STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	sipfep	A. BUILDING: _____ B. WING _____	C 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ECHELON LAKE	207 LAUREL ROAD VOORHEES, NJ 08043

(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 and COVID-19 Focused Infection Control COMPLAINT #: NJ00138367 CENSUS: 71 SAMPLE SIZE: 1 SURVEY DATE: 10/21/20 - 10/22/20 The facility is not in 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, based on this Complaint Survey. The facility was found to be in compliance with the New Jersey Administrative Code 3:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs, based on this COVID-19 Focused Infection Control Survey. This 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

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #00138367

Based on record review, interview and facility policy review, the Administrator failed to implement the facility's policies and procedures to complete an incident report for an injury of unknown origin, and failed to maintain a written record of an investigation for an allegation of abuse/neglect for one of one sampled resident, Resident #1, whose clinical record was reviewed for an injury of unknown origin/abuse/neglect. This had the potential to affect all 71 residents who resided in the facility.

Findings included:

The facility's "BAIRS [Brookdale Automated Incident Reporting System] Incident Reporting Policy," revised 09/01/19, revealed the following forms do not document: ". . .In the event that a resident or visitor experiences an occurrence such as, but not limited to:. . .injury of unknown origin; the associate reporting the incident along with the supervisor or management representative, must either complete the Preliminary Draft Notes of a Reported Incident. . .or enter the incident into the BAIRS during the shift on the day of the incident. . ."

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A 310	Continued From page 2 The facility's "Abuse, Neglect & Exploitation Policy," revised 12/2018, revealed the following: ". . .Upon receipt of an allegation of abuse, neglect or exploitation, the Executive Director, or designee, should conduct a confidential internal investigation of the incident. The Executive Director or designee should maintain a written record of the investigation. A summary of interviews should be prepared by the Executive Director or designee, including the date, time, name of person being questioned and an impartial report of the facts. . ." Resident #1 was admitted to the facility in [redacted] with diagnoses which included [redacted] A progress note dated [redacted] at 8:00 AM, revealed Resident #1 was observed leaning over the [redacted] side of [redacted] recliner, [redacted] Upon assessment, his/her [redacted], [redacted] was noted to his/her [redacted] his/her [redacted] was noted to have [redacted]), his/her [redacted] and vital signs were taken. His/her power of attorney (POA) was notified, and the POA requested the resident be sent to a local hospital. The resident's physician was notified, and the resident was transferred. On 10/21/20 at 1:21 PM, the Administrator was interviewed regarding Resident #1. He stated a full investigation of the resident's [redacted] to his/her [redacted] had been completed. He stated all staff who had worked with the resident the evening and night before and the morning he/she was transferred had been interviewed. He stated no staff	A 310		

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A 310	Continued From page 3	A 310		

member was aware if the resident might have fallen. The Administrator was asked to provide the surveyor with a copy of the investigation.

On 10/21/20 at 2:10 PM, the Administrator stated he could not find documentation of an investigation.

On 10/21/20 at 2:05 PM, in a telephone interview, Resident #1's family member stated [redacted] was present at the hospital emergency room when [redacted] arrived by ambulance the morning of [redacted] stated the resident's entire [redacted] was [redacted] and the [redacted] of his/her [redacted] She stated she contacted the Administrator on [redacted] and reported the [redacted] and asked questions about what had happened to his/her family member.

On 10/22/20 at 4:00 PM, the Administrator was interviewed. The above documented incident report policy was reviewed. The Administrator was asked if Resident #1's family member had reported to him on or about [redacted] that the resident had significant [redacted] to his/her [redacted] to the [redacted] of his/her [redacted] when he/she arrived at the hospital emergency department on [redacted]. He stated, [redacted] definitely reported it, but I'm not sure about the date." When asked if an incident report had been completed when Resident #1's family member reported the [redacted] and [redacted], he stated no incident report had been completed. When asked if the significant [redacted] would be considered an injury of unknown origin, the Administrator stated, "If you ask us, it didn't appear to be [redacted] The Administrator was asked if it would have been helpful to obtain the emergency room records to determine the extent of Resident #1's [redacted].

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A 310	Continued From page 4 He replied, "Yes," and stated he had not attempted to obtain the emergency room records. The Administrator was asked if he had considered Resident #1's family member's report of significant [redacted] to his/her [redacted] and [redacted] to the [redacted] of his/her [redacted] as an allegation of potential abuse or neglect. He stated, "No." When asked if he should have considered the information an allegation of abuse or neglect, he stated, "No." The Administrator was asked if he had implemented the facility's policy to complete an incident report for Resident #1's injury of unknown origin. He stated, "No." The above documented section of the facility's "Abuse, Neglect, & Exploitation Policy" was reviewed with the Administrator. He was asked if he had implemented the facility's abuse/neglect policy to investigate and to maintain a written record of the investigation. He stated, "No."	A 310		