STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a008	A. BUILDING: _____ B. WING _____	01/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

(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: REVISED TYPE OF SURVEY: Standard Survey with Covid-19 Focused Infection Control Census: 55 Sample Size: 5 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 COVID-19 Focused Infection Control Survey was conducted by the State Agency on 01/24/2022. The facility was found to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The census was 55.	A 000		
A 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and	A 517		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 517	Continued From page 1 implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures; 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19.	A 517		

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A 517	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and review of employee files and facility policy, it was determined the facility failed to ensure staff received an in-service training on pain management, at least annually, for five of five employees reviewed (Certified Medication Aide (CMA) #1, Nursing Assistant (NA) #1, Licensed Practical Nurse (LPN) #1, LPN #2, and Dietary Aide (DA) #1. Findings included: On 1/24/22, surveyor's review of five employees' in-service records revealed the following: 1. CMA #1's employee file revealed the last in-service on pain management was 06/24/2020. 2. NA #1's employee file revealed the last in-service on pain management was 06/17/2020. 3. LPN #1's employee file revealed the last in-service on pain management was 06/24/2020. 4. LPN #2's employee file revealed the last in-service on pain management was 06/24/2020. 5. DA #1's employee file revealed there was no in-service for pain management. On 01/24/2022 at 3:59 PM, during an interview with the Interim Executive Director, he stated that the pain management in-services were last conducted in 2020.	A 517		

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A 517	Continued From page 3 On 01/24/2022 at 4:42 PM, during an interview with the Resident Care Director (RCD), she stated that the company usually scheduled all annual in-services. She stated that was not sure why this did not occur in 2021 and that it would be expected that all annual in-services be completed in a timely manner. The surveyor's review of the facility policy titled, "Pain Management," dated 12/14/2020, revealed, " ... 9. Staff education and training programs include the following: a ...procedures on pain, incorporation of observation, monitoring and management, through Sunrise's training program ...." This policy was not implemented.	A 517		
A1089	8:36-16.3(b) Physical Plant (b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by mechanical ventilation. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined that the facility failed to consistently ensure ventilation was	A1089		

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A1089	Continued From page 4 present and properly functioning for [redacted] of [redacted] resident apartment bathrooms that did not have a window outside, Room #'s [redacted]. Findings included: 1. On 01/24/2022 at 9:41 AM, surveyor's observation was conducted in randomly selected residents' rooms throughout the facility in the presence of the Maintenance Director. The surveyor's observation included conducting a test for presence of ventilation in residents' rooms which involved attaching a light-weighted tissue paper to an antenna-like clip. The clip was suspended towards the vents in residents' bathrooms. The vent was considered operational if it sucked the tissue paper described above towards itself. Tests were conducted in five random residents' bathrooms which revealed Room #'s [redacted], had no operational ventilation system. These residents' bathrooms did not have windows that opened to the outside. During an interview on 01/24/2022 at 11:50 AM, the Maintenance Director stated that all ventilation systems in residents' bathrooms should work. He stated that he had a record which indicated his inspection of the ventilation systems in residents' rooms. The Maintenance Director stated that it was important for the ventilation systems in the resident bathrooms to work because the bathrooms were without windows. The Maintenance Director illustrated that mist was produced when residents had hot showers and resulted in moisture build-up in the residents' bathrooms. He stated that a working ventilation system helped remove moisture build-up which could promote mold and or mildew growth in the residents' bathrooms. The Maintenance Director concluded that he would	A1089		

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A1089	Continued From page 5 get the system repaired or replaced. During an interview on 01/24/2022 at 3:56 PM, the facility's Interim Executive Director stated that the ventilation system in residents' bathrooms should be properly functioning as it helped take moisture build-up out and prevent bacteria, mold, and mildew growth in the residents' bathrooms. According to the facility's undated policy, titled "TELS [a building management for senior living buildings]," ... under the Bathroom Fan portion of the policy, indicated, " ...Conduct a visual inspection of the unit, address/repair abnormal conditions as required; properly re-assemble unit, restore to service and verify proper operation ...."	A1089		
A1201	8:36-17.3(a)(8) Housekeeping-Sanitation-Safety-Maintenance (a) The housekeeping and sanitation conditions in paragraphs 1 through 12 below shall be met. Application of this requirement with respect to the individual living environment shall take into consideration residents' personal preferences for style of living: 8. Articles in storage shall be elevated from the floor and away from walls (if moisture is present), ceilings, and air vents; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of the facility's policy, it was determined the facility failed to ensure items stored in storage	A1201		

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A1201	Continued From page 6	A1201		

areas were at least 18 inches below the sprinkler heads in 6 of 8 storage areas inspected. This deficient practice is a fire hazard which had the potential to disrupt the effectiveness of the facility's sprinkler system and placed all residents safety at risks.

