STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A008	A. BUILDING: _____ B. WING _____	C 11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF EVESHAM, LLC	302 LIPPINCOTT DRIVE EVESHAM, NJ 08053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00148998 CENSUS: 50 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 607	8:36-5.15(a)(1) General Requirements (a) The resident's family, guardian, and/or designated responsible person or community agency shall be notified, when known, and with the resident's consent, immediately after the occurrence, in the event of the following: 1. The resident acquires an acute illness requiring medical care; This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00148998	A 607		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 607	Continued From page 1 Based on interview and record review it was determined that the facility failed to notify a resident's Power of Attorney of a change in the residents condition that required medical treatment for 1 of 3 residents reviewed, Resident [redacted]. This deficient practice was evidenced by the following: On 11/24/21 at 10:45 a.m., the Surveyor inquired of the Licensed Practical Nurse (LPN) the procedure followed when when there was a change in a resident's status or medical condition. The LPN informed the surveyor that she would notify the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) and would call the resident's Medical Doctor (MD) and family. At 11:00 a.m., the Surveyor interviewed the ADON who informed the surveyor that if a resident had a change in status or medical condition, the resident's family and MD would be called. The ADON added that the Executive Director (ED) would notify the family member. In addition, the family would be notified by telephone if the MD provided any new orders. The ADON, in the presence of the ED, explained to the Surveyor that on [redacted] there had been an outbreak of [redacted] in the facility which required all residents to be treated. In addition, the residents were isolated and assessed by their physicians who ordered treatment of the infection. Also, the families were made aware that there would be no visitation. The surveyor asked the ADON and the ED how the families were notified. The ED stated that typically the facility used email and text to communicate with families or Power of Attorney (POA).	A 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 607	Continued From page 2 At 11:15 a.m., the Surveyor reviewed Resident [redacted]s medical record which showed that Resident [redacted] was admitted to the facility on [redacted] with diagnoses which included [redacted] During surveyor review of Resident [redacted]s Assessment dated [redacted], Resident [redacted] was [redacted] and able to communicate needs. The "Nursing Notes" of [redacted] by the ADON identified that Resident [redacted] was [redacted] however there was no prior documentation that Resident [redacted] had [redacted] and was treated or that family and or POA had been notified. According to Resident [redacted] Medication Administration Record (MAR), Resident [redacted] was administered [redacted] cream on [redacted] and on [redacted] Resident [redacted] was administered [redacted] tablets, both medications were used to treat [redacted] According to the facility document titled "Change of Condition," listed under "Policy: ...prompt notification to the resident's physician and family/responsible party. Procedures: 4. ... The DHW/designee will document his/her ...notification of the family/responsible party ... in the Nursing care Notes of the Individual Resident Record." At 1:45 p.m., the Surveyor asked the ED to explain the facility system used to send emails or texts. The ED informed the surveyor that the facility used a notification system in which the facility would send a text message and an email to the POA and an email to the rest of the family that were listed on the residents' contact list. In addition, after an email or text message had been sent, the facility would receive confirmation that the email or text was opened. At 2:00 p.m., the Surveyor reviewed a copy of the email and text report sent in regard to Resident	A 607		

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A 607	Continued From page 3 [redacted] condition which displayed that the POA was emailed on [redacted] and a text message had been sent. According to the facility email message, Resident[redacted] POA was informed that there was a scabies out break in the facility and that if their loved one developed a [redacted], diagnosed or expected [redacted], the POA would receive a separate notification by telephone or email. According to the facility Line Listing dated [redacted], Resident [redacted] had [redacted]. Ongoing surveyor review of the report identified that there was no separate emails sent to Resident[redacted] POA other than [redacted] regarding the resident's individualized condition. At 3;00 p.m., the ED informed the Surveyor that the residents signed a move in agreement to participate in the facility's notification system. The surveyor than asked the ED for a copy of the agreements for Resident [redacted] and [redacted] The ED informed the surveyor that she would have to email the agreements to the surveyor since the facility liaison was not available. On 11/26/21 at 3:14 p.m., the ED emailed the surveyor that she was unable to find the notification agreement for Resident [redacted]. The facility was unable to provide information to verify that Resident [redacted]s POA agreed to be contacted by email, text or by telephone call for change in Resident [redacted]'s medical condition or treatment.	A 607		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of	A1073		

