New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER: HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE: 11 HISTORY LANE, 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 #: NJ00155759 CENSUS: 73 SAMPLE SIZE: 5 Revised report based on supervisory review. 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 313	8:36-3.4(a)(4) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 4. Ensuring the provision of staff orientation and staff education; This REQUIREMENT is not met as evidenced by: C# 155759	A 313		

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 A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER

HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE

11 HISTORY LANE
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 313	Continued From page 1 Based on observation, interview and record review, it was determined that the facility failed to ensure that care staff were educated and trained on [redacted] safety to prevent injury during transportation of a resident for 1 of 5 residents, Resident #2. This deficient practice was evidenced by the following: On 7/15/22 at 11:10 a.m., the surveyor toured the facility and observed that some residents' [redacted] had [redacted] attached and some residents' [redacted] were without [redacted]. On 7/15/22 at 11:25 a.m., the surveyor interviewed the Licensed Practical Nurse (LPN) who explained that residents whose [redacted] were without [redacted], self-propelled their own [redacted] and those residents who required assistance or needed to be pushed in their [redacted], used [redacted]. The LPN informed the surveyor that the therapy department trained staff on the proper use of resident equipment which included training on the use of [redacted]. On 7/15/22 at 11:40 a.m., the surveyor reviewed the closed medical record (MR) of Resident #2 which identified that Resident #2 moved into the facility on [redacted] and expired on [redacted] with diagnoses that included [redacted] According to the [redacted] evaluation assessment dated [redacted], Resident #2 was [redacted]. The surveyor than reviewed Resident #2's Individual Service Plan (ISP) dated for [redacted] which identified that Resident #2 used a [redacted] for mobility related to [redacted] and [redacted], The ISP did not specify whether Resident #2 was able to self-propel [redacted].	A 313		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER
HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE
11 HISTORY LANE
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 313	Continued From page 2 Further review of the MR, the surveyor observed that the LPN documented under "Progress Notes" (PN) dated [redacted] at 9:21 a.m., that Resident #2 was being pushed by Aide in a [redacted] and Resident #2 placed the [redacted] down on the floor and fell forward out of the wheelchair "hitting [redacted] on the floor, sustaining a [redacted], a [redacted] to the [redacted], and with complaints of [redacted] and [redacted] Further, Resident #2 was transferred to the hospital." On 7/15/22 at 12:00 p.m., the surveyor interviewed the facility Physical Therapist (PT) regarding the use of [redacted] and resident equipment. PT explained that therapy, in conjunction with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), conducted staff training on resident equipment use and [redacted] safety. The PT explained that some residents used their [redacted] to self-propel [redacted] but all residents being pushed or assisted by staff with transport required [redacted] on their [redacted] On 7/15/22 at 2:00 p.m., the surveyor interviewed the Certified Nursing Aide (CNA) who explained that Resident #2 was not able to self-propel in a [redacted] The CNA explained to the surveyor that she was pushing Resident #2 in the wheelchair on [redacted] when Resident #2 placed his/her [redacted] down on the floor in mid push and [redacted] out of the wheelchair onto the floor. The CNA continued to explain that she was taking Resident #2 to be weighed and did not place the resident's [redacted] on the [redacted]. In addition, the CNA explained that she was not allowed to push residents in [redacted] without the [redacted] in place, but thought that she would place the [redacted]	A 313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER: HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE: 11 HISTORY LANE, 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 313	Continued From page 3 [redacted] on Resident #2's wheelchair after taking the residents's weight. The surveyor than asked the CNA if she had received training on the use of [redacted] and [redacted] prevention prior to [redacted]. The CNA explained to the surveyor that she had received training on [redacted] and the proper use of [redacted] but could not remember the date. Also, the CNA informed the surveyor that she received education and training on the safe use of [redacted] after the incident on [redacted] On 7/15/22 at 2:30 p.m., the surveyor inquired of the Executive Director (ED) and the Director of Nursing (DON) if staff received training on [redacted] safety, transporting residents, and equipment use prior to [redacted]. The ED and the DON explained that trainings were electronic and consisted of transferring, transporting and equipment use but was not sure if [redacted] safety was included in the electronic training. Further, the ED provided the surveyor with a copy of the CNA's training on [redacted] safety dated [redacted] and a copy of education and training for all staff on [redacted] safety dated [redacted] The facility ED or the DON were unable to provide the surveyor with documented evidence of training prior to [redacted] to confirm that staff were trained on [redacted] safety to prevent injury for Resident #2. Reference: 8:36-3.4(a)(4)	A 313		
A 357	8:36-4.1(a)(2) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and	A 357		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER

HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE

11 HISTORY LANE
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 357	Continued From page 4	A 357		

assisted living programs. Each resident is entitled to the following rights:

2. The right to receive a level of care and services that addresses the resident's changing physical and psychosocial status;

This REQUIREMENT is not met as evidenced by:
C# 155759

Based on interview and record review, it was determined that the facility failed to implement [redacted] safety precautions for [redacted] and [redacted] residents during transport which resulted in a [redacted] with injuries for 1 of 5 residents, Resident #2. This deficient practice was evidenced by the following:

On 7/15/22 at 11:40 a.m., the surveyor reviewed the closed medical record (MR) of Resident #2 which identified that Resident #2 moved into the facility on [redacted] and expired on [redacted] with diagnoses that included [redacted] According to the [redacted] evaluation assessment dated [redacted], Resident #2 was [redacted] and [redacted] with [redacted]. The surveyor then reviewed Resident #2's Individual Service Plan (ISP) dated for [redacted] which identified that Resident #2 used a [redacted] for mobility.

The surveyor reviewed the "Progress Notes" (PN) dated [redacted] at 9:21 a.m. written by the Licensed Practical Nurse (LPN) that Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER: HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE: 11 HISTORY LANE, 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 357	Continued From page 5 was being pushed by an Aide while in a [redacted] and Resident #2 placed the [redacted] down on the floor and [redacted] forward out of the wheelchair [redacted] on the floor, sustaining a [redacted], a [redacted], and with complaints of [redacted]. Resident #2 was transferred to the hospital." On [redacted] at 7:22 p.m., the Director of Nursing (DON) documented in the PN's that Resident #2 was "admitted for [redacted] The surveyor reviewed the LPN PN's of 6/15/22 at 10:14 p.m., that Resident #2 returned to the facility with diagnoses of '[redacted], stable [redacted] .. [redacted] and [redacted]) maintained on at all times ...." On 7/15/22 at 12:00 p.m., the surveyor interviewed the facility Physical Therapist (PT) regarding the proper protocol for [redacted] use. The PT explained that residents who were transported by staff through the facility in a [redacted] were to utilize [redacted] while being pushed by staff. On 7/15/22 at 12:45 p.m., the surveyor interviewed the DON regarding Resident #2 having [redacted] from the [redacted] on [redacted] The DON explained that when she was called to the unit, she observed Resident #2 lying on the floor. The DON informed the surveyor that the CNA was transporting Resident #2 to get weighed when Resident #2 placed his/her [redacted] on the floor causing the resident to [redacted] forward out of the [redacted] onto the floor. Also, the DON informed the surveyor that the CNA had not placed the [redacted] on Resident #2's [redacted] prior to transporting the resident. On 7/15/22 at 2:00 p.m., the surveyor interviewed	A 357		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER

HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE

11 HISTORY LANE
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 357	Continued From page 6 the Certified Nursing Aide (CNA) who explained that Resident #2 was not able to self-propel in the [redacted] The CNA continued to explain that she was pushing Resident #2 in the [redacted] on [redacted] when Resident #2 placed his/her [redacted] down on the floor in mid push and [redacted] out of the [redacted] onto the floor. The CNA stated that she was taking Resident #2 to be weighed and did not place the [redacted] on the [redacted]. In addition, the CNA explained that she was not allowed to push residents in [redacted] without the [redacted] in place but thought that she would place the [redacted] on Resident #2's [redacted] after obtaining the resident's weight. On 7/15/22 at 2:15 p.m., the surveyor reviewed the facility policy titled "Falls and Fall Risk, Managing ...Policy Statement Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling ...Fall Risk Factors ... e. improperly fitted or maintained wheelchairs; and f. foot wear that is unsafe or absent...." The facility failed to provide appropriate care measures to ensure safe transport in a wheelchair of Resident #2 who was [redacted] and [redacted].	A 357		
A 749	8:36-7.3(a) Resident Assessments and Care Plans (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER: HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE: 11 HISTORY LANE, 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 749	Continued From page 7 provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by: C# 155759 Based on interview and record review it was determined that the facility failed to ensure that the Individual Service Plan (ISP) was updated or revised to include specific interventions following a fall which required hospitalization for a change in condition for 1 of 5 residents, Resident #2. This deficient practice was evidenced by the following: On 7/15/22 at 11:40 a.m., the surveyor reviewed the closed medical record (MR) of Resident #2 which showed that Resident #2 moved into the facility on [redacted] and expired on [redacted] with diagnoses that included [redacted]. According to the [redacted] evaluation assessment dated [redacted], Resident #2 was [redacted] and [redacted] with [redacted] The surveyor than reviewed Resident #2's Individual Service Plan (ISP) dated for [redacted] which revealed that Resident #2 used a [redacted] for mobility. Further review of the MR, the surveyor observed that the Licensed Practical Nurse (LPN) documented under "Progress Notes" (PN) dated [redacted] at 9:21 a.m., that Resident #2 was being pushed by Aide in a [redacted] and Resident #2 placed the [redacted] down on the floor and [redacted] forward out of the wheelchair [redacted]	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER: HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE: 11 HISTORY LANE, 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 749	Continued From page 8 and [redacted] on the floor, sustaining [redacted] to the [redacted], and with complaints of [redacted]. Resident #2 was transferred to the hospital." On [redacted] at 7:22 p.m., the Director of Nursing (DON) documented in the PN's that Resident #2 was "admitted for [redacted]" The surveyor than observed that the LPN documented in the PN's on [redacted] at 10:14 p.m., that Resident #2 returned to the facility with diagnoses of [redacted] maintained on at all times ...." On 7/15/22 at 1:30 p.m., the surveyor reviewed Resident #2's hospital report with a start date of [redacted] and a discharge date of [redacted] in which Resident #2 was discharged with diagnoses of [redacted] and a [redacted]. During MR review, the surveyor identified that the DON documented on [redacted] at 3:54 p.m., in the PN's that the "health service plan (HSP) was reviewed and required a revision for [redacted] management and [redacted] care." Further, that Resident #2 "recently returned from the hospital after a [redacted] with [redacted], [redacted] and [redacted]] and was wearing an [redacted]) and a [redacted] On 7/15/22 at 1:30 p.m., the surveyor interviewed the DON regarding Resident #2's fall on [redacted] and care upon return to the facility on [redacted]. The DON explained that Resident #2 was being pushed by an Aide in the [redacted] and Resident #2 placed [redacted] down on the floor during transport causing the resident to [redacted] out of the [redacted] The Aide did not place Resident #2's [redacted] on the [redacted] prior to transporting in	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER: HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE: 11 HISTORY LANE, 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 749	Continued From page 9	A 749		

the [redacted]. The DON informed the surveyor that Resident #2 was under [redacted] services and that the [redacted] staff and the facility staff collaborated monthly to discuss Resident #2's plan of care. The surveyor than requested a copy of Resident #2's Individual Service Plan (ISP).

On 7/15/22 at 2:15 p.m., the surveyor reviewed Resident #2's ISP that was observed in the closed MR. The surveyor observed documented under "Safety" that Resident #2 utilized [redacted] on bed for function and bed mobility and was not listed as a [redacted] risk. Further, listed under "Mobility," Resident #2 had [redacted], [redacted] and used a [redacted] for mobility. The surveyor than reviewed the ISP that was requested from the DON which was not observed in the closed MR. The surveyor identified that the ISP was dated for [redacted] and that there were no updates for [redacted] risk listed under "Safety." However, the surveyor identified listed under 'Mobility that staff will ensure [redacted] [redacted] are in place prior to transporting Resident #2." The surveyor did not identify any revisions on the ISP to address care of Resident #2's [redacted] or [redacted]. Additionally, the surveyor observed that the date on the ISP was as of [redacted], which was the day of the survey and past Resident #2's date of death of [redacted].

