New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A000	A. BUILDING: ______ B. WING ______	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EVESHAM	**ONE BRENDENWOOD DRIVE VOORHEES, NJ 08043**

(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 #: NJ00145964 CENSUS: 136 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 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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

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This REQUIREMENT is not met as evidenced by:
Complaint #NJ00145964

Based on observation, interview and record review it was determined that the facility failed to implement its policy and procedures titled, "[redacted] Environment and Electronic [redacted] Policy," to ensure residents identified as having unsafe [redacted] behaviors were supervised for 2 of 3 residents reviewed for smoking, Resident #1 and Resident #3, which placed all residents at risk for injury or harm. This deficient practice was evidenced by the following:

On 6/14/21 at 9:25 a.m., during the entrance conference of the survey the surveyor interviewed the Health and Wellness Director (HWD) and requested the facility census and policies and procedures on resident rights, and resident safety.

On 6/14/21 at 9:40 a.m. the surveyor, in the presence of the Business Manager (BM), began the tour of the facility. During the tour of the courtyard the surveyor observed that residents were [redacted] The surveyor asked the BM were residents monitored by staff while they smoked. The BM stated that the residents were not monitored by staff and that they [redacted] on their own. Further, the BM stated that staff only escorted residents to the courtyard to [redacted] when the care plan indicated that it was necessary to do so.

On 6/14/21 at 10:30 a.m., the surveyor interviewed the Executive Director (ED), who

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stated that residents were informed upon admission of the facility policy and procedure for [redacted] The surveyor questioned the ED on what would happen if a resident did not follow the facility policy and procedure for [redacted] The ED stated that the resident would be re-educated on the facility's policy and procedure and if that resident continued to be non-compliant, the resident would be discharged.

On 6/14/21 at 11:00 a.m., the surveyor interviewed various facility staff members who all stated that all residents were informed of the [redacted] policy and procedure. The staff members further explained that if a resident was caught [redacted] in the facility, the supervisor would be notified and what was done after that was up to administration.

The surveyor then continued the tour of the facility and observed the smell of [redacted] [redacted] upon exiting the elevator onto the [redacted] floor. At 11:20 a.m., the surveyor interviewed the ED regarding the smell of [redacted] on the [redacted] floor and inquired about residents smoking in the facility. The ED stated that Resident #1 and Resident #3 were non-compliant with the facility's [redacted] policy and procedure. The surveyor asked the ED if there were any supervised or scheduled [redacted] breaks for any of the residents of the facility. The ED stated that there were not enough staff to have supervised/scheduled [redacted] breaks for the residents that [redacted].

On 6/14/21 at 12:20 p.m., the surveyor interviewed the HWD, who also stated that Resident #1 and Resident #3 were not compliant with the facility's [redacted] policy. Further, the HWD stated that Resident #1 has sent Resident #3 out of the facility to purchase [redacted] for him/her [Resident #1].

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A 310	Continued From page 3 1. On 6/14/21 at 12:35 p.m., the surveyor reviewed Resident #1's medical record which indicated that Resident #1 was admitted to the facility on [redacted] with diagnoses which included [redacted]. According to Resident #1's "Personal Service Plan" dated [redacted], Resident #1 was [redacted] and [redacted] [redacted], required the use of a wheelchair for locomotion and required the assistance of two-persons for transfers. The "Personal Service Plan" indicated under the section titled, "Behavior Management," that the facility staff would assist Resident #1 with transfers in and out of bed to a wheelchair to [redacted] on the patio. The facility identified that Resident #1 continued to [redacted] in his/her room as evidenced by the smell of [redacted] and the presence of [redacted]r, and a box of [redacted] in the resident's belongings. Further review of Resident #1's "Personal Service Plan' revealed that the facility failed to update the plan since [redacted] to include interventions to address the ongoing unsafe [redacted] behaviors of [redacted] in the apartment/room, no interventions to remove the [redacted] and other items used to [redacted], from the resident and keep with the staff as indicated in the facility policy and procedure indicated below, also there were no interventions for staff to supervise Resident #1 while [redacted] The surveyor reviewed Resident #1's Progress Notes (PN) and observed the following notes regarding Resident #1's noncompliance with the facility policy and procedure for [redacted] a. A PN dated 3/5/21 at 2:56 p.m. written by a Registered Nurse (RN) documented that	A 310		

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Resident #1's apartment smelled like

b. A PN dated 3/6/21 at 11:29 a.m. written by a Licensed Practical Nurse (LPN) indicated, "Smelled in hallway. Went in to check on resident who states that [he/she] is fine." Observed water bottle on side chair with in it."

c. A PN dated 3/7/21 at 12:14 p.m. written by an LPN indicated that a facility "Aide" reported that he, [the Aide] asked Resident #1 if he could throw away the water bottle, that the resident kept by the bedside and used to put out after The Aide reported that Resident #1 would not allow the Aide to throw the bottle away. According to the PN, the Aide then reminded Resident #1 that he/she was not supposed to in the room.

d. A PN dated 3/15/21 at 11:51 a.m. written by an LPN which indicated that the staff went into Resident #1's bedroom area of the apartment/room and observed the resident actively , the resident then tried to put the out by putting it in a bottle of water, and covered the bottle to try to prevent the from escaping the bottle.

