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 08/28/2020

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 #: NJ 00138627 CENSUS: 53 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 611	8:36-5.15(a)(3) 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: 3. The resident is transferred from the facility; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00138627 Based on interview and record review it was	A 611		

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A 611	Continued From page 1 determined that the facility failed to notify the Responsible Party (RP) of a hospital transfer following a fall for 1 of 3 residents reviewed for falls, Resident #2. This deficient practice was evidenced by the following: On 8/28/20 at 10:55 a.m., the surveyor reviewed Resident #2's closed medical record and according to the "Emergency Information/Face Sheet", the resident move-in date was [redacted] with diagnoses which included but were not limited to [redacted] The "New Jersey Universal Transfer" form dated [redacted] indicated that the resident was alert, forgetful and had poor short term memory. Surveyor continued review of the medical record showed "Nurse's Notes" (NN) dated [redacted] which revealed that Resident #2 was found on the floor between a dresser and bed during the 11-7 shift. A Licensed Practical Nurse (LPN) documented that the Director of Nursing (DON) and physician were notified of the incident and that family would be notified in the morning. The LPN documented that at 4 a.m., the resident had a change in mental and physical status and the DON/physician were notified and that the resident was sent out [hospital] via 911, "Family to be notified in the morning." The NN dated [redacted] on the "7-3" shift written as signed by the LPN documented that she spoke with Resident #2's RP at approximately 6:40 a.m., and that he/she [RP] was upset that he/she [RP] had not gotten a telephone call from the facility regarding the resident's condition. The LPN documented that she explained to the RP that she was going to call the RP at 7 a.m.	A 611		

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A 611	Continued From page 2 At 11:40 a.m., the surveyor interviewed the Director of Health and Wellness (DOHW) regarding the aforementioned. She stated that Resident #2 fell on [redacted] at 11:30 p.m., and on 8/10/20 at 4:13 a.m., she received a call from the LPN that the resident was [redacted] and was not [redacted] She stated that the resident was transferred to the hospital for further evaluation and expired at the hospital. During continued interview, the surveyor asked the DOHW about the facility's protocol in notification of family when there was incident and accident. The DOHW stated that incident/accident without injury that occurred late at night, that the family was notified first thing in the morning. She stated that incident/accident with injury including hospital transfers, that the family was notified immediately. The DOHW explained that Resident #2's RP should had been notified of the hospital transfer immediately. Further review of the medical record indicated that the RP was not notified of the [redacted] incident and the resident's transfer to the hospital as a result of the fall. Surveyor review of the facility policy and procedures titled, "Incident/Accident Reporting" indicated, "The family or responsible party will be notified as soon as possible concerning the accident/incident."	A 611		

ARTIS
SENIOR LIVING
Evesham
Your Partner In Memory Care

Plan of Correction for Artis Senior Living of Evesham

1. The corrective action for the resident that was affected (Resident #2) by the deficient practice was to contact the family concerning the transfer to the hospital. Also, educate associates concerning policy of family notification. See policy attached. This was accomplished by providing an in service to associates on 10/09/2020.

2. There were no other residents affected by this deficient practice.

3. The following measures will be put in place to ensure the deficient practice is corrected. The Registered Professional Nurse will enter a note in a residents chart certifying of notification of responsible party. (See attached in service sheets.) The Director of Health and Wellness (Director of Nursing), or designee, will enter a note upon incident and review charts weekly as added measure.

4. The facility will continue this practice and has updated its Policy and Procedure as noted in attached policy and highlighted. This practice is in effect and date of compliance is 10/7/2020.