STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A010	A. BUILDING: _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS, THE	289 GORDONS CORNER ROAD MANALAPAN, NJ 07726

(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 #: NJ00167999, NJ00166513, NJ00165668, NJ00166718, NJ00163518 CENSUS: 76 SAMPLE SIZE: 4 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 735	8:36-7.2(e)(1-5) Resident Assessments and Care Plans (e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following: 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services,	A 735		

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 735	Continued From page 1	A 735		

if appropriate;

4. The time intervals at which the resident's response to
treatment will be reviewed; and

5. The measures to be used to assess the effects of treatment.

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00167999, NJ00166513, NJ00165668, NJ00166718, NJ00163518

Based on interview and record review, it was determined that the facility failed to develop and implement a written health service plan (HSP) when Resident #2 was noted with NJ EX Order. 264b1 upon admission. There was no HSP developed upon move in to ensure goals, interventions and effects of treatments were evaluated and reassessed for efficacy. This deficient practice was evidenced by the following:

On 10/4/2023 the surveyor reviewed Resident #2's medical record which revealed that the resident moved into the facility on NJ EX Order. 264b1 with diagnoses which included NJ EX Order. 264b1 The surveyor reviewed a facility document titled "Nursing Assessment" dated NJ EX Order. 264b1, which revealed that Resident #2 had NJ EX Order. 264b1 to his/her NJ EX Order. 264b1 with NJ EX Order. 264b1 and a NJ EX Order. 264b1, NJ EX Order. 264b1 to NJ EX Order. 264b1 J EX Order. 264b1 and NJ EX Order. 264b1. The nursing assessment also revealed that Resident #2's NJ EX Or will be

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 735	Continued From page 2 reassessed weekly. The facility failed to provide documentation that Resident #2's [redacted] was reassessed weekly. On 10/4/2023 at 1:30 p.m., the surveyor interviewed the Executive Director and Director of Nursing, both who started working at the assisted living facility in [redacted] Upon interview, it was determined that there was not a HSP developed for Resident #2 prior to [redacted]. Surveyor review of "Nursing Notes" revealed that Resident #2 went out to the hospital on [redacted]. Upon review of the wound care notes dated [redacted] from the hospital, it was identified that Resident #2 had [redacted] and [redacted] with [redacted] to [redacted] and [redacted]. Continued review of the hospitals [redacted] care notes revealed that the resident had a [redacted] to the [redacted] and [redacted]. Resident #2's [redacted] was intact; [redacted] have [redacted] related to [redacted] from [redacted] The facility failed to develop a HSP upon move in for Resident #2 who was identified with [redacted].	A 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 735	8:36-7.2(e)(1-5) Resident Assessments and Care Plans (e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following: 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services,	A 735		

The Villas
289 Gordons Corner Road
Manalapan, NJ 07726

A735

Plan of Correction	Date of Compliance
1. The corrective actions accomplished for the residents affected by the deficient practice: *Resident #2 was discharged to hospital on* [redacted] *and did not return to facility.*	October 27, 2023
2. How the facility will identify other residents having the potential to be affected by the same deficient practice: *All residents with altered* [redacted] *may be affected by the deficient practice. An audit of* [redacted] *assessments already completed and documented, on all admissions and readmissions, over the past 6 months completed on 10/26/23 to ensure a Health Service Plan (HSP) was in place.* *In addition,* [redacted] *assessments performed between 9/21/23 and 9/26/23 for all residents identified as high-risk for* [redacted]	October 27, 2023
3. Measures put into place to ensure the deficient practice will not recur: *The RN will initiate HSP for all residents assessed to have* [redacted] *including new admissions and readmissions.* *In-Services occurred on 10/24/23 and ongoing with all nursing and caregiver staff on the prompt reporting of any* [redacted] *issues. In-Services provided to all licensed nurses on 10/24/23 on the HSP policy.*	October 27, 2023
4. Corrective actions will be monitored to ensure the deficient practice will not recur: *As part of the Quality Assurance program, the Director of Nursing and/or Designee will audit 100% of the new admissions and readmissions for 1 month, and then 50% of the new admissions and readmissions monthly for 6 months to ensure a HSP is initiated when appropriate. Audit tool to be submitted to QA Committee and reviewed at quarterly QA meeting.*	October 27, 2023

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
13A010 (Y1)	A. Building B. Wing (Y2)	4/15/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS, THE	289 GORDONS CORNER ROAD MANALAPAN, NJ 07726

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 A0735 Reg. # 8:36-7.2(e)(1-5) LSC	Correction Completed 10/27/2023	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
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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	
10/5/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO