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
	25a002	A. BUILDING: ______ B. WING ______	C **06/29/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING OAK ASSISTED LIVING AT VINELAND	**1611 SOUTH MAIN ROAD** **VINELAND, NJ 08360**

(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 00146304 CENSUS: 68 SAMPLE SIZE: 7 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
08/06/21

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00146304

Based on observation, interview and record review it was determined that the facility's Executive Director (ED) failed to conduct a thorough investigation of the alleged use of [redacted], a dietary supplement used to treat [redacted], as a [redacted] in accordance with their policy and procedure titled, "Accidents/Incidents of Abuse or Suspected Abuse of Residents ..." for [redacted] of [redacted] residents reviewed, Resident [redacted]. The deficient practice was evidenced by the following:

On 6/29/21 at 9:05 a.m., during an entrance conference, the surveyor interviewed the ED and inquired if there had been any incident or accident investigated in the past three months. The ED stated that she had been on a leave of absence for six months and returned to work the first week of June. She later informed the surveyor that she asked the Assistant Executive Director who reported that there had not been any incidents.

At 9:15 a.m., during the tour of the [redacted] [redacted] unit, the surveyor observed Resident [redacted] in his/her room in bed. At 11:20 a.m., the surveyor observed Resident [redacted] in the Common Area sitting in an upright position in a wheelchair at a table with an Activity Aide. The resident was [redacted] and [redacted] but was not interviewable due to [redacted].

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A 310	Continued From page 2 At 1:05 p.m., the surveyor reviewed Resident medical record which indicated that the resident was admitted to the facility in with diagnoses which included and disorder. According to the surveyor review of Resident "Resident Health Assessment," dated , completed by a Registered Nurse (RN), the resident was and only, had and required assistance with Activity of Daily Living (ADL). The surveyor interviewed Certified Medication Aide (CMA) #3, CMA #4, CMA #5, CMA #6, Certified Home Health Aide (CHHA) #1, CHHA #2 from a Hospice agency and Activity Aide separately between 9:35 a.m., until 11:25 a.m. regarding administration of elation to resident(s) on the unit. is a dietary supplement used to treat . The staff members stated that they were not aware of any residents being medicated with CMA #3 stated that there was no resident currently on on the unit and that the residents were always when she arrived at work. CMA #3 explained that the CMAs were not allowed to administer medications to residents without a prescription from a physician. Resident had physician's orders for the following medications: an a , for , a concentrate an for , an . Resident had no physician's order for . At 12:45 p.m., the surveyor interviewed the facility's Wellness Director (WD) and inquired if she was aware of resident(s) being with	A 310		

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A 310	Continued From page 3	A 310		

Continued From page 3

by staff. The WD stated that on at approximately 4 p.m., she was notified by CMA #1 that CMA #2 administered to Resident "to keep the resident ." The surveyor then asked the WD if she investigated the incident and if the allegation was substantiated. The WD stated that she had not yet started an investigation or spoken to any staff member about the allegation. The WD explained that she had installed a camera in the medication room on the date that she was informed of the incident but she was not aware that the camera had not recorded until she went to view it. The surveyor asked the WD if the ED was made aware of the allegation of the use of The WD confirmed that the ED was notified on , 3 days after she had been informed of the allegation. The surveyor then requested the facility's policy on incident and accident investigation for review.

At 1:15 p.m., the surveyor interviewed the ED regarding the alleged administration of elation to Resident for use as a . The ED stated that she was informed of the incident late afternoon on and confirmed that no investigation had been conducted.

At 2:15 p.m., the surveyor interviewed CMA #1 regarding the administration to Resident . CMA #1 stated that on at approximately 2:10 p.m., during change of shift, she heard CMA #2 tell CHHA #1 that she [CMA #2] had administered to Resident and that "it still did not work." CMA #1 stated that she reported the incident to the WD the next day. CMA #1 stated that according to a few other staff members, this has been ongoing since "to keep the residents

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A 310	Continued From page 4	A 310		

CMA #1 added that the residents were more when CMA #2 and CHHA #1 were not on duty.

The facility failed to complete an investigation of the use of as a to Resident when the ED and the WD became aware of the allegation. In addition, the facility continued to allow CMA #2 to work on and 1. CMA #2 was again scheduled to work on but was suspended during the surveyor's visit.

Surveyor review of the policy and procedure titled, "Accidents/Incidents of Abuse or Suspected Abuse of Residents, ..." identified the following violations of facility policy:

1. Procedure #1: Immediate action will be taken to protect the resident from further abuse, prevent reoccurrences and ensure resident safety. The facility continued to allow CMA #2 to work on . CMA #2 was again scheduled to work on but was suspended during the surveyor's visit.
2. Procedure #3: The incident should be reported immediately in detail to the appropriate department head or administration. CMA #1 stated that she reported the incident to the WD "the next day." The WD told the surveyor that she informed the ED on 3 days after she had been informed of the allegation.
3. Procedure #4: Open (SIC Upon) notification, administrative staff will take immediate steps to protect the resident from further harm. The facility continued to allow CMA #2 work on CMA #2 was again scheduled to work on but was suspended during the surveyor's

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A 310	Continued From page 5 visit. 4. Procedure #5: The incident shall be fully investigated ... The ED stated that she was informed of the incident late afternoon on [redacted] and confirmed that no investigation had been conducted. 5. Employee/Resident Abuse: "If an employee is accused of or is seen abusing a resident, immediate action will consist of suspension of all duties until an investigation is completed by the Ombudsman' office ..., and/or by the facility." The facility continued to allow CMA #2 work on [redacted], [redacted] and [redacted] CMA #2 was again scheduled to work on [redacted] but was suspended during the surveyor's visit.	A 310		
A 563	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, elopements, and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages;	A 563		

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A 563	Continued From page 6 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00146304 Based on interview and record review it was determined that the facility failed to notify the Department of Health (DOH) of a [redacted] of unknown origin for [redacted] of [redacted] residents reviewed for falls, Resident [redacted]. This deficient practice was evidenced by the following: At 1:05 p.m., the surveyor reviewed Resident [redacted] medical record which indicated that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted] and [redacted]. According to the surveyor review of Resident [redacted] "Resident Health Assessment" dated [redacted] completed by a Registered Nurse (RN), the resident was [redacted] and [redacted] only, [redacted] and required assistance with Activity of Daily Living (ADSL). Further, the surveyor reviewed an RN's "Resident Notes" written on [redacted] [no time], which indicated that the resident was unable to ambulate and in addition, showed signs and symptoms of [redacted] on the [redacted]. The resident's [redacted] was assessed by the RN on the [redacted] as [redacted] out of [redacted] The RN documented that [redacted] was notified and requested the resident be sent to the emergency room for evaluation at 10:10 p.m. The RN documented that the resident was admitted to the hospital with a diagnosis of [redacted].	A 563		

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A 563	Continued From page 7 At 12:45 p.m., the surveyor interviewed the Wellness Director/RN (WD) regarding her documentation on [redacted]. The WD stated that Resident [redacted] did not sustain [redacted] and that she did not know how the [redacted] occurred. She explained that the [redacted] of unknown origin may had been from the resident leaning across an end table from a couch earlier that day. The surveyor then inquired from the WD if the fracture of unknown origin was reported to the DOH. The WD replied, "No" and explained that she did not know she had to report it to the DOH. The facility failed to report the incident of unknown origin of the right hip fracture of Resident [redacted] of [redacted] to the DOH as required by this regulation.	A 563		