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A1073	Continued From page 4 professional practice. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00148998 Based on interview and record review it was determined that the facility failed to implement and provide documentation in the residents' medical record for assessments, treatments, or physician instructions during a communicable disease outbreak for 2 of 3 residents reviewed, Residents [redacted] and [redacted] This deficient practice was evidenced by the following: On 11/24/21 at 9:30 a.m., the Department of Health (DOH) conducted a survey of the facility regarding a complaint concerning notification of residents change in medical condition, delay in treatment and infection control. On 11/24/21 at 9:30 a.m., during the entrance conference for this complaint survey, the Executive Director (ED) informed the surveyor that she had just started as the Interim ED on [redacted] due to the resignation of the previous ED. Further, the ED stated that the Director of Nursing (DON) was on vacation but the Assistant Director of Nursing (ADON) was on duty. At 10:45 a.m., the Surveyor asked the Licensed Practical Nurse (LPN) how a resident's change in medical condition would be communicated to other care staff. The LPN informed the surveyor that she, the LPN, would document this information on the twenty-four-hour report and in the resident's medical record.	A1073		

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A1073	Continued From page 5 At 11:00 a.m., the ADON informed the Surveyor that if there was a change in a resident's status, an assessment would be performed and the Medical Doctor (MD) and the family would be notified. Also, the change in condition or any new treatments ordered by the MD would be documented in the resident's medical record and the family would be notified. At 11:12 a.m., the surveyor began medical record review for Resident [redacted] and Resident [redacted]. 1. Surveyor review of Resident [redacted]s medical record, revealed that Resident [redacted] was admitted to the facility on [redacted] with diagnoses which included [redacted]. According to Resident [redacted]'s Assessment Plan dated [redacted], Resident [redacted] was [redacted], but needed reminders. During Surveyor review of Resident [redacted] Medication Administration Record (MAR) dated [redacted], identified that on [redacted] (used to treat [redacted]) [redacted] mg give [redacted] tablets by mouth times one was documented as administered to Resident [redacted] on [redacted] and again on [redacted] Resident [redacted]s "Nurse's Notes" failed to identify a rationale for treatment with this medication on [redacted] 2. Surveyor Review of Resident [redacted]s medical record revealed that Resident [redacted] was admitted to the facility on [redacted] with diagnoses which included [redacted]. Resident [redacted]'s Assessment Plan dated [redacted] identified Resident [redacted] as [redacted] and able to communicate needs. According to Resident [redacted]s MAR dated [redacted] cream (used to treat [redacted]) was documented as applied to Resident [redacted] on [redacted] and [redacted]. Resident [redacted]'s MAR identified that [redacted] (used to treat [redacted]	A1073		

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A1073	Continued From page 6	A1073		

infections) was documented as administered to Resident [redacted] on [redacted]. The Surveyor reviewed Resident [redacted] "Nurse's Notes" and there was no documentation concerning the rationale for treatment with these medications on the dates administered [redacted] and [redacted]. Further surveyor review of Resident [redacted]'s Nurse's Notes identified that on [redacted], the ADON documented that Resident [redacted] was [redacted] However, there was no documentation of the onset or course of the [redacted]

At 1:40 p.m., the ADON and the ED explained to the Surveyor that on [redacted], the facility had an outbreak of [redacted] in which all residents had to be treated. In addition, the residents were isolated and assessed by their MD's and treatments were ordered. The Surveyor asked the ADON where the documentation for the outbreak was related to assessments, MD instructions, and treatments ordered in the resident medical record and the ADON was unable to answer or provide the documentation.

At 3:00 p.m., the Surveyor reviewed the facility policy and procedures for documentation titled "Individual Resident Record Documentation Guideline VII.2 updated 1/2020" and under "Procedures: ...2. Document to pertinent changes in the resident's condition, reaction to treatment, medication, etc., as well as routine observations and changes in physician orders or the service plan."