Findings included:

On 01/24/2022 from 9:54 AM through 12:03 PM, during the facility inspection tour with the Maintenance Director, the following were observed:

1. An observation in the Director of Sales office revealed folders containing documents that were stacked on shelves in the office. The Maintenance Director took a measurement of the folders and verified they were 13 inches below the sprinkler head instead of the required 18 inches.

2. An observation in the facility's copy room revealed a pile of boxes containing documents sitting on the shelves in the room. The Maintenance Director measured the distance of the boxes from the sprinkler head which revealed that the boxes were 10 inches from the sprinkler head.

3. The observation and inspection of the facility's housekeeping supplies room revealed linens in plastic bags and two boxes of paper towels stacked four inches below the sprinkler head in the room.

4. Furthermore, in the facility's maintenance room, boxes containing documents were observed eight inches below the sprinkler head.

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A1201	Continued From page 7 5. An observation conducted in the facility's kitchen storage room revealed boxes of Styrofoam serving wares that sat six inches below the sprinkler head. 6. An observation of the storage closet located beside Room [redacted], revealed that there were adult briefs stacked eight inches below the sprinkler head. On 01/24/2022 at 10:58 AM, during a follow-up interview with the Maintenance Director, he stated that it was important for the facility to ensure that items were stored at a minimum of 18 inches below the sprinkler heads. The Maintenance Director stated that adherence to the recommendation helped ensure that the water flow from the sprinkler heads reached their target in the event of fire. On 01/24/2022 at 12:40 PM, the Interim Executive Director stated that it was important to store articles below the recommended distance from the sprinkler head, and that failure to comply could result in water from the sprinkler head being unable to reach its target during a fire outbreak. The facility's "Fire Prevention Policy," reviewed on 07/07/2017, under the "Sprinkler Clearance" portion of the policy, revealed, " ...Individual sprinkler heads are typically designed to cover approximately 100 square feet. Effective coverage is dependent upon clear, unobstructed access to the source of the flames. In sprinkled spaces, items must not be stored within 18" of the bottom of the sprinkler head. In dedicated storage rooms, communities are encouraged to tape a line at 18" from the bottom of the sprinkler head to ensure the minimum standard is maintained	A1201		

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A1201	Continued From page 8 ...."	A1201		
A1217	8:36-17.3(b)(4) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 4. All household and cleaning products used by facility staff shall be identified, labeled, and secured. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room. The telephone number of the poison control center shall be conspicuously posted in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined that the facility failed to ensure chemical cleaning supplies were locked and secured for one of one cleaning cart observed. The facility's failed practice had the potential to affect the health and safety of facility residents. Findings included: 1. On 01/24/2022 at 9:54 AM, during the facility inspection tour with the Maintenance Director, the surveyor observed the following chemicals on a cleaning cart assigned to Housekeeper (HSK) #1: Crew Clinging Toilet Bowl Cleaner, Glance NA Glass & Multi-purpose Cleaner, Good Sense Liquid Air Freshener, Virex II 256 One-Step Disinfectant Cleaner and Deodorant, Protein	A1217		

