STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7EKKEK	A. BUILDING: _____ B. WING _____	C 03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT REFLECTIONS AT C(	3 MERIDIAN CIRCLE COLTS NECK, NJ 07722

(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 00152594, NJ 00152687, NJ 00152681, NJ 00152689 CENSUS: 55 SAMPLE SIZE: 4 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 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 05/03/22

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00152594

Based on interview and record review it was determined that the Executive Director (ED) failed to ensure that the facility policies were consistently implemented to ensure residents were free of abuse, responsible party (RP) and Registered Nurse (RN) were notified of a residents' change in condition and failed to update the General Service Plans (GSP) when necessary. This deficient practice was evidenced by the following:

1. The surveyor reviewed Resident [redacted]'s Progress Notes (PN) and observed a note dated [redacted] at 2:30 p.m., written by Licensed Practical Nurse (LPN), LPN #5, which revealed that Resident [redacted] stated that another resident, Resident [redacted] tried to grab his/her coat off Resident [redacted]'s [redacted]. LPN #5 documented that Resident [redacted] hit his/her [redacted] while he/she attempted to back away from the [redacted]. The note continued that Resident [redacted] experienced some soreness as a result of hitting his/her [redacted] on the [redacted] in the process of backing away.

Further review of a PN dated [redacted] at 2 p.m., written by LPN #6 revealed that at approximately 11:30 a.m., while Resident [redacted] was waiting to obtain his/her [redacted], Resident [redacted] walked by and [redacted]" Resident [redacted]'s [redacted], as if "to tell

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A 310	Continued From page 2 the resident something." LPN #6 documented that Resident [redacted] was "upset and carried on" and went into his/her apartment to call 911. LPN #6 also documented that two police officers arrived, took statements, and after being assured that both residents did not have any injuries, left the facility. The PN dated [redacted] at 1 p.m., written by the ED indicated that the ED spoke with Resident [redacted] regarding the [redacted] incident. The ED documented that Resident [redacted] stated that Resident [redacted] "[redacted]" his/her [redacted] and he/she was "afraid" of Resident [redacted]. Another PN dated [redacted] written by the WD revealed, that Resident [redacted] entered abruptly into the ED's office and stated that Resident [redacted] [redacted] Resident [redacted] on the [redacted] and the incident was witnessed by a staff. The PN also indicated that the incident did not occur as stated by Resident [redacted]. The surveyor reviewed the "Rights" section in the "New Jersey Residency Agreement" which documented each resident's rights and observed the following: "The right to be free from physical and mental abuse and/or neglect." Additionally, the surveyor reviewed the facility policy titled, "T.R.U.S.T Program: Abuse Prohibition" which documented, "This program is a Zero Tolerance for Abuse Program and is reflective of..." the facility's "...commitment to provide an environment of care that protects our residents from any form of resident abuse." Refer to 8:36-4.1(a)(16) 2. On 3/2/22 the surveyor reviewed Resident [redacted]'s PN and observed a note dated [redacted] at 10:15 p.m., written by a Licensed Practical Nurse	A 310		

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A 310	Continued From page 3 that Resident [redacted] was found on the ground by the Care Manager. At 12:10 p.m., on 3/2/22 the surveyor interviewed the Wellness Director (WD) regarding the above mentioned fall that occurred on [redacted] and asked if Resident [redacted]'s RP was notified. The WD stated that the RP had not be notified. The surveyor reviewed the facility's policy and procedure titled, "Resident Fall Intervention Policy" which indicated, "ALL falls will be reported to the...and responsible party immediately on the day of the fall." Refer to 8:36-5.15(b) 3. Surveyor review of Resident [redacted]'s PNs dated [redacted] at 3:45 p.m., written by LPN #1, indicated that Resident [redacted] was found on his/her [redacted] side on the floor, and required the assistance of two staff to get off the floor. LPN #1 also documented that she assessed Resident [redacted], who had no injuries. Review of Resident [redacted]'s PNs revealed that on [redacted] at 7:30 p.m., LPN #2 documented that at 4:10 p.m. Resident [redacted] was found on the floor in the hallway and was unable to explain how he/she got there. On 3/2/22 at 11:25 a.m., the surveyor reviewed Resident [redacted]'s medical record and observed that the resident moved into the facility in [redacted] with a diagnosis of [redacted]. Review of Resident [redacted]'s PNs dated [redacted] at 10:15 p.m., revealed that LPN #3 documented that Resident [redacted] was found on the floor by the Care Manager. At 12:10 p.m., on 3/2/22 the surveyor interviewed	A 310		

