STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1EGWIO	A. BUILDING: _____ B. WING _____	C 06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON ESTATES	**2018 HIGHWAY 35 SPRING LAKE, NJ 07762**

(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 00131958 CENSUS: 85 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 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;	A 765		

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

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A 765	Continued From page 1	A 765		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00131958

Based on interview and record review it was determined that the facility failed to reassess a resident with altered skin integrity post hospitalization in order to determine the resident's medical needs for 1 of 3 residents reviewed for care and services, Resident #2. This deficient practice was evidenced by the following:

On 6/30/20 at 10:10 a.m., the surveyor observed Resident #2 in [redacted] room seated at the edge of a bed getting dressed. The surveyor observed an oxygen tank in the resident's sit to stand walker next to the resident's bed. The resident stated that he/she applied own oxygen as needed. During continued interview, the surveyor asked the resident if he/she had any concern with care and the resident stated, "No." The surveyor asked the resident if he/she had any open area on the skin and the resident stated "No", and added that [redacted] but could not recall when.

At 11:45 a.m., the surveyor reviewed Resident #2's medical record and observed that he/she moved into the facility in [redacted] with diagnoses which included [redacted] According to review of the Interdisciplinary Progress Notes (IPN) dated 11/3/19 as written and signed by a Licensed Practical Nurse (LPN), the resident stated that he/she fell in the bathroom and got him/herself off the floor. The LPN documented that the resident sustained a [redacted] to the [redacted]

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A 765	Continued From page 2	A 765		

(LLE) and Executive Order 26, 4.b.. The LPN documented that the resident was taken to the emergency room by the resident's Power of Attorney (POA) and was Executive Order 26, 4.b. Executive Order 26, 4.b. Also, the LPN documented that the Registered Nurse (RN) was made aware.

The IPN dated Executive Order 2 at Executive Order 26, 4.b. as written and signed by an LPN documented that the resident returned to the facility with a Executive Order 26, 4 to the Executive Order 26, 4. The "Nursing Re-Assessment" dated Executive Order 2 signed by an RN documented a Executive Order 26, 4 to the Executive Order 26, 4.b. However, the surveyor did not observe any documentation in the IPN by a RN after the resident's Executive Order 26, 4.b. to the Executive Orde on Executive Order 2.

The IPN dated Executive Order 26, 4 at Executive Order 26, 4.b. as written and signed by an LPN documented that the resident's POA visited and requested to send the resident to the emergency room for Executive Order 26, 4.b. Additionally, she documented that the Executive C was cleansed with Executive Order 26, 4.b. and a Executive Order 26, 4.b. and Executive Order 26, 4.b.. The LPN documented that the resident was transported to the Executive Order 2 l at Executive Order 26, 4.b. and the RN was made aware.

The IPN dated Executive Order 26, 4 at Executive Order 26, 4., as written and signed by an LPN documented that Resident #2 was Executive Order 26, 4 to the Executive Order 2 l with Executive Order 26, 4.

The surveyor interviewed the DON at 12:15 p.m. regarding above concerns. The DON continued that she received a telephone call from the resident's POA in Executive Order 26, 4.b.Executive Orde post Executive Order 2 Executive Order 26, 4.b. that the resident's Executive Order 26, 4.b. had gotten worse and would like the resident to

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A 765	Continued From page 3 be transferred to the hospital for evaluation. The DON stated that the resident was transferred to the hospital and that she (DON) did not see the resident's [Executive Order]. Additionally, the DON explained that the "Nursing Re-assessment" form dated [Executive Order 2] was completed by an LPN and that she (DON) was not aware of the [Executive Order 2] The DON confirmed that she signed off on the LPN's "Re-admission Assessment" form without completing an assessment on Resident #2 when he/she was re-admitted to the facility, "I missed it." The LPN was not available for interview. The facility RN failed to reassess Resident #2 post hospitalization on [Executive Order 2] which caused the resident to be re-hospitalized on [Executive Order 26,] with a [Executive Order 26, 4.b.]	A 765		