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A1217	Continued From page 9 Spotter, and Shine-up Lemon Furniture Polish. The surveyor observed that the cart was positioned across the hall from Room [redacted]. The observation revealed the cart was not within HSK #1's view as she was cleaning inside Room [redacted] at the time of the observation. The cleaning cart had a section which stored cleaning chemicals which had a clear lid with an attachment for locking the unit with a padlock. The observation revealed an unsecured padlock attached to the described lid. In addition, a bunch of keys sat on the topmost part of the cart. During the observation, the Maintenance Director verified that the padlock on the cart was not secured. The Maintenance Director acknowledged that a resident who sat in a wheelchair, just about a foot away from the cart, could easily access the cart. The Maintenance Director then went in Room [redacted] to call the attention of HSK #1 to the situation. Upon HSK #1's arrival at the cart's location, she verbalized that she simply forgot to secure the cart with the padlock. HSK #1 stated that she had been trained by the facility on the need to "always" ensure cleaning chemicals were secured in the cleaning carts. HSK #1 proceeded to secure the chemical compartment of the cart using the padlock, however, she left the keys and did not take the keys with her. To verify that the keys on the cleaning cart were the keys to the chemical compartment of the cart, the surveyor directed the Maintenance Director to open the chemical compartment of the cart using one of the keys, and was able to unlock the cart. During a follow-up interview with HSK #1 on 01/24/2022 at 10:32 AM, HSK #1 reiterated she had been trained by the facility on the need to always ensure cleaning chemicals were secured	A1217		

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A1217	Continued From page 10 on the cleaning carts. She added that failure to secure the chemical compartment of the cleaning cart could result in residents being able to access harmful chemicals. On 01/24/2022 at 10:58 AM, during a follow-up interview with the Maintenance Director, he stated that it was important that all chemicals be stored and secured away from residents due to safety concerns. The Maintenance Director stated that HSK #1's failure to secure the chemical compart of the cleaning cart assigned to her, did not reflect the training that she was provided. The Maintenance Director provided the surveyor with the sign-in sheet which recorded the series of in-services that the facility conducted with housekeeping staff. The training record indicated the facility trained staff on the importance of securing all cleaning chemicals from the residents. The Maintenance Director concluded that he would retrain all housekeeping staff. On 01/24/2022 at 12:40 PM, the facility's Interim Executive Director stated that chemicals were to be stored behind locked doors and should only be out when staff needed to use them. The Interim Executive Director stated that it was important to keep chemicals behind locked doors for residents' safety, and that it was the responsibility of the Maintenance Director to ensure housekeeping staff were adequately trained and monitored for compliance to prevent chemical-related accidents. According to the facility's "Housekeeping Safety Policy," effective 2015, under the "Chemical Safety" part of the policy, indicated, "Keep cleaning chemicals, the housekeeping cart, and equipment in view at all times. Properly secure cleaning items when they are not in use."	A1217		

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
80a008 Y1	A. Building B. Wing Y2	3/4/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BASKING RIDGE	404 KING GEORGE ROAD BASKING RIDGE, NJ 07920

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 A0517	Correction	ID Prefix A1089	Correction	ID Prefix A1201	Correction
Reg. # 8:36-5.6(b)(1-7)	Completed	Reg. # 8:36-16.3(b)	Completed	Reg. # 8:36-17.3(a)(8)	Completed
LSC	03/10/2022	LSC	03/10/2022	LSC	03/10/2022
ID Prefix A1217	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.3(b)(4)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/10/2022	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/24/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Sunrise Senior Living
Plan of Correction

Name of Community: Sunrise Senior Living of Basking Ridge
Address of Community: 404 King George Road, Basking Ridge, NJ 07920
License number: 80A088
Inspection date(s): January 24, 2022
Name/Title of Legal Entity Representative Signing the Plan of Correction:
Jonathan Todd Graf, Executive Director

Signature of Sunrise Representative: _____
Date of Submission: February 23, 2022

Regulation	Target Date by Which Correction will be completed	Plan of Correction
8:36-5.6(b)(1-7) General Requirements	3/15/2022	CMA #1, NA #1, LPN #1, LPN #2 and DA #1 are scheduled to complete an in-service on Pain Management.
	1/24/2022	A review of training in-services was completed and all other community team members that did not receive an in-service on Pain Management in 2021 are scheduled to complete the training.
	3/15/2022	The Business Office Coordinator (BOC) will track and monitor completion of training per community team member.
	1/1/2022	An annual training plan has been established for 2022, which includes Pain Management as a topic. The plan identifies which training are completed via an electronic training platform and which are held in person during our monthly town hall meetings.
	2/10/2022	The Executive Director (ED) reviewed the 2022 training plan with the Department heads.
	3/15/2022	Monthly the ED assigns who will cover which topic at the monthly town hall meeting. Upon completion of training at the town hall meetings the ED or designee provides the BOC with training sign-in sheets and the BOC verifies attendance and completion of training per required team member.
	3/10/2022	The plan of correction and monitoring of training completion outcomes are discussed during the monthly in the Quality Assurance and Performance Improvement (QAPI) meeting for