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A 310	Continued From page 4 the facility's WD regarding the above mentioned falls which occurred on [redacted], [redacted], and [redacted], and inquired if a RN was notified of the incidents. The WD stated that as per the PNs, an RN was not notified. The WD stated that she should have been notified of the falls that occurred on [redacted] and [redacted]. She added that she was on vacation on [redacted], and the RN on call should have been notified. According to the facility policy titled, "Nursing Documentation/Service notes/Registered nurse role NJ/DE/, Service Plans, Health service Plans in NJ" with a revision date of 4/2010, indicated, "The registered nurse will be called at the onset of illness, injury, or change in condition of any resident to arrange for assessment of the resident's care needs or medical needs and for needed nursing intervention or medical care..." Refer to 8:36-7.5(c) 4. According to surveyor review of Resident [redacted]'s PNs, the resident fell on [redacted] at 4:10 p.m., [redacted] at 2:15 p.m., twice on [redacted] and on [redacted] at 1:00 a.m. Further review of the GSP, and a document titled "Current Ongoing Care Plan" revealed that there were no updates or interventions on the GSP after each fall. According to surveyor review of Resident [redacted]s PNs, the resident had three falls on [redacted]. at 7 a.m., at 3:15 p.m., and at 10:15 p.m. Lastly, the PN on [redacted] at 5:10 a.m., Resident [redacted] was found by staff lying on the floor in the [redacted] wing with his/her [redacted] against the wall, unable to explain what happened. Further review of the "Current Ongoing Care Plan" and the GSP dated [redacted], revealed that there were no updates or	A 310		

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A 310	Continued From page 5 interventions added after each fall. Further review of the "Current Ongoing Care Plan" and the GSP dated [redacted], revealed that there were no updates or interventions added after each fall. At 12:00 p.m., on 3/2/22 the surveyor interviewed the Wellness Director (WD) regarding the above mentioned falls and asked if there were any updated GSP's for Resident [redacted] and/or Resident [redacted] The WD was unable to provide the surveyor with updated documents and stated that both the GSP and Current Ongoing Care Plan should have been updated to reflect the falls and interventions to prevent future falls. According to the facility policy titled, "Nursing Documentation/Service notes/Registered nurse role NJ/DE/, Service Plans, Health service Plans in NJ" with a revision date of 4/2010, indicated, "The registered nurse will be called at the onset of illness, injury, or change in condition of any resident to arrange for assessment of the resident's care needs or medical needs and for needed nursing intervention or medical care...Service plans will be updated at least every 6 months or upon significant change of the resident." Refer to 8:36 7.3(c)	A 310		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is	A 389		

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A 389	Continued From page 6 entitled to the following rights: 16. The right to be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00152681, NJ 00152689 Based on observation, interview and record review it was determined that the facility failed to ensure each resident's right to be free from abuse was enforced when 2 of 4 residents reviewed for abuse experienced resident to resident abuse, Resident [redacted], Resident [redacted] by one (1) resident, Resident [redacted]. This deficient practice was evidenced by the following: 1. On 3/1/22 at 10:20 a.m., the surveyors toured the [redacted] unit and observed Resident [redacted] in his/her apartment. Resident [redacted] was assessed by the facility to be [redacted] and able to ambulate independently. During interview the resident stated that he/she was moved to a new apartment yesterday, [redacted] because he/she was constantly being "[redacted]" by another resident, Resident [redacted] since [redacted] when Resident [redacted] moved into the [redacted] unit. Resident [redacted] continued and stated that Resident [redacted] hit him/her on the [redacted] and knocked his/her [redacted] the resident's [redacted], and also [redacted] his/her [redacted] Resident [redacted] stated that he/she had to call the local police. Resident [redacted] stated that	A 389		

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A 389	Continued From page 7	A 389		

he/she was afraid of Resident [redacted] and explained that he/she spent more time in his/her apartment to avoid being "attacked" by Resident [redacted]. Finally, Resident [redacted] stated that he/she felt safe now that he/she is on a different unit than Resident [redacted]

At 11:30 a.m., the surveyor reviewed Resident [redacted]'s medical record and according to the "Resident Information Sheet" the resident was admitted to the facility on [redacted] with diagnoses which include [redacted]. The surveyor also reviewed a [redacted] evaluation dated [redacted] which indicated that Resident [redacted] complained that another resident had been hitting him/her.

