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
	15a006	A. BUILDING: ______ B. WING ______	C 07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA VOORHEES ASSISTED LIVING RESIDEI	**1301 LAUREL OAK ROAD 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 #: NJ00126214 CENSUS: 64 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 779	8:36-7.5(c) Resident Assessments and Care Plans (c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care. This REQUIREMENT is not met as evidenced	A 779		

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

New Jersey Department of Health

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ATRIA VOORHEES ASSISTED LIVING RESIDEI	1301 LAUREL OAK ROAD VOORHEES, NJ 08043

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A 779	Continued From page 1	A 779		

by:
Complaint #: NJ00126214

Based on interview and record review it was determined that the facility failed to notify the Registered Nurse (RN) when a resident had a change in condition for [Exe] of [Exec] residents reviewed, Resident [Executive] This deficient practice was evidenced by the following:

On 7/26/19 at 10:00 a.m., the surveyor reviewed the medical record of Resident [Execu] who moved in the facility [Executive Order 26] with diagnoses which included [Executive Order 26, 4.b.] The surveyor reviewed the "Resident Functional Needs Assessment" form dated [Executive Order 26] and observed documented that the resident [Executive Order 26, 4.b.] but required assistance of staff.

The surveyor also reviewed the "Resident Notes" section of the medical record and observed documented by a Licensed Practical Nurse (LPN) that on [Executive Order 26, 4.b.] that the caregiver informed the LPN that Resident [Execu] complained of [Executive Order 26, 4.b.] and was unable to get out of bed. Further, as a result, Resident [Execu] was sent to the [Executive Order 26, 4.b.] for evaluation.

On 7/26/19 at 1:30 p.m., the surveyor interviewed the Resident Service Director (RSD) who stated that on [Executive Orde] she was unaware that the resident required a two person assist with transfers and that the Aides should have transferred Resident [Execu] back to bed with a wheelchair. The RSD further stated that the staff did not inform her that the resident had [Executive Order 26, 4.b.]

The RSD stated that she was notified that the

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ATRIA VOORHEES ASSISTED LIVING RESIDEI	1301 LAUREL OAK ROAD VOORHEES, NJ 08043

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A 779	Continued From page 2 resident was transferred to the hospital, however, she was not notified when there was a change in condition during the night. The RSD further stated that Resident [Execu] would have required assistance if he/she had fallen. The RSD confirmed that the date was [Executive Orde] when Resident [Execu] was transferred to the hospital and not [Executive Order 26] which was documented in the "Resident Notes." At 2:30 p.m., the surveyor interviewed the Executive Director (ED) who stated that the Aides should have called the RN when Resident [Execu] had a change in condition and required a two-person transfer. The surveyor requested facility policy on RN notification. The ED informed the surveyor that the facility did not have a policy on RN notification.	A 779		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
15a006 (Y1)	(Y2)	8/28/2019 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA VOORHEES ASSISTED LIVING RESIDENCE	1301 LAUREL OAK ROAD VOORHEES, NJ 08043

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 A0779 Reg. # 8:36-7.5(c) LSC	Correction Completed 08/28/2019	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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
7/26/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: 9DH912

Atria VOORHEES

State of New Jersey
Department of Health
P.O. Box 367
Trenton NJ 08625-0367

Dear Ms. Shirley Gil,

Please see the below Plan of Correction related to compliant survey dated 7/26/19.

POC for SOD 7/26/19 Atria Voorhees

H5790

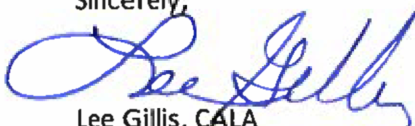
1. Resident ██ upon transfer we did not retain a copy of the UTF.
2. All residents have the potential to be affected, no other resident was affected by the practice.
3. Our Resident Service Director is in -servicing all nursing team members to ensure a copy of the UTF is retained in the medical records upon transfer of a resident to another healthcare setting. All staff will be in-serviced by 8/28/19, and then quarterly thereafter.
4. The Executive Director or designee will review all medical records of those who have been sent to anther healthcare facility to ensure a copy of UTF is present monthly and reported upon at Quarterly Quality Enhancement meetings.

A779

1. Resident ██ RN was not notified timely of change of condition.
2. All residents have the potential to be affected, no other resident was affected by the practice.
3. Our Resident Service Director is in -servicing all nursing team members regarding change of condition notification protocol. RN notification is required, and documentation of notification is to be made in the shift report and or medical record. All care staff will be in-serviced by 8/28/19 and quarterly thereafter.
4. The Executive Director and or designee will monitor weekly to ensure RN notification has been made when a change of condition occurs.

Please also find the signed first page of the Statement of Deficiencies. If you have any questions, please contact me at 856-783-8383 or via email at Lee.Gillis@AtriaSeniorLiving.com.

Sincerely,



Lee Gillis, CALA
Executive Director

PRINTED: 08/09/2019
FORM APPROVED

New Jersey Department of Health

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ATRIA VOORHEES ASSISTED LIVING RESIDENCE	1301 LAUREL OAK ROAD VOORHEES, NJ 08043

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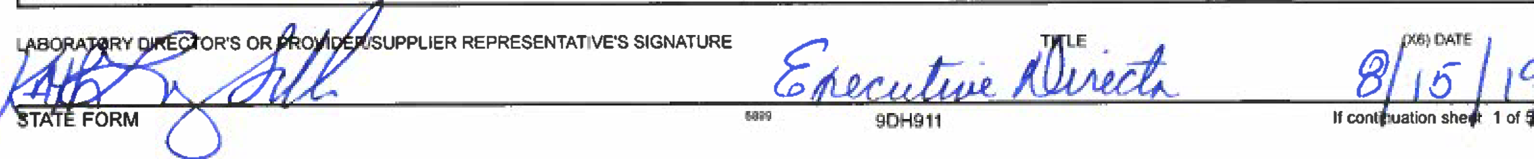
H 000	Initials Comments TYPE OF SURVEY: Complaint COMPLAINT #: NJ00126214 CENSUS: 64 SAMPLE SIZE: 3 The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00126214 Based on interview and record review it was determined that the facility failed to retain a completed copy of the Universal Transfer Form (UTF) in the medical records fo[redacted] of [redacted] residents reviewed, Residen[redacted] This deficie[redacted] practice was evidenced by the following:	H5790		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Executive Director | (X6) DATE 8/15/19