

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/06/2019
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NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF EDISON	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 OAK TREE ROAD EDISON, NJ 08820
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(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
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A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00121541, NJ00129388</p> <p>CENSUS: 102</p> <p>SAMPLE SIZE: 4</p> <p>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.</p>	A 000		
A 313	<p>8:36-3.4(a)(4) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>4. Ensuring the provision of staff orientation and staff education;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00129388</p> <p>Based on interview and record review it was determined that the Executive Director (ED) failed</p>	A 313		

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

TITLE

(X6) DATE

12/24/19

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/06/2019
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A 313	<p>Continued From page 2</p> <p>unavailable for interview.</p> <p>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 the date Resident [redacted] was [redacted] during Executive Order 26, 4.b. 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.</p> <p>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 [redacted].</p> <p>The ED failed to ensure that the nursing staff were trained to provide resident care based on an assessment and the acuity of the residents' needs.</p>	A 313		
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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 50A001	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 12/24/2019	Y3
NAME OF FACILITY BRIGHTON GARDENS OF EDISON			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0313	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:36-3.4(a)(4)	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 _____	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 _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/6/2019		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> 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 [REDACTED] with the mechanical lift on [REDACTED] received training by the Sales Representative for the use of mechanical lifts that are used in the Community.
- Resident [REDACTED] continues to reside in the community.
- Resident [REDACTED]'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