At 1:45 p.m. the surveyor interviewed the WD regarding Resident [redacted]'s complaint to the [redacted]. The WD stated that she was aware of the complaint, and that Resident [redacted] and Resident [redacted] do not get along.

The surveyor reviewed Resident [redacted]'s Progress Notes (PN) section of the chart and observed a note dated [redacted] at 2:30 p.m., written by Licensed Practical Nurse (LPN), LPN #5, which revealed that Resident [redacted] stated that another resident, Resident #4 tried to grab his/her coat off Resident [redacted]'s [redacted]r. LPN #5 documented that Resident [redacted] hit his/her [redacted] while he/she attempted to back away from the [redacted]. The note continued that Resident [redacted] experienced some soreness as a result of hitting his/her [redacted] on the [redacted] in the process of backing away.

Surveyor review of a PN dated [redacted] at 2 p.m., written by LPN #6 revealed that at approximately 11:30 a.m., while Resident [redacted] was waiting to obtain his/her [redacted], Resident [redacted] walked

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A 389	Continued From page 8 by and [redacted]" Resident #1's [redacted], as if "to tell the resident something." LPN #6 documented that Resident [redacted] was "upset and carried on" and went into his/her apartment to call 911. LPN #6 also documented that two police officers arrived, took statements, and after being assured that both residents did not have any injuries, left the facility. The PN dated [redacted] at 1 p.m., written by the Executive Director (ED) indicated that the ED spoke with Resident [redacted] regarding the [redacted] incident. The ED documented that Resident [redacted] stated that Resident [redacted] "[redacted]" his/her [redacted] and he/she was "afraid" of Resident [redacted] Another PN dated [redacted] written by the WD revealed, that Resident [redacted] entered abruptly into the ED's office and stated that Resident [redacted] hit Resident [redacted] on the [redacted] and the incident was witnessed by a staff. The PN also indicated that the incident did not occur as stated by Resident [redacted]. At 10:30 a.m., during tour of the [redacted], a [redacted] unit of the facility, the surveyor observed Resident [redacted], who was pacing up and down the hallways with a [redacted] Staff Member (SM), SM #1. The surveyor interviewed SM #1, who stated that she was assigned to monitor Resident [redacted] to prevent the resident from hitting other residents. At 10:35 a.m., the surveyor interviewed SM #2 regarding Resident [redacted] and she stated that Resident [redacted] was new to the facility and was moved from [redacted] to the [redacted] unit in [redacted] due to exit seeking behaviors. SM #2 stated that Resident [redacted] had periods of outburst, had [redacted]	A 389		

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A 389	Continued From page 9 behaviors and was verbally and physically abusive towards other residents and staff members. SM #2 also stated that during the day, the residents could not move freely and were supervised in the common areas to avoid physical contact with Resident [redacted]. She explained that Resident [redacted] was currently on one-to-one supervision to decrease interaction with other residents. On 3/2/22 at 12:30 p.m., the surveyor interviewed the Executive Director (ED) regarding Resident [redacted]'s concerns. The ED stated that both incidents were investigated and the two residents did not get along with each other. The ED explained that Resident [redacted] was placed on a [redacted] on [redacted], and that the resident was issued a 30 day notice of discharge on [redacted]. The surveyor reviewed the "Rights" section in the "New Jersey Residency Agreement" which documented each resident's rights and observed the following: "The right to be free from physical and mental abuse and/or neglect." Additionally, the surveyor reviewed the facility policy titled, "T.R.U.S.T Program: Abuse Prohibition" which documented, "This program is a Zero Tolerance for Abuse Program and is reflective of..." the facility's "...commitment to provide an environment of care that protects our residents from any form of resident abuse." Complaint #: NJ 00152594, NJ00152687 2. On 3/1/22 at 10:30 a.m., the surveyor toured the [redacted] unit [redacted]) of the facility and observed Resident [redacted] seated on a [redacted] chair. Resident [redacted] was unable to participate in the interview process due to [redacted]	A 389		

