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
	65A113	A. BUILDING: ______ B. WING ______	C 10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING OAK OF TOMS RIVER	**2145 WHITESVILLE ROAD TOMS RIVER, NJ 08755**

(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 00129282 CENSUS: 104 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 355	8:36-4.1(a)(1) Resident Rights comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, 1. The right to receive personalized services and care in accordance with the resident's individualized general service and/or health service plan;	A 355		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/19/19

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A 355	Continued From page 1	A 355		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00129282

Based on observation, interview and record review it was determined that the facility failed to implement interventions from a resident's Care Plan (CP) after the resident threatened to EX. Order other residents and staff EX. Order 26.(4) B1 for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 10/16/19 at 9:05 a.m., the surveyor interviewed the Administrator of the Assisted Living Program (ALP), in the absence of the Administrator for the Assisted Living Residence, regarding a Facility Reportable Event (FRE) which occurred on 10/10/19 and was reported to the Department of Health on 10/11/19. The ALP Administrator escorted the surveyor to the dining room where the surveyor observed Resident #2 seated at a table, close to the hallway, eating breakfast. At that time the surveyor did not observe any staff near Resident #2.

At 9:35 a.m., the surveyor interviewed Resident #1, who appeared to be alert and oriented to person, place and time. Resident #1 stated that last EX. Order 26.(4) B1 at approximately 12 p.m., he/she had a verbal altercation with Resident #2 while exiting an elevator. During interview, Resident #1 stated that he/she was non ambulatory and used an EX. Order 26.(4) B1 as his/her EX. Order 26.(4) B1. Resident #1 stated that while attempting to exit the elevator on the EX. Order 26.(4) floor with other residents, Resident #2 was at the same time attempting to enter the

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A 355	Continued From page 2 elevator. Resident #1 continued that Resident #2 became upset and EX. Order 26 and EX. Order 26.(4) B1 him/her [Resident #1] on the EX. Order 26.(4) B1 when he/she [Resident #1] told Resident #2 to wait. Resident #1 stated that no staff were present at that time, however, a visitor was present and immediately intervened. Resident #1 continued and stated that he/she reported the incident to the Director of Wellness immediately after the incident. At 10:10 a.m., the surveyor observed Resident #2 in his/her room and he/she self propelled in a wheelchair with a staff member present. The resident asked the surveyor who the surveyor was and appeared EX. Order 26.(4) B and stated that he/she did not understand why someone had to EX. Order 26.(4) him/her. Additionally, the resident stated that the facility claimed he/she EX. Order 26.(4) B1 someone, however Resident #2 stated that he/she could not remember EX. Order 26.(4) B1 anyone. At that time the surveyor interviewed a staff member that was nearby who stated that she was assigned to be Resident #2's EX. Or Aide. She stated that her duties included escorting the resident to breakfast, to the medication room and to activities. The staff member confirmed that she was not with the resident when the surveyor observed the resident in the dining room eating breakfast. At 10:25 a.m., the surveyor interviewed the Director of Wellness regarding the FRE and she stated that on EXEX. Order 26.(4) at approximately 11:45 a.m., Resident #1 approached her in her office and stated that Resident #2 EX. Order 26.(4) B1 him/her on the EX. Order while he/she [Resident #1] exited the elevator. She stated that Resident #1 was seen and assessed by a Nurse Practitioner following	A 355		