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		up to three months, by the Executive Director or designee to confirm that the processes outlined above are sustained. During and at the conclusion of the 3-month period, the committee will re-evaluate and initiate any necessary action or extend the review process. The Executive Director is responsible for verifying implementation, and the ongoing compliance of this POC and addressing and resolving any variances that may occur.
8:36-16.3(b) Physical Plant	1/25/2022 1/28/2022 3/1/2022 3/10/2022	The Heating, Ventilation, and Air Conditioning (HVAC) vendor inspected the exhaust fans of room #'s Executive Order 26, 4.b. The exhaust fans of residents' suites were inspected by the Maintenance Coordinator (MC) and found to be in good working order. The maintenance team will create and implement a quarterly inspection schedule of exhaust fans in resident apartments and bathrooms to verify the mechanical ventilation is operational. The MC will keep documentation of the quarterly inspection electronically. The plan of correction and inspection of exhaust fans outcomes are discussed during the monthly in the Quality Assurance and Performance Improvement (QAPI) meeting for up to three months, by the Executive Director or designee to confirm that the processes outlined above are sustained. During and at the conclusion of the 3-month period, the committee will re-evaluate and initiate any necessary action or extend the review process. The Executive Director is responsible for verifying implementation, and the ongoing compliance of this POC and addressing and resolving any variances that may occur.
8:36-17.3(a)(8) Housekeeping-Sanitation-Safety-	2/8/2022	The maintenance and leadership team relocated and properly stored the items that were in storage areas that were identified to not be at least 18 inches below the sprinkler heads, this included:

Regulation	Target Date by Which Correction will be completed	Plan of Correction
Maintenance	2/17/2022 3/1/2022 3/10/2022	• Folders in the Director of Sales office • Boxes sitting on the shelves in the copy room • The housekeeping supplies; linens in plastic bags and two boxes of paper towels • Boxes containing documents in the maintenance room • Boxes of Styrofoam serving wares in the kitchen storage • adult briefs stacked the storage closet located • beside Room [redacted] The maintenance team inspected the community and relocated identified all areas that failed to meet the requirement of at least 18 inches below the sprinkler heads. The maintenance team will create and implement a quarterly inspection schedule of storage areas to verify items are stored at least 18 inches below the sprinkler heads. The MC will keep documentation of the quarterly inspection electronically. The plan of correction and inspection of storage area outcomes are discussed during the monthly in the Quality Assurance and Performance Improvement (QAPI) meeting for up to three months, by the Executive Director or designee to confirm that the processes outlined above are sustained. During and at the conclusion of the 3-month period, the committee will re-evaluate and initiate any necessary action or extend the review process. The Executive Director is responsible for verifying implementation, and the ongoing compliance of this POC and addressing and resolving any variances that may occur.
8:36-17.3(b)(4) Housekeeping-Sanitation-Safety-Maintenance	1/24/2022 1/24/2022 1/24/2022	At time of inspection, when the cleaning cart assigned to Housekeeper (HSK) #1 was identified to be unsecured, the MC locked the cart. The maintenance team inspected housekeeping carts on premises to verify cleaning products were secured. The MC immediately provided an in-service to housekeepers

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		on shift, regarding the requirement to secure all poisonous and toxic materials in a locked cabinet or room.
	1/26/2022	All housekeeping carts were inspected to ensure correct functionality and all housekeeping / maintenance staff were in-serviced on policies regarding chemical safety.
	1/26/2022	Upon hire and annually training is provided to housekeeping staff on proper chemical storage. Reminders of chemical safety/storage will be included in the monthly maintenance/housekeeping department meetings.
	3/15/2022 3/10/2022	The MC will conduct monthly random inspections of housekeeper cleaning carts and chemical storage areas to verify they are being maintained secured. The plan of correction and monthly inspections of housekeeper cleaning carts and chemical storage areas outcomes are discussed during the monthly in the Quality Assurance and Performance Improvement (QAPI) meeting for up to three months, by the Executive Director or designee to confirm that the processes outlined above are sustained. During and at the conclusion of the 3-month period, the committee will re-evaluate and initiate any necessary action or extend the review process. The Executive Director is responsible for verifying implementation, and the ongoing compliance of this POC and addressing and resolving any variances that may occur.