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A 389	Continued From page 10 The surveyor also observed that Resident [redacted] was pacing the [redacted] while a staff member provided [redacted] supervision. The surveyor did not observe any other residents walking on the [redacted] at that time. At 11:00 a.m., on 3/1/2022 the surveyor reviewed Resident [redacted] medical record (MR), and observed that the resident moved into the facility in [redacted] with a diagnosis which a diagnosis of [redacted]. Further review of MR that the "General Service Plan" (GSP) indicated that the resident was [redacted] and required the assistance of staff for activities of daily living. Continued review of the MR revealed in the PN on [redacted] at 2:15 p.m., that while Resident [redacted] was being escorted to the dining room for breakfast, another resident, Resident [redacted], pushed Resident [redacted] and he/she fell on the floor on his/her [redacted] The surveyor observed a PN dated [redacted] at 5:00 p.m., which indicated that Resident [redacted] stumbled and fell to the floor when another resident bumped into him/her. The PN did not specify who the other resident was, however, surveyor interview with the WD confirmed that the other resident was Resident [redacted] At 10:45 a.m., on 3/1/22 the surveyor interviewed SM#1 who stated that she was instructed to keep space between Resident [redacted] and other residents. SM#1 also stated that Resident [redacted] was [redacted] at times. At 10:41 a.m., on 3/2/2022 the surveyor interviewed the WD who confirmed that on	A 389		

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A 389	Continued From page 11 [redacted], Resident [redacted] bumped into Resident [redacted] which caused Resident [redacted] to fall. The WD also confirmed that no interventions were implemented in attempt to stop the resident-to-resident physical interaction at that time. The facility failed to protect Resident [redacted] and other residents, potential harm when the resident repeatedly reported that he/she was being physically abused by Resident [redacted] until [redacted] when Resident [redacted] was placed on [redacted] and issued an involuntary discharge notice.	A 389		
A 565	8:36-5.10(a)(3) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 3. All suspected cases of resident abuse, neglect, or misappropriation of resident property, including, but not limited to, those which have been reported to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly for residents over 60 years of age; This REQUIREMENT is not met as evidenced by:	A 565		

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A 565	Continued From page 12 Complaint #: NJ 00152689, NJ 00152681 Based on interview and record review it was determined that the facility failed to immediately report resident to resident physical abuse allegations to the Department of Health (DOH) that occurred on [redacted], not reported and [redacted] which was not reported until 2/22/22 for 2 of 4 residents reviewed for abuse, Resident [redacted] and Resident [redacted]. This deficient practice was evidenced by the following: The surveyor reviewed the Facility Reportable Event document (FRE) dated 2/22/22, in which the facility reported resident to resident abuse which involved Resident [redacted], the victim, and Resident [redacted], the aggressor on [redacted]. On 3/1/22 at 11:15 a.m., the surveyor interviewed the Executive Director (ED) and the Wellness Director (WD) regarding the FRE allegation of resident to resident physical abuse that occurred on [redacted]. During the interview, the ED stated that Resident [redacted] came into her office and stated that he/she was [redacted] on the [redacted] by Resident [redacted] The ED stated that she investigated the incident and concluded that the incident did not occur as reported by Resident [redacted]. In addition, the WD stated that she assessed Resident [redacted]'s [redacted] and there was no redness noted. During continued interview, the surveyor asked the ED and the WD why the facility delayed reporting the [redacted] incident to the DOH until 2/22/22. The WD explained that Resident [redacted] can be accusatory at times, and it wasn't until after Resident [redacted]s Responsible Party (RP) contacted the facility on [redacted] and reported that another resident, Resident [redacted] physically abused	A 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7EKKEK	A. BUILDING: _____ B. WING _____	C 03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 565	Continued From page 13 Resident [redacted] that the facility decided to report the incident. At 11:30 a.m., the surveyor reviewed Resident [redacted]'s medical record and according to the "Resident Information Sheet," the resident was admitted to the facility in [redacted] with diagnoses which included [redacted] and was assessed by the facility to be [redacted], and able to independently ambulate. At 10:20 a.m., the surveyor observed the resident in his/her apartment and conducted an interview at that time. Resident [redacted] stated that since Resident [redacted] moved to the [redacted] unit in [redacted] Resident [redacted] had on multiple occasions, "attacked" him/her for no reason. The surveyor reviewed the Progress Note (PN) dated [redacted] at 2 p.m., written by a Licensed Practical Nurse (LPN) #6. She documented that at approximately 11:30 a.m., while Resident [redacted] was waiting to obtain his/her [redacted], Resident [redacted] walked by and, [redacted] ..., Resident [redacted]'s [redacted] to tell the resident something". LPN #6 documented that Resident [redacted] was "upset and carried on" and went into his/her apartment to call 911. She documented that two Police Officers (PO) arrived, took statements, and left after being assured that both residents did not have any injuries. Further, surveyor review of a PN dated [redacted] at 5:15 p.m., written by the WD indicated, Resident [redacted] rushed into the ED's office and stated that Resident [redacted] had hit him/her (Resident [redacted]) and that a staff member witnessed the incident. However, after the facility investigated the allegation, it was documented that the event did	A 565		

