		Iealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		50A001	B. WING		C 11/06/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BRIGHT	ON GARDENS OF ED	ISON	K TREE ROAD , NJ 08820)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
A 000	Initial Comments		A 000			
	Initial Comments: TYPE OF SURVE	7: Complaint				
	COMPLAINT #: N	J00121541, NJ00129388				
	CENSUS: 102					
	SAMPLE SIZE: 4					
	all of the standards Administrative Cod Licensure of Assist Comprehensive Per Assisted Living Pro- submit a plan of co completion date for that the plan is imp deficiencies may re accordance with pr Administrative Cod	a substantial compliance with a in the New Jersey le 8:36, Standards for red Living Residences, ersonal Care Homes and ograms. The facility must prrection, including a r each deficiency and ensure elemented. Failure to correct esult in enforcement action in rovisions of New Jersey le Title 8, Chapter 43E, rensure Regulations.				
A 313	8:36-3.4(a)(4) Adm	inistration	A 313			
		tor or designee shall be t not limited to, the following:				
	4. Ensuring the and staff education	e provision of staff orientation ;				
	This REQUIREME by: Complaint #: NJ 0	NT is not met as evidenced 0129388				
		and record review it was Executive Director (ED) faile	d			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/24/19

Y6UC11

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New Jersey Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A001			CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED C	
		B. WING	B. WING			
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
BRIGHT	ON GARDENS OF ED	ISON	K TREE ROAD , NJ 08820			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
A 313	to ensure that the n training for the use used for transfers for for the use of a med Resident This of evidenced by the for On 11/6/19 the surv record of Resident on with diage Executive Order The surveyor review Plan" (ISP) dated Executive Order assessment, both of required a mechanit the resident was at related to Executive Order documented, "res Surveyor review of dated Executive Order documented, "res Executive Order Executive Order Con 11/6/19 at 11:30 interviewed the ED completed an invess Resident Executive Order On 11/6/19 at 11:30 interviewed the ED completed an invess Resident Executive Order Con 11/6/19 at 11:30 interviewed the ED completed an invess Resident Executive Order	ursing staff received sufficient of a mechanical lift device or of residents reviewed chanical lift during transfers, deficient practice was allowing: vevor reviewed the medical who moved into the facility noses which included r 26, 4.b. wed the second a document titled, and dated which the e Registered Nurse (RN) documented that Resident ical lift when transferred, as risk for second 20,415 and required full assistance N assessment. the "Progress Notes" (PN) r 26, 4.b. Executive Order 20,415 and required full assistance N assessment. the "Progress Notes" (PN) r 26, 4.b. Executive Order 20,415 and required full assistance N assessment. the "Progress Notes" (PN) r 26, 4.b. r 26, 4.b. i a a a b b b b b c c c c c c c c c c				

STATE FORM

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If continuation sheet 2 of 3

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF				(X3) DATE SURVEY COMPLETED		
		A. BUILDING:		С		
50A001		B. WING			11/06/2019	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ON GARDENS OF ED	ISON					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE	
Continued From pa	age 2	A 313				
unavailable for inte	erview.					
surveyor review, the records on the use the date Executive Orde that she believed to the use of the med but would confirm documentation at a On 11/7/19, post st informed the surve trained the staff on prior to The ED failed to en were trained to pro-	the staff education and training of the mechanical lift prior to Resident was during or 26, 4.b. The ED stated hat the RN trained the staff on chanical lift prior to the incident, with the RN and provide a later date. urvey via email, the ED eyor that the facility had not the use of the mechanical lift					
	PROVIDER OR SUPPLIER ON GARDENS OF EE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pa unavailable for inte The surveyor requisurveyor review, th records on the use that she believed to that she believed to that she believed to the use of the mech but would confirm documentation at a On 11/7/19, post s informed the surve trained the staff or prior to The ED failed to en were trained to pro- assessment and th	OF CORRECTION IDENTIFICATION NUMBER: 50A001 50A001 PROVIDER OR SUPPLIER STREET A ON GARDENS OF EDISON 1801 OA EDISON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 unavailable for interview. The surveyor requested that the ED provide, for surveyor review, the staff education and training records on the use of the mechanical lift prior to Executive Order 26, 4.D. The ED stated that she believed that the RN trained the staff on the use of the mechanical lift prior to the incident, but would confirm with the RN and provide documentation at a later date. On 11/7/19, post survey via email, the ED informed the surveyor that the facility had not trained the staff on the use of the mechanical lift prior to The ED failed to ensure that the nursing staff were trained to provide resident care based on ar assessment and the acuity of the residents'	NT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: 	NT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: 	NT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIENCLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:	

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STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVI	SIT
IDENTIFICATION NUMBER	A. Building				
50A001 _{Y1}	B. Wing		Y2	12/24/2019	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		-	
BRIGHTON GARDENS OF EDISON		1801 OAK TREE ROAD			
		EDISON, NJ 08820			

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM		DATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix A0313	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC	01/06/2020	LSC		-	LSC		
ID Prefix	Correction	ID Prefix _		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC _		-	LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC _		_	LSC		
ID Prefix Reg. # LSC	Correction Completed	ID Prefix _ Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix	Correction	ID Prefix _		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC _		-	LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR		DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVE 11/6/2019	Y COMPLETED ON		K FOR ANY UNCORRE				s 🗆 no

Brighton Gardens of Edison – Plan of Correction Date of Complaint Survey: November 6th, 2019

Regulation A313 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.

1. With respect to the specific resident/situation cited:

- The team members that transferred resident with the mechanical lift on received training by the Sales Representative for the use of mechanical lifts that are used in the Community.
- Resident continues to reside in the community.
- Resident s injury is progressing in accordance with physician orders and physician oversight.

Target date by which correction will be completed: 01/06/2020

2. With respect to how the facility will identify residents/situations with the potential for the identified concerns:

- Community care team staff will receive training by the sales representative/trained community designee on mechanical lifts that are used in the Community.
- Mechanical lift training will be added to Orientation for new care staff.

Target date by which correction will be completed: 01/06/2020

3. With respect to what systemic measures have been put into place to address the stated concern:

- The Resident Care Director/Designee will observe a mechanical lift transfer of Resident #2 monthly for 3 months to confirm that that the proper procedure is being followed.
- In addition, the Resident Care Director / Designee will observe 3 random mechanical lift transfers per month x 3 months to confirm that proper procedure is being followed.
- Issues identified will be addressed and resolved and refresher training initiated as needed.

Target date by which correction will be completed: 01/06/2020

4. With respect to how the plan of correction will be monitored:

- In order to confirm that the processes outlined above are sustained, the Resident Care Director/Designee will report the findings of the above transfer via mechanical lift observations to the QAPI Committee monthly for the next 3 months.
- During and at the conclusion of the 3 month period, the Committee will reevaluate and initiate necessary action or extend the review period.

• The Executive Director is responsible for confirming implementation and ongoing compliance with this POC and addressing and resolving variances that may occur.

Target date by which correction will be completed: 01/06/2020