Additionally, the surveyor reviewed a document provided by the ED titled, "Resident #1's Timeline regarding Policy" which indicated that there was evidence that Resident #1 continued to in his/her room on and .

On 6/14/21 at 1:00 p.m., the surveyor observed the smell of upon entering Resident #1's apartment. The surveyor observed that Resident #1 was to so the surveyor

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A 310	Continued From page 5 interviewed the resident. The surveyor asked Resident #1 was he/she made aware of the facility's [redacted] policy. Resident #1 stated that he/she was aware of the facility [redacted] policy and procedure, however, Resident #1 explained that his/her wheelchair was broken, and he/she usually went outside to [redacted] when his/her wheelchair was working. Resident #1 further stated that his/her roommate, Resident #3, comes into the room and [redacted] 2. On 6/14/21 at 1:15 p.m., the surveyor reviewed Resident #3's medical record and observed that Resident #3 was admitted to the facility on [redacted] with diagnoses which included [redacted]. According to Resident #3's "Personal Service Plan" dated [redacted] Resident #3 was [redacted] to [redacted] and ambulated independently. a. The surveyor reviewed Resident #3's "Personal Service Plan" dated [redacted], which indicated that staff reported the smell of [redacted] [redacted] and observed [redacted] and [redacted] in Resident #3's room. The surveyor observed that the facility failed to update Resident #3's plan since [redacted] with interventions to address the continued unsafe [redacted] behaviors and non compliance with the facility [redacted] policy and procedure. Additionally, there was no intervention on the plan to address staff supervision of Resident #3 while [redacted] or the removal of [redacted], lighter or other items used to [redacted] from the resident and given to staff per the facility policy and procedure on [redacted] as indicated below. b. The surveyor reviewed Resident #3's PN's and observed a PN dated [redacted] at 2:06 p.m., written by the HWD, which indicated that on [redacted]	A 310		

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Resident #3's room smelled of [redacted] [redacted] were observed in the trash can, there was a bottle of water with used [redacted] [redacted] in it, and the resident admitted to [redacted] despite being on a [redacted] [redacted]), and despite the facility policy of no [redacted] in the facility.

c. The surveyor reviewed a document titled provided by the ED titled, "Resident #3's Timeline regarding [redacted] Policy," which indicated that on [redacted] staff observed Resident #3 [redacted] in his/her room.

On 6/14/21 at 1:45 p.m., the surveyor went to Resident #3's room, and upon entering the room, noted the smell of [redacted]. The surveyor observed that Resident #3 was [redacted] to [redacted] and conducted an interview with the resident. The surveyor asked Resident #3 was he/she made aware of the facility's [redacted] policy. Resident #3 stated that he/she was aware of the [redacted] policy and then denied [redacted] in the room, however, the surveyor observed that Resident #3 was in the room alone at that time.

On 6/14/21 at 4:15 p.m., the surveyor reviewed the facility policy and procedure titled, "[redacted] [redacted] Environment and [redacted] Policy," which was last revised on 7/2015 and indicated, "..[redacted] is not permitted in any part of the community. Residents who [redacted] in their apartments will not be admitted or retained. 3. All ... residents... who have demonstrated unsafe [redacted] behaviors, must be supervised by associates at all times while [redacted] [redacted] and [redacted] may not be left with these residents while [redacted] 4. All... residents who have demonstrated unsafe [redacted] behaviors may not retain [redacted] materials [redacted],

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[REDACTED], etc.) All materials must be labeled with the residents name and securely stored by the community."

On 6/14/21 at 4:30 p.m., the surveyor requested a removal plan from the ED for the deficient practice of unsupervised [REDACTED] of residents that were identified as requiring supervision while smoking due to unsafe [REDACTED] behaviors, and for the deficient practice of residents [REDACTED] in the facility. The ED provided the surveyor with an acceptable removal plan prior to surveyor leaving the facility on 6/14/21.

On 6/24/21 the surveyor returned to the facility and at 9:45 a.m. began the tour of the facility. During the tour of the facility the surveyor interviewed an LPN regarding residents [REDACTED] in the facility. The LPN stated that a Direct Care Staff (DCS) found [REDACTED] in a bottle of water under Resident #1's bed linens and documented it on the 24-hour report.

On 6/24/21 at 10:30 a.m., the surveyor interviewed the DCS regarding residents smoking in the facility and the DCS stated that on or around [REDACTED] the DCS observed [REDACTED] and [REDACTED] in a water bottle under the bed linen of Resident #1. The DCS also stated that they reported it to an LPN.

On 6/24/21 at 12:30 p.m. the surveyor reviewed a facility document titled, "Shift Report" dated [REDACTED] which indicated that an LPN indicated in a report that [REDACTED] were found in a water bottle on Resident #1's bed.

On 6/24/21 at 1:00 p.m., the surveyor, in the presence of the HWD, spoke to the ED on the telephone and the surveyor requested another written removal plan. The HWD provided the

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A 310	Continued From page 8 surveyor with an acceptable removal plan prior to the surveyor leaving the facility on 6/24/21. On 6/28/21 the surveyor returned to the facility to conduct a second revisit to ensure the removal plan was implemented and the surveyor found that the removal plan had been successfully implemented.	A 310		