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A 565	Continued From page 14 not take place. At 1:50 p.m., the surveyor interviewed the ED and asked if she reported the [redacted] incident to the DOH. The ED stated that she did not report the incident to the DOH because the incident was witnessed by the LPN and there was no injury observed. The surveyor reviewed the local police report dated [redacted], which was provided by the WD. According to the police report, two POs arrived at the facility due to a report of a "disorderly person" that was pushing people around, and "knocking them over." The police report indicated that on arrival, the Nurse stated that everything was "ok" and that the two residents involved, Resident [redacted] and Resident [redacted] did not get along. Further, the police report indicated that Resident [redacted] [redacted] Resident [redacted]'s [redacted], however, there were no injuries and both residents were separated. The facility failed to report to the DOH in a timely manner incidents of resident to resident physical abuse which occurred on [redacted] when Resident [redacted] contacted the local police department and, on [redacted] when Resident [redacted] reported to the ED and WD that Resident [redacted] hit him/her on the [redacted]. Refer to 8:36-4.1(a)(16)	A 565		
A 615	8:36-5.15(b) General Requirements (b) Notification of any occurrence noted in (a) above shall be documented in the resident's record. The documentation with regard to an occurrence noted in (a)4 above shall include confirmation and written documentation of that notification.	A 615		

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A 615	Continued From page 15 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00152594 Based on interview and record review it was determined that the facility failed to notify a residents' Responsible Party (RP) when the resident experienced a fall for 1 of 4 residents reviewed, Resident [redacted]. This deficient practice was evidenced by the following: On 3/2/22 at 11:25 a.m., the surveyor reviewed Resident [redacted]'s medical record and observed documented on the "Resident Information Sheet," (a document used to provide information about a resident) that the resident moved into the facility in [redacted] with a diagnosis of [redacted]. The surveyor reviewed Resident [redacted]'s Progress Note and observed a note dated [redacted] at 10:15 p.m., written by a Licensed Practical Nurse that Resident [redacted] was found on the ground by the Care Manager. At 12:10 p.m., on 3/2/22 the surveyor interviewed the Wellness Director (WD) regarding the above mentioned fall that occurred on [redacted] and asked if Resident [redacted]'s RP was notified. The WD stated that the RP had not be notified. The surveyor reviewed the facility's policy and procedure titled, "Resident Fall Intervention Policy" which indicated, "ALL falls will be reported to the...and responsible party immediately on the day of the fall."	A 615		

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 753	Continued From page 16	A 753		
A 753	8:36-7.3(c) Resident Assessments and Care Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to revise and update the General Service Plan (GSP) for 2 of 4 residents reviewed for falls, Resident [redacted] and Resident [redacted]. This deficient practice was evidenced by the following: 1. On 3/1/22 at 11:00 a.m., the surveyor reviewed Resident [redacted]'s medical record and observed on the "Resident Information Sheet," (a document used to provide information about a resident), that the resident moved into the facility in [redacted] with a diagnosis of [redacted] According to surveyor review of Resident [redacted]'s Progress Notes (PN), Resident [redacted] had a fall on [redacted] 4:10 p.m. the resident was found on floor in the [redacted] wing hallway, the resident unable to explain how he/she got there, and was assisted from the floor by 2 staff. On [redacted] at 2:15 p.m., while being escorted to the dining room for breakfast, Resident [redacted] was pushed by another resident, Resident [redacted], and landed on his/her [redacted] on the floor. According to the PN, Resident [redacted] fell twice on [redacted]. The first	A 753		

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A 753	Continued From page 17 fall was at 3 p.m. the notes indicated that the resident fell in the hallway, and at 5 p.m. the notes indicated that the resident was bumped into by another resident, Resident [redacted] and fell to the floor. Lastly, the notes indicated that on [redacted] at 1 a.m. the resident was found on the floor between the bed and the wall. The surveyor observed in the PNs that after each fall listed above for Resident [redacted] there were no injuries documented. The surveyor also reviewed Resident [redacted]'s GSP dated [redacted], which revealed that the resident was [redacted] and required the assistance of staff for activities of daily living. Further review of the GSP, and a document titled "Current Ongoing Care Plan" revealed that there were no updates or interventions on the GSP after each fall. 2. On 3/2/22 at 11:25 a.m., the surveyor reviewed the MR of Resident [redacted] and observed that the resident moved into the facility in [redacted] with a diagnosis of [redacted]. According to surveyor review of Resident [redacted]'s PNs, the resident had three falls on [redacted]. On [redacted] at 7 a.m. another resident, Resident [redacted] was observed by staff pushing Resident [redacted] to the floor on his/her knees, at 3:15 p.m. Resident [redacted] was reported to have fallen on his/her [redacted], and at 10:15 p.m. the resident was found on the ground by the Care Manager. Lastly, according to the PNs on [redacted] at 5:10 a.m. Resident [redacted] was found by staff lying on the floor in the [redacted] wing with his/her [redacted] against the wall, unable to explain what happened. Further review of the "Current Ongoing Care Plan" and the GSP dated [redacted], revealed that	A 753		