The Surveyor also reviewed the facility policy and procedure titled "Change of Condition." Listed under "Procedures: ...4. The DHW/designee will document his/her assessment of the condition change, notification of the physician and family/responsible party and interventions taken including new orders, in the Nursing Care Notes

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A1073	Continued From page 7 of the individual Resident Record."	A1073		

ARTIS
SENIOR LIVING
Evesham
MEMORY CARE BY DESIGN

January 28, 2021

[redacted]

Dear Ms. [redacted]

Enclosed please find the Plan of Correction for the Survey conducted at Artis of Evesham on November 24, 2021.

I would like to add that the surveyor was extremely knowledgeable and I appreciate the time spent in my community.

Should you have any further questions concerning the POC please feel to reach out at cfallick@artismgmt.com or by phone at 856-810-0007.

Kindly,

Cheyenne Fallick, CDP, CALA
Artis Senior Living of Evesham

ARTIS
SENIOR LIVING
Evesham
MEMORY CARE BY DESIGN

Plan of Correction for Artis Senior Living of Evesham

A6078;36-515(a)(1)

1. DON reviewed the records of Resident #3 for the deficient practice on 12/09/2021. Nurses and ADON were in- serviced by the DON on 12/13/2021, on the ways to properly Notify and Notate as per our Policy & Procedure. Whenever there's a change in treatment or status to resident # 3 the current shift will notify POA and notate in chart. Follow up calls were made to resident #3 POA on 12/13/2021 and will be made by the DON, ADON or designee ongoing.
2. All residents are at risk for this deficient practice.
3. DON, ADON or designee will perform update calls weekly for twelve weeks to resident #3 POA to ensure clear and transparent communication between the community and the POA. DON will perform yearly in-services to ensure Nurse's are aware of Notation and Notification protocols to all residents POA's per our Policy & Procedures. Resident #3 POA will notified by staff if there's a change in status per our Policy & Procedures. Nurses and ADON were in- serviced by the DON on 12/13/2021, on the ways to properly Notify and Notate as per our Policy & Procedure.
4. ED or designee will perform weekly calls to resident #3 POA to ensure they have been notify of any changes, ongoing for four months. Charts will be audited by DON, ADON or designee quarterly to ensure Notification and Notation compliance per our Policy & Procedures. Chart Audit reviews will be added to quarterly meetings agenda to ensure we remain compliant.

Completion date: 12/17/2021

ARTIS
SENIOR LIVING
Evesham
MEMORY CARE BY DESIGN

A1073836-15.6(b)

1. DON reviewed the records of resident #1 and resident #3 for the deficient practice on 12/09/2021. Nurses and ADON were in-serviced by the DON on the way to properly perform documentation in resident #1 and resident #3 charts on 12/13/2021 as per our Policy & Procedure. Whenever there's a change in treatment or status to resident #1 and resident #3, the nurse on shift will notify POA, DON, ADON and MD and document in the chart as such. Checks will be completed by the DON, ADON or designee weekly for twelve weeks.
2. All residents are at risk for this deficient practice.
3. DON, ADON or designee will review charts of resident #1 and resident #3 daily for any changes in status or treatment for eight weeks to ensure Nurses our compliant with documentation as per our Policy & Procedures.
4. Findings will be reported to the Executive Director for 2 months until Compliance is reached. DON performed full audit on 12/09/2021 of all residents charts outcome was reported to Executive Director. Executive Director will monitor DON's quarterly in-services and chart audits during weekly meetings ongoing to ensure compliance with our Policy & Procedure.

