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
	16A001	A. BUILDING: ______ B. WING ______	C **03/29/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL RESIDENCES BY COMPLETE CARE	**338 CHESTNUT STREET** **PASSAIC, NJ 07055**

(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 00143955 CENSUS: 63 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 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 #: NJ 00143955

Based on interview and record review it was determined that the Executive Director (ED) failed to ensure the implementation of the facility's policy titled, "Abuse Investigations Policy" when a Certified Nursing Assistant (CNA) continued to care for residents despite an allegation of physical abuse, and when an investigation of the allegation of staff to resident physical abuse was not completed for 1 of 4 residents reviewed, Resident #1. This deficient practice was evidenced by the following:

On 3/22/21 the Department of Health (DOH) received a Reportable Event Report (RER) regarding an allegation of staff to resident physical abuse was reported to have occurred on 3/18/21 at the facility.

On 3/29/21 at 10:05 a.m., the surveyor interviewed the ED and the Wellness Director (WD) regarding the allegation which was reported to have occurred on [redacted] The ED stated that on [redacted] at approximately 3:30 p.m., she received a telephone call from Resident #1's Power of Attorney (POA). According to the ED, the POA stated that Resident #1 informed the POA that a Certified Nursing Assistant (CNA) pushed another resident against a wall last night [redacted].

The ED stated that the allegation was reported to have occurred on [redacted], during the 3-11 shift, in the dining room. The ED stated that she interviewed Resident #1, who stated that an

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A 310	Continued From page 2 employee [CNA #1] was mean and gets mad all the time and that he/she [Resident #1] did not like the CNA. The ED stated that Resident #1 stated that he/she witnessed CNA #1 push someone against the wall but could not recall if the person was a male or female. The ED also stated that Resident #1 reported that he/she could not recall the description of the person that CNA #1 pushed against the wall. In addition, the ED stated that she asked Resident #1 who else was present in the dining room when the incident occurred, and the resident stated that he/she was with two other residents and that they were not pushed. Further, the ED stated that on [redacted], the WD interviewed CNA #1, who seemed surprised at the allegation, and stated that she [CNA #1] was not aware of the allegation against her. The ED stated that CNA #1 was off duty on [redacted] and returned to work on [redacted], and at that time, was reassigned to another floor. The surveyor then requested the investigative report and the facility's policy on Abuse. The ED continued that she interviewed CNA #2, who worked with CNA #1 on the night of the alleged incident, and CNA #2 stated that CNA #1 was assigned to provide care to Resident #2, including the residents' laundry on [redacted] and that nothing happened on that shift, and that everything was good. At 10:15 a.m., the surveyor toured the memory care unit and observed Resident #1 seated in a wheelchair self-propelling in his/her room. The surveyor interviewed Resident #1, who stated that he/she could not recall the incident of [redacted] The surveyor then asked Resident #1 if he/she knew CNA #1 and the resident stated that CNA	A 310		

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#1 was not a very nice worker and that CNA #1 got mad at people at times. During the interview Resident #1 explained that he/she at times does not remember things and becomes angry and has outbursts. The surveyor observed that Resident #1 then began to ramble on to another topic, and was unable to stay on topic, despite the surveyors attempts to redirect the conversation.

At 10:55 a.m., the surveyor reviewed Resident #1's medical record and observed documented that the resident was admitted to the facility [redacted] with diagnoses which included [redacted]. According to the "Residence Assessment" document dated [redacted], Resident #1 was assessed to be [redacted] and [redacted]

At 10:25 a.m., the surveyor observed Resident #3 and Resident #4 in a group activity and the surveyor attempted to interview these residents as Resident #1 stated that they were present during the event of [redacted]. However, the surveyor was unable to conduct an interview with them due to their cognitive deficits.

The surveyor reviewed the "Incident report description of event" dated [redacted], written by the ED, which documented that the investigation was to be continued, however, the surveyor did not observe documented evidence that the investigation was completed prior to CNA #1 returning to work on [redacted] and [redacted] to provide care to residents.

During surveyor interview with the ED, the ED stated that stated that the WD spoke with CNA #1 on [redacted] prior to starting her shift and was reassigned to another floor.

The surveyor conducted a post survey telephone

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A 310	Continued From page 4 interview with CNA #1 on 3/18/21. CNA 1 stated that she was off on [redacted] and returned to work on [redacted] and that the WD called her into her office on [redacted] and informed her about the allegation against her. CNA #1 stated that she did not have any contact with Resident #1 and denied pushing any resident against a wall. Surveyor review of the facility's policy titled, "Abuse Investigation" revealed the following: "Employees of this facility who have been accused of resident abuse may be reassigned to non-resident duties or suspended from duty until the results of the investigation have been reviewed by the Administrator." Additionally, "The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the State Survey and Certification Agency immediately upon completion." The ED failed to complete the investigation by not providing a conclusion of the outcome of the investigation, additionally, CNA #1 was not reassigned to non resident duties or suspended pending the outcome of the investigation.	A 310		