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A 753	Continued From page 18 there were no updates or interventions added after each fall. At 12:00 p.m., on 3/2/22 the surveyor interviewed the Wellness Director (WD) regarding the above mentioned falls and asked if there were any updated GSP's for Resident [redacted] and/or Resident [redacted]. The WD was unable to provide the surveyor with updated documents and stated that both the GSP and Current Ongoing Care Plan should have been updated to reflect the falls and interventions to prevent future falls. According to the facility policy titled, "Nursing Documentation/Service notes/Registered nurse role NJ/DE/, Service Plans, Health service Plans in NJ" with a revision date of 4/2010, indicated, "The registered nurse will be called at the onset of illness, injury, or change in condition of any resident to arrange for assessment of the resident's care needs or medical needs and for needed nursing intervention or medical care...Service plans will be updated at least every 6 months or upon significant change of the resident."	A 753		
A 779	8:36-7.5(c) Resident Assessments and Care Plans (c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care.	A 779		

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A 779	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to notify a Registered Nurse (RN) of a change in condition for 3 of 4 residents reviewed for assessments and nursing care needs, Resident [redacted], Resident [redacted], and Resident [redacted]. This deficient practice was evidenced by the following: 1. On 3/1/22 at 11:00 a.m., the surveyor reviewed Resident [redacted]'s medical record and observed on the "Resident Information Sheet" (a document used to provide information about the resident), that the resident moved into the facility in [redacted] with a diagnosis of [redacted]. Additionally, according to the "General Service Plan" (GSP), Resident [redacted] was [redacted] and required the assistance of staff for activities of daily living. Surveyor review of Resident [redacted]'s Progress Notes (PNs) dated [redacted] at 3:45 p.m., written by LPN #1, indicated that Resident [redacted] was found on his/her left side on the floor, and required the assistance of two staff to get off the floor. LPN #1 also documented that she assessed Resident [redacted], who had no injuries. Review of Resident [redacted]'s PNs revealed that on [redacted] at 7:30 p.m., a Licensed Practical Nurse (LPN), LPN #2 documented that at 4:10 p.m. Resident [redacted] was found on the floor in the hallway and was unable to explain how he/she got there. 2. On 3/2/22 at 11:25 a.m., the surveyor reviewed	A 779		

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A 779	Continued From page 20 Resident [redacted]'s medical record and observed that the resident moved into the facility in [redacted] with a diagnosis of [redacted]. Review of Resident [redacted]'s PNs dated [redacted] at 10:15 p.m., revealed that LPN #3 documented that Resident [redacted] was found on the floor by the Care Manager. At 12:10 p.m., on 3/2/22 the surveyor interviewed the facility's Wellness Director (WD) regarding the above mentioned falls which occurred on [redacted], and [redacted], and inquired if a RN was notified of the incidents. The WD stated that as per the PNs, an RN was not notified. The WD stated that she should have been notified of the falls that occurred on [redacted] and [redacted]. She added that she was on vacation on [redacted], and the RN on call should have been notified. According to the facility policy titled, "Nursing Documentation/Service notes/Registered nurse role NJ/DE/, Service Plans, Health service Plans in NJ" with a revision date of 4/2010, indicated, "The registered nurse will be called at the onset of illness, injury, or change in condition of any resident to arrange for assessment of the resident's care needs or medical needs and for needed nursing intervention or medical care..." 3. On 3/2/22 at 11:30 a.m., the surveyor reviewed Resident [redacted]'s medical record and observed documented on the "Resident Information Sheet," that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted] and [redacted]. At 10:20 a.m., the surveyor observed Resident [redacted] in his/her apartment and conducted an interview. Resident [redacted] stated that another	A 779		