Completion date: 12/30/2021

New Jersey Department of Health

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00148998 CENSUS: 50 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 607	8:36-5.15(a)(1) General Requirements (a) The resident's family, guardian, and/or designated responsible person or community agency shall be notified, when known, and with the resident's consent, immediately after the occurrence, in the event of the following: 1. The resident acquires an acute illness requiring medical care; This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00148998	A 607		

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

1/28/22

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A 607	Continued From page 1 Based on interview and record review it was determined that the facility failed to notify a resident's Power of Attorney of a change in the residents condition that required medical treatment for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following: On 11/24/21 at 10:45 a.m., the Surveyor inquired of the Licensed Practical Nurse (LPN) the procedure followed when when there was a change in a resident's status or medical condition. The LPN informed the surveyor that she would notify the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) and would call the resident's Medical Doctor (MD) and family. At 11:00 a.m., the Surveyor interviewed the ADON who informed the surveyor that if a resident had a change in status or medical condition, the resident's family and MD would be called. The ADON added that the Executive Director (ED) would notify the family member. In addition, the family would be notified by telephone if the MD provided any new orders. The ADON, in the presence of the ED, explained to the Surveyor that on 9/24/21 there had been an [redacted] in the facility which required all residents to be treated. In addition, the residents were isolated and assessed by their physicians who ordered treatment of the infection. Also, the families were made aware that there would be no visitation. The surveyor asked the ADON and the ED how the families were notified. The ED stated that typically the facility used email and text to	A 607		

1/28/22

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A 607	Continued From page 2 communicate with families or Power of Attorney (POA). At 11:15 a.m., the Surveyor reviewed Resident #3's medical record which showed that Resident #3 was admitted to the facility on [redacted] with diagnoses which included [redacted] During surveyor review of Resident #3's Assessment dated [redacted], Resident #3 was alert and able to communicate needs. The "Nursing Notes" of [redacted] by the ADON identified that Resident #3 was post a [redacted] however there was no prior documentation that Resident #3 had scabies and was treated or that family and or POA had been notified. According to Resident #3's Medication Administration Record (MAR), Resident #3 was administered [redacted] cream on [redacted] and on [redacted] Resident #3 was administered [redacted] tablets, both medications were used to treat [redacted]. According to the facility document titled "Change of Condition," listed under "Policy: ...prompt notification to the resident's physician and family/responsible party. Procedures: 4. ... The DHW/designee will document his/her ...notification of the family/responsible party ... in the Nursing care Notes of the Individual Resident Record." At 1:45 p.m., the Surveyor asked the ED to explain the facility system used to send emails or texts. The ED informed the surveyor that the facility used a notification system in which the facility would send a text message and an email to the POA and an email to the rest of the family that were listed on the residents' contact list. In addition, after an email or text message had been sent, the facility would receive confirmation that the email or text was opened.	A 607		

1/28/22

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A 607	Continued From page 3 At 2:00 p.m., the Surveyor reviewed a copy of the email and text report sent in regard to Resident #3's condition which displayed that the POA was emailed on [redacted] and a text message had been sent. According to the facility email message, Resident #3's POA was informed that there was a [redacted] out break in the facility and that if their loved one developed a [redacted] diagnosed or expected [redacted] the POA would receive a separate notification by telephone or email. According to the facility Line Listing dated [redacted] Resident #3 had a rash. Ongoing surveyor review of the report identified that there was no separate emails sent to Resident #3's POA other than [redacted] regarding the resident's individualized condition. At 3;00 p.m., the ED informed the Surveyor that the residents signed a move in agreement to participate in the facility's notification system. The surveyor than asked the ED for a copy of the agreements for Resident #1, #2, and #3. The ED informed the surveyor that she would have to email the agreements to the surveyor since the facility liaison was not available. On 11/26/21 at 3:14 p.m., the ED emailed the surveyor that she was unable to find the notification agreement for Resident #3. The facility was unable to provide information to verify that Resident #3's POA agreed to be contacted by email, text or by telephone call for change in Resident #3's medical condition or treatment.	A 607		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered	A1073		

