1:40 PM, during an interview, the CNA routinely assigned to Resident #32's care stated that she usually shaved her residents every 2-3 days unless they refused. The surveyor asked the CNA when she last shaved Resident #32. The CNA replied, he refuses; you want to go in now and see that he refuses? At that time, the surveyor accompanied the CNA into the resident's room. The CNA said to the resident, don't you refuse to be shaved? The resident replied, well no, I have never refused, I may be on the phone with my daughter and say not right now, but I have never refused. I wanted to be shaved. I feel so much better. The surveyor observed the resident was smiling as he rubbed his clean-shaven face. The CNA turned and walked out of the room. The surveyor viewed the resident's admission picture with an admitted [DATE] and observed that the resident had short hair and short facial whiskers; no beard or mustache. The surveyor reviewed the CNA assignment/tablet, which reflected the resident had a self-care performance deficit and required staff assistance for personal hygiene. On 10/9/20 at 2:15 PM, the surveyor discussed the above observations and concerns with the Administrator, DON, and Regional Nurse. No further information was provided by the facility. NJAC 8:39-27.1 (a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 31656 36419 Based on observation, interview, and record review, it was determined that the facility failed to: a) ensure that contracting agents who provided services to residents were familiar and adhered to infection practice guidelines according to the facility's policy, Contracting Agents Policy and Center for Disease Control (CDC) identified for 2 of 25 residents, (Resident's #227, #226) observed during lab procedures rendered by a Certified Phlebotomy Technician (trained professional that draws blood for medical testing) (CPT); and, b.) ensure that staff perform hand washing as per the facility's policy to prevent the spread of infection while rendering care for resident for 1 of 25 residents (Resident #49). This deficient practice was evidenced by the following: 1. On 10/5/20 at 9:13 AM, the surveyor observed the CPT, wearing gloves and facemask, completing the blood draw for Resident #227. Resident #227 was observed lying in bed. The CPT's plastic supply carrier with attached sharps container (hard plastic container used to safely dispose of blood-contaminated needles) was noted on the resident's overbed table. On 10/5/20 at 9:14 AM, the surveyor observed the CPT removing her gloves and remaining in the room, conversing with Resident #227. On 10/5/20 at 9:25 AM, the surveyor observed the CPT exit Resident #227's room, carrying the supply carrier with sharps container attached and entering the room of Resident #226. The CPT did not wash or sanitizing her hands nor clean the supply carrier with the sharps container attached before exiting Resident #227's room or entering Resident #226's room. The CPT was then observed, placing the plastic supply carrier with sharps container attached on Resident #226's nightstand located near the resident's bed. On 10/5/20 at 9:28 AM, the surveyor observed as the CPT put on a new pair of surgical gloves without washing or sanitizing her hands. The surveyor interrupted the CPT and asked if she could step out of the resident's room to speak. The surveyor interviewed the CPT, who stated that she should wash her hands before and after each resident, putting on and removing gloves. The CPT also showed the surveyor disinfectant wipes, Hype Wipe, stored in the plastic supply carrier with a sharps container. The CPT stated that the Hype Wipe should be used to wipe down the plastic supply carrier with a sharps container before leaving one resident and entering another resident's room. The CPT stated that she was in a rush and forgot to wash her hands or disinfect the plastic supply carrier with sharps container, I'm supposed to do that. I did clean the carrier before I came into the facility. The CPT immediately left the facility and did not enter other units or have contact with any other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #227's Face Sheet documented that the resident had diagnoses that included but were not limited to Diabetes Mellitus (DM), Hypertension (HTN), Hyperlipidemia, and Epilepsy. Difficulty walking with muscle weakness. Resident #213's room was located in an Observation Quarantine Unit to rule out COVID-19 infection for facility newly admitted residents. Resident's remain on the Observation Quarantine Unit for 14 days until they are cleared of any COVID 19 infection or any other infectious disease state. A review of Resident #226's Face Sheet documented that the resident had diagnoses that included but was not limited to HTN, Hyperlipidemia, and Gastro-Esophageal Reflux Disease (GERD). Resident #226's room was also located in the Observation Quarantine Unit to rule out COVID-19 infection for facility newly admitted residents. On 10/5/20 at 10:30 AM, the surveyor met with the facility Administrator and Director of Nursing, who stated that the CPT should be wiping down all the equipment entering the facility, between each resident and washing or sanitizing hands before and after putting on gloves. On 10/5/20 at 1:30 PM, the Administrator presented the policies related to infection control and phlebotomy care. The surveyor reviewed the vendor policy dated 3/30/20 Cleaning your Phlebotomy Kit and Personal Protective Equipment policies supplied to the facility by the vendor and presented to the surveyor by the facility Administrator. The policy stated, Only bring with you the needed phlebotomy supplies into the room. Place needed supplies into plastic bag, Place paper towels on table and place equipment on the towels. Once drawn, place tubes into biohazard bag and then double bag it and Hands should be washed with soap and water or hand sanitizer when changing or removing gloves. 2. On 10/5/20 at 10:40 AM, the surveyor observed Resident #49 lying in bed with head leaning to the left side. The resident greeted the surveyor and stated that they had Parkinson's Disease. Resident #49 explained that because of Parkinson's Disease, they had no neck muscle control. Resident #49 also stated that they wanted to get out of bed, and were waiting for the Certified Nursing Assistant (CNA) to come in and assist them. The surveyor reviewed the resident's admission record, which indicated that Resident #49 was admitted to the facility with diagnoses, including Parkinson's Disease, Muscle Weakness, Depression, and Dysphagia (difficulty swallowing). A review of the 4/26/20 Quarterly Minimum Data Set (MDS), an assessment tool, reflected a Brief interview for Mental Status (BIMS) score of 9 out of 15, which indicated that the resident had a moderate cognitive impairment. The MDS further reflected that Resident #49 required extensive staff assistance for transfers and was occasionally incontinent of bowel and bladder. On 10/5/20 at 11:06 AM, CNA #1 entered Resident 49's room and put on gloves without first washing her hands or using hand sanitizer. CNA #1 gathered supplies and stated she needed to go and get a basin. CNA #1 removed her gloves, and the surveyor accompanied her to the supply room where she obtained the basin and then went back into Resident #49's room. CNA #1 again put on a new set of gloves without first washing or sanitizing her hands. CNA #1 then transferred the resident from their bed to the wheelchair and assisted the resident with incontinence and hygienic care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315335	A. Building B. Wing	10/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Post Acute Care of Wayne	1120 Alps Road Wayne, NJ 07470

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/5/20 at 12:22 PM, the surveyor observed CNA #1 leave Resident #49's room without washing or sanitizing her hands. On 10/14/20 at 1:31 PM, the surveyor reviewed the facility policy for Hand Hygiene dated 10/5/2020, which read: * Employee should perform hand hygiene before and after all resident contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. *Employee should perform hand hygiene by using ABHR with 60-95% alcohol or washing hands with soap and water and vigorously scrubbing with soap for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR. *Hand hygiene supplies should be available to all personnel in every care location. NJAC 8:39-19.4 (a)