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A 779	Continued From page 21 resident, Resident [redacted] "attacked" him/her on multiple occasions. Surveyor review of the PNs section of the medical record revealed a note dated [redacted] at 2:30 p.m., written by LPN #5 which indicated that Resident [redacted] stated that another resident, Resident [redacted] tried to "grab" his/her coat off Resident [redacted]'s [redacted]. LPN #5 documented that as a result of this encounter with Resident [redacted], Resident [redacted] hit his/her [redacted] and experienced some discomfort while trying to back away from the [redacted]. The surveyor interviewed the WD at 1:10 p.m., regarding the above incident and inquired if she was notified of the incident. The WD confirmed that she was notified of the incident and had assessed Resident [redacted]. However, there was no documented evidence in the medical record that the resident was assessed for nursing care needs.	A 779		

New Jersey Department of Health

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00152594, NJ 00152687, NJ 00152681, NJ 00152689 CENSUS: 55 SAMPLE SIZE: 4 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 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: CALA — (X6) DATE: 4/25/22

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The following Plan of Correction correlates to the Statement of Deficiencies resulting from the New Jersey Department of Health Compliance Survey completed at this facility on 3/02/2022.

A310

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;

Plan of Correction:

1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: **The resident ([redacted] no longer resides in the facility (discharged[redacted]). The resident (#1) was moved to room [redacted], a room on the opposite side of the facility (on [redacted]),**

2.How the facility will identify other residents having the potential to be affected by the same deficient practice: **All residents have the potential to be affected.**

3.What measures will be put into place or systemic changes made to ensure the deficient practice will not occur: **The administrator will have read nursing notes and communication logs daily to ensure the proper policies and procedures are being carried out. The administrator will intervene if staff falls short of following policies and procedure and immediately in-service necessary staff and correct the action.The administrator will ensue that an in-service is provided on "residents rights" that will be given to all staff to re-educate. The administrator will maintain an open line of communication and foster trust so the staff feels comfortable reporting or voicing their concerns for the residents rights and potential noncompliance to policy and procedure, including resident rights.**

4.How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur; i.e. What program will be put into place to monitor the continued effectiveness of changes: **Corporate conducts yearly QI and unannounced times to monitor policy and procedure adherence.The administrator shall review daily the communication log and nursing notes for any injury or allegation of abuse and report to the DOH. The administrator has reviewed policy and procedure and residents rights to become better skilled at recognizing non-compliance.**

3 MERIDIAN CIRCLE COLTS NECK new jersey 07722

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All LPNs were inserviced on Reporting to RN/ED any Allegations of Abuse (zoom 2/25/22). All LPNs were inserviced on Documentation (zoom 2/24/22).

The facility will be in compliance 4/13/22.

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A389

8:36-4.1 (a) (16)

1.How the corrective action will be accomplished for the residents found to have been affected by the deficient practice: **The resident ([redacted]) continues to reside in the facility and did not sustain injury.**

2.How facility will identify other residents having the potential to be affected by the same deficient practice: **All residents have the potential to be affected.**

3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: **All will be reported to the responsible party immediately on the day of the fall. All LPNs will be in-serviced on Policy and Procedures regarding falls.**

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: **All nurses will inform and document that DON, MD and responsible party were notified of falls immediately on the day of the fall. RN or appropriate designee shall review daily, the communication log / nurses notes for any fall and report to ED. ED and DON will review all falls and witness statements, ensuring daily that all parties are contacted.**

The facility will be in compliance by 4/22/22.

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8:36-5.15 (b)

1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: **The resident ([redacted])continues to reside in the facility but was issued a 30day Involuntary Discharge ([redacted]) and will be discharged to LTC as soon as family decides on an appropriate facility. The resident ([redacted]) continues to reside in the facility .**

2.How the facility will identify other residents having the potential to be affected by the same deficient practice: **All residents have the potential to be affected.**

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: **All falls will be reported by the LPN to the RN immediately on the day of the fall and documented in the nurse's notes. The RN will complete an assessment of the resident within 72hours and document in the nurse's notes. All LPN's will be in-serviced on the policy and procedure following falls.**

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of systemic changes: **DON and ED will review the Nursing Notes and Communication logs daily to ensure all Fall Policies are followed.**

The facility will be in compliance by 4/22/22.