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A 355	Continued From page 3 the incident and no injuries were observed. During continued interview with the Director of Wellness she stated that she went to Resident #2's room and the resident was "EX. Order 26.(4) B" and denied EX. Order 26.(anyone. She stated that at approximately 1:40 p.m., the resident became EX. Order 26.(and threw EX. Order 26.(4) B1 and at that time a staff member was assigned to monitor the resident EX. Or. The Director of Wellness added that at approximately 2:20 p.m., Resident #2 threatened to EX. Order 26.(4) B1 and was seen and assessed by a EX. Order 26 Nurse Practitioner in the facility. The DOW explained that according to the EX. Order 26 Nurse Practitioner, Resident #2 did not fit the criteria to be committed to a EX. Order 26.(4) B1 facility. According to the Director of Wellness, on the same day at approximately 7:45 p.m., she received a telephone call from the facility that Resident #2 stated that he/she would EX. Order 26 anyone who came close to him/her. The Director of Wellness stated that she immediately returned to the facility and searched the resident's room and removed all EX. Order 26.(4) B1. Additionally, the Director of Wellness stated that at approximately 8:07 p.m., Resident #2 was observed to be EX. Order 26.(4) B1 and she placed a telephone call to 911. She explained that three officers responded and the resident was EX. Order 26.(4) B1 and was transported to the EX. Order 26.(4) B1 for evaluation. She further stated that on EX. Order 26.(4) B1 at 7:45 a.m., the resident was cleared by a EX. Order 26.(4) B1 and returned to the facility. The Director of Wellness explained that the resident was placed back on a EX. Or until 4:30 p.m.,	A 355		

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A 355	Continued From page 4	A 355		

when the resident was sent back to the EX. Order 26. Center because the resident was observed in his/her room opening drawers and stated that he/she was looking for EX. Order 26.(4) B1 his/her EX. Order. She stated that the resident returned to the facility before midnight on the same day, was stable, was monitored by staff and that a EXEX. was no longer needed.

The Director of Wellness stated that on EXEX. Order 26.(4) at 3 p.m., the facility placed Resident #2 on a EX. Or and put the following interventions in place: EX. Order from 8 a.m. to 10 p.m., every (1) hour check from 10 p.m. to 6 a.m., EX. Order 26.(4) B1 consult, EX. Order 26.(as needed and discharge planing to an appropriate setting.

On 10/16 at 12:05 p.m., the surveyor reviewed Resident #2's medical record and according to the "Resident Information" form, the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1 and EX. Order 26.(4) B1. The "Resident Health Assessment" documented that the resident was EX. Order 26.(4) B1, was EX. Order 26.(4) B1 had EX. Order 26.(4) B1 making ability and EX. Order 26.(4) B1.

At 12:45 p.m., the surveyor observed as Resident #2 approached the Director of Wellness office and asked to speak with the person in charge of making decisions at the facility. The surveyor observed that there was no staff member in sight of the resident, despite the resident being assigned a EX. Or staff at that point in time. The surveyor notified the Assistant Director of Wellness who came and took the resident with her.

At 12:55 p.m., the EX. Or staff member entered the

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A 355	Continued From page 5 Wellness office looking for Resident #2. The staff member stated that she was assisting another resident into the elevator when Resident #2 walked away. At 1:05 p.m., the surveyor informed the Director of Wellness and the Administrator of the above observation and concern. The Administrator stated that the staff member was supposed to be with Resident #2. The Director of Wellness then informed the surveyor that the Ex. Or that was assigned to Resident #2 was assisting another resident that placed a pendant call when the surveyor first observed Resident #2 in the dining room eating breakfast without a Ex. Orde Surveyor review of the General Service Plan or care plan, updated Ex. Order 26.(4) B, the facility revealed documented, "Resident will be kept on Ex. Or. Staff to assure resident acts appropriate towards other residents/staff, that resident does not have any interaction with Resident #1. Ex. Or in effect from 7 a.m. to 10 p.m." The surveyor observed that the facility did not consistently implement the General Service Plan or Care Plan as mentioned above when Resident was observed several times with a staff member and/or the assigned Ex. Ex staff member in the resident's presence. The surveyor identified an Immediate Jeopardy situation for Resident #2 on 10/16/19 at 12:45 p.m., and notified the facility at that time. The facility corrected the Immediate Jeopardy situation at 1 p.m. when they implemented a removal plan. The CP was revised and accepted at 4 p.m.	A 355		