1/28/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF EVESHAM, LLC	302 LIPPINCOTT DRIVE EVESHAM, NJ 08053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1073	Continued From page 4 according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00148998 Based on interview and record review it was determined that the facility failed to implement and provide documentation in the residents' medical record for assessments, treatments, or physician instructions during a [redacted] for 2 of 3 residents reviewed, Residents #1 and #3. This deficient practice was evidenced by the following: On 11/24/21 at 9:30 a.m., the Department of Health (DOH) conducted a survey of the facility regarding a complaint concerning notification of residents change in medical condition, delay in treatment and infection control. On 11/24/21 at 9:30 a.m., during the entrance conference for this complaint survey, the Executive Director (ED) informed the surveyor that she had just started as the Interim ED on [redacted] due to the resignation of the previous ED. Further, the ED stated that the Director of Nursing (DON) was on vacation but the Assistant Director of Nursing (ADON) was on duty. At 10:45 a.m., the Surveyor asked the Licensed Practical Nurse (LPN) how a resident's change in	A1073		

11/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A008	A. BUILDING: _____ B. WING _____	C 11/24/2021

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A1073	Continued From page 5	A1073		

medical condition would be communicated to other care staff. The LPN informed the surveyor that she, the LPN, would document this information on the twenty-four-hour report and in the resident's medical record.

At 11:00 a.m., the ADON informed the Surveyor that if there was a change in a resident's status, an assessment would be performed and the Medical Doctor (MD) and the family would be notified. Also, the change in condition or any new treatments ordered by the MD would be documented in the resident's medical record and the family would be notified.

At 11:12 a.m., the surveyor began medical record review for Resident #1 and Resident #3.

1. Surveyor review of Resident #1's medical record, revealed that Resident #1 was admitted to the facility on [redacted] with diagnoses which included [redacted]. According to Resident #3's Assessment Plan dated [redacted], Resident #1 was alert, but needed reminders. During Surveyor review of Resident #1's Medication Administration Record (MAR) dated [redacted], identified that on [redacted] EX Order 264b1 [redacted] mg give [redacted] tablets by mouth times one was documented as administered to Resident #1 on [redacted] and again on [redacted] Resident #1's "Nurse's Notes" failed to identify a rationale for treatment with this medication on [redacted] NJ EX Order 264b1

2. Surveyor Review of Resident #3's medical record revealed that Resident #3 was admitted to the facility on [redacted] with diagnoses which included [redacted]. Resident #3's Assessment Plan dated [redacted] identified Resident #3 as [redacted] and able to communicate needs. According to

1/28/22

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	03A008	A. BUILDING: _____ B. WING _____	C 11/24/2021

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A1073	Continued From page 6 Resident #3's MAR dated [redacted] cream (used to treat [redacted] a condition caused by [redacted] was documented as applied to Resident #3 on [redacted] Resident #3's MAR identified that [redacted] (used to [redacted] infections) was documented as administered to Resident #3 on [redacted] The Surveyor reviewed Resident #3's "Nurse's Notes" and there was no documentation concerning the rationale for treatment with these medications on the dates administered [redacted] and [redacted] Further surveyor review of Resident #3's Nurse's Notes identified that on [redacted] the ADON documented that Resident #3 was [redacted] However, there was no documentation of the onset or course of the [redacted] At 1:40 p.m., the ADON and the ED explained to the Surveyor that on [redacted] the facility had an outbreak of [redacted] in which all residents had to be treated. In addition, the residents were isolated and assessed by their MD's and treatments were ordered. The Surveyor asked the ADON where the documentation for the outbreak was related to assessments, MD instructions, and treatments ordered in the resident medical record and the ADON was unable to answer or provide the documentation. At 3:00 p.m., the Surveyor reviewed the facility policy and procedures for documentation titled "Individual Resident Record Documentation Guideline VII.2 updated 1/2020" and under "Procedures: ...2. Document to pertinent changes in the resident's condition, reaction to treatment, medication, etc., as well as routine observations and changes in physician orders or the service plan."	A1073		

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A1073	Continued From page 7 The Surveyor also reviewed the facility policy and procedure titled "Change of Condition." Listed under "Procedures: ...4. The DHW/designee will document his/her assessment of the condition change, notification of the physician and family/responsible party and interventions taken including new orders, in the Nursing Care Notes of the individual Resident Record."	A1073		

1/28/22