STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A112	A. BUILDING: _____ B. WING _____	C 12/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF JACKSON	390 NORTH COUNTY LINE ROAD JACKSON, NJ 08527

(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 00142020 CENSUS: 71 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 01/25/21

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00142020

Based on interview and record review it was determined that the facility failed to enforce and implement its policy and procedure on Cardiopulmonary Resuscitation (CPR) for 1 of 3 residents reviewed, Resident #1. This deficient practice was evidenced by the following:

On 12/30/20 at 9:30 a.m., the Department of Health (DOH) investigated a Reportable Event Report (RER) that occurred on [redacted] regarding a resident that was observed [redacted] on the floor [redacted].

On 12/30/20 at 10:30 a.m., during tour of the Memory Care unit, the surveyor interviewed a Certified Medical Assistant (CMA) regarding the facility's protocol on CPR. In addition, the surveyor asked the CMA if she was aware with the incident that occurred with Resident #1 on [redacted] The CMA stated that she was aware and that she was on duty the date of the incident.

During continued interview, the CMA stated that on [redacted] at approximately 6 a.m., that she was notified by Care Manager (CM) #1 that Resident #1 was observed [redacted] on the floor by his/her walker with no [redacted] and appeared, [redacted]" The CMA stated that she immediately went into to the room, and observed the resident [redacted] over a walker [redacted] and was cold to touch. The CMA explained that CM #2 placed a telephone call to the Resident Care Director (RCD) while she (CMA) placed a call to 911 [Emergency Service]. The CMA stated that the RCD

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A 310	Continued From page 2	A 310		

instructed them over the telephone not to touch the resident until 911 arrived.

Further, the CMA stated that she placed a telephone call to 911 and that 911 asked her (CMA) if CPR and/or Automated External Defibrillator (AED) was initiated and she replied, "No." The CMA stated that Resident #1 was a Full Code and did not have a Do Not Resuscitate (DNR) order. The CMA stated that she was CPR certified and confirmed that she did not use the AED [a portable electronic device used to help those experiencing sudden cardiac arrest]nor perform CPR to Resident #1 until 911 arrived.

At 10:55 a.m., the surveyor interviewed CM #1 via telephone regarding Resident #1 and she stated that at approximately 5:30 a.m., during her last round, she observed the resident [redacted] on the floor on his/her walker. She stated that the resident was cold to touch and did not respond to his/her name, and that she immediately called the two staff members that were on duty for assistance [CM #2 and a CMA].

At 11 a.m., the surveyor reviewed Resident #1's medical record which revealed that the resident was admitted to the facility [redacted] with diagnoses which included but were not limited to [redacted]. The "NJ 3.0 SEHA-V8" a [tool used for residents' assessment] dated [redacted] which indicated that the resident was alert and oriented to person, place and time. According to the assessment tool, the resident required wheelchair/walker for mobility. Further review of the assessment tool indicated under "Health Care Directives, Code Status" that the resident was a "Full Code."

The "Progress Notes" dated [redacted] at 08:58 revealed, "Received a call at 559am today from

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A 310	Continued From page 3 Care Manager that this resident was observed on ... [his/her] [redacted] in front of ... [him/her] [redacted] and no[redacted] in ... [his/her] bedroom. 911 had been called and the ... Resident was pronounced by the Paramedic physician. The Medical Examiner further states to Dr. ... and this writer this is not a suspicious death." At 11:30 a.m., the surveyor interviewed the RCD regarding the [redacted] incident and her documentation. The RCD stated that she was on-call on the night of [redacted] and received a telephone call at 5:59 a.m. According to the RCD, that Resident #1 was observed next to the bed [redacted] in front of a [redacted] with the resident's [redacted] bent over the [redacted] cross bar, [a tool for people who need additional support to maintain balance or stability while walking]. In addition, the RCD explained that she was told that the resident was "[redacted]. The RCD stated that she then instructed the staff not to touch the resident until 911 arrived and that the resident's death could be "suspicious." The RCD added that 911 arrived and performed CPR and later pronounced the resident. At 12:05 p.m., the surveyor interviewed the Executive Director who stated that on [redacted] at approximately 6 a.m., she received a call from the facility that Resident #1 had expired. She stated that she arrived at the facility at 6:30 a.m., and met with the Township's First Responders, Detective and Medical Examiner (ME) and that the ME confirmed that Resident #1's death was not a suspicious death. On 1/5/21 at 2 p.m., post survey, the surveyor interviewed CM #2 regarding Resident #1 and	A 310		

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A 310	Continued From page 4 she stated that they [CMA, CM #1 and CM #2] were instructed by the RCD not to touch the resident until 911 arrived. CM #2 confirmed that she was CPR certified and confirmed that she did not perform CPR to Resident #1. Surveyor review of the facility policy and procedure titled, "Cardiopulmonary Resuscitation (CPR) revealed, "It is the policy of the community that a resident, who is found [redacted] and does not have a Do Not Resuscitate order (DNR), will have CPR initiated by a team member certified in CPR unless it is determined by a healthcare professional acting with established scope of practice that obvious clinical signs of irreversible death are present." Further review of the policy indicated, "Action Steps: A resident who is found unresponsive, without a pulse the Team Member will: a. Validate the resident's code status ... b. if the resident does not have a DNR order: ...; The CPR Certified Team Member will start CPR; Utilize an AED if present on site, per state requirements; Continue CPR until Emergency Services arrive and assumes care of the resident."	A 310		