On 7/15/22 at 2:30 p.m., the DON informed the surveyor that the as of date or effective date on the ISP changes to the date of print out.

The facility failed to ensure that Resident #2's ISP was revised to include [redacted] risk interventions to prevent future [redacted] and injury. In addition, the facility failed to include care procedures and interventions in Resident #2's ISP for a change in condition that required the use of a [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER

HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE

11 HISTORY LANE
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 749	Continued From page 10 and [redacted]. Reference: 8:36-4.1(a)(3)	A 749		
A 765	8:36-7.4(c)(1) Resident Assessments and Care Plans (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital; This REQUIREMENT is not met as evidenced by: C#155759 Based on interview and record review, it was determined that the facility failed to ensure that a Registered Nurse (RN) reassessed a resident's change in condition upon return from the hospital for 1 of 5 residents, Resident #2. This deficient practice was evidenced by the following: On 7/15/22 at 11:40 a.m., the surveyor reviewed the closed medical record (MR) of Resident #2 which showed that Resident #2 moved into the facility on [redacted] and expired on [redacted]	A 765		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER: HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE: 11 HISTORY LANE, 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 765	Continued From page 11 with diagnoses that included [redacted] According to the [redacted] evaluation assessment dated [redacted] Resident #2 was [redacted] with [redacted]. The surveyor than reviewed Resident #2's Individual Service Plan (ISP) dated for [redacted] which identified that Resident #2 used a [redacted] for mobility. Further review of the MR showed that the Licensed Practical Nurse (LPN) documented in the "Progress Notes" (PN) that on [redacted] at 9:21 a.m., Resident #2 "while being pushed by an Aide placed [redacted] foot down on the floor and [redacted] forward; hitting the [redacted] and [redacted] on the floor; sustaining a [redacted] to the [redacted], and complaints of [redacted] and [redacted] ...[Resident #2] was transferred to the hospital." On [redacted] at 10:14 p.m., the LPN documented in the PN's that Resident #2 returned from the hospital "at 8:30 p.m. ...with diagnoses of [redacted] ..." Further, the LPN documented that Resident #2 "was assessed with the [redacted] nurse for [redacted] to all [redacted], [redacted], and [redacted] ...Supervisor, POA [power of attorney], and PMD [primary medical doctor] made aware." The surveyor did not observe any documentation in Resident #2's MR identifying that Resident #2 was assessed by the RN upon return from the hospital. On 7/15/22 at 2:30 p.m., the surveyor interviewed the Director of Nursing (DON) who explained that Resident #2 was hospitalized for a [redacted] out of the wheelchair and was re-admitted to the facility	A 765		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	15A115		C 07/15/2022

NAME OF PROVIDER OR SUPPLIER

HARMONY VILLAGE AT CAREONE JACKSON

STREET ADDRESS, CITY, STATE, ZIP CODE

11 HISTORY LANE
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 765	Continued From page 12 following the [redacted] The DON was not sure of the date of the [redacted] or the date of re-admission. The surveyor then requested a copy of Resident #2's initial admission assessment and Resident #2's last assessment conducted by the RN. The DON provided the surveyor with a copy of Resident #2's initial assessment dated for [redacted] and a copy of a [redacted] assessment dated for [redacted] which included documentation from [redacted] Additionally, the DON provided the surveyor with a copy of Resident #2's hospital reports which showed that Resident #2 was discharged from the hospital on [redacted] as documented by the LPN. The DON was unable to provide the surveyor with a copy of Resident #2's re-admission assessment upon request. The facility failed to provide documented evidence that Resident #2 was assessed by a RN upon return to the facility from the hospital following a [redacted] with [redacted] and a change of condition. Reference: 8:36-4.1(a)(3)	A 765		