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A310

8:36-7.5 (c)

1.How the corrective action will be accomplished for those residents found to been affected by the deficient practice: **The resident ([redacted]) presently resides in the facility but due to continued falls and unsuccessful interventions was issued a 30day Involuntary Discharge ([redacted]) and will be discharged to a LTC as soon as family decides on an appropriate facility. The Resident ([redacted]) continues to reside in the facility and his General Service Plan has been appropriately updated with successful fall interventions.**

2.How the facility will identify other residents having the potential to be affected by the sane deficient practice: **All residents have the potential to be affected.**

3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: **Any fall will be reported to the DON and investigation will be initiated immediately. A resident assessment will be conducted by the RN within 72 hours and the appropriate changes in interventions and care will be documented and put into place immediately .Conclusions will be documented in the nursing notes. RN or appropriate designee shall review daily, the communication log/nursing notes for falls and report to the ED. ED and DON will review all falls and the General Service Plan book will be brought to daily morning meeting and updated with necessary interventions as needed.**

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of systemic changes: **RN or appropriate designee shall review daily the communications log for any injury and report to the ED. ED and DON will review any and all falls/injuries, statements and witnesses. General Service Plan book will be brought to morning meeting and updated with the necessary interventions as needed. ED and DON will monitor and review on a quarterly basis.**

The facility will be in compliance on 4/12/22.

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A 565

8:36-5.10(a) (3)

(a)The facility shall notify the DOH immediately by telephone at 609-633-9034 (609-392-2020 after business hours) followed within 72hours by written confirmation of the following:

3. All suspected cases of resident abuse, neglect or misappropriation of resident property including but not limited to, those which have been reported to NJS Office o Ombudsman for the Institutionalized Elderly for residents over 60 years of age.

1.How the corrective action will be accomplished for those residents found to been affected by the deficient practice: **The resident ([redacted]) continues to reside in the facility and was moved to room #[redacted] ([redacted]). The resident ([redacted]) was discharged from facility ([redacted]).**

2.How the facility will identify other residents having the potential to be affected by the sane deficient practice: **All residents have the potential to be affected.**

3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: **Any allegations of resident abuse will be called into the DOH and Ombudsman office with in 72hours regardless of resident's diagnosis or history of allegations. In-service for all staff on Abuse and Residents Rights. In-service to review the TRUST program with all staff to ensure residents are free of abuse.**

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of systemic changes: **ED and DON will review the communications log and nurses notes daily and maintain an open dialogue with the residents so they may feel comfortable to report issues.**

The facility will be in compliance on 4/12/22.

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8:36-5.15(b) General Requirements

(b)Notification of any occurrence noted in (a) above shall be documented in the residents record. The documentation with regard to an occurrence noted in (a)4 above shall include confirmation and written documentation of that notification.

1.How the corrective action will be accomplished for those residents found to been affected by the deficient practice: **The resident ([redacted]) still resides in the facility. 1:1 is in affect to prevent falls and behaviors, POA is updated via phone by WD every few days. All nurses were given an inservice on reporting falls immediately on day of the falls to the RP.**

2.How the facility will identify other residents having the potential to be affected by the sane deficient practice :**All residents have potential for behaviors**

3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: : **Any injury/fall will be reported to the responsible party immediately on the day of the fall. All LPNs will be in-serviced on Policy and Procedures regarding falls.**

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of systemic changes: : **All nurses will document that DON, MD and responsible party were informed of falls immediately on the day of the fall. RN or appropriate designee shall review daily, the communication log / nurses notes for any fall and report to ED. ED and DON will review all falls and statements from witnesses , ensuring daily that all parties are contacted.**

The facility will be in compliance on 4/22/22

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8:36-7.3(c) Resident Assessments and Care Plans

(c)Documentation in the residents record shall indicate review and any necessary revision of the resident service plan and and/or health service plan.

1.How the corrective action will be accomplished for those residents found to been affected by the deficient practice: **The resident ([redacted]) continues to reside in the facility. Her GSP with interventions have been updated but due to ineffective interventions and safety concerns. Resident ([redacted]) continues to reside in the community and Service Plans have been appropriately updated.**

2.How the facility will identify other residents having the potential to be affected by the same deficient practice: **All residents have the potential to be affected**

3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: **Any fall or change in condition will be reported to the DON and investigation will be initiated immediately. RN will then conduct a resident assessment and change service plan and care as necessary. Conclusions will be documented in the nursing notes. RN or appropriate designee shall review daily, the communication log/nursing notes for falls and report to the ED. ED and DON will review all falls and the General Service Plan book will be brought to daily morning meeting and updated with necessary interventions as needed.**

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of systemic changes : **RN or appropriate designee shall review daily the communications log for any injury and report to the ED. ED and DON will review all falls/injuries, statements and witnesses. General Service Plan book will be brought to morning meeting and updated with the necessary interventions as needed. ED and DON will monitor and review on a quarterly basis.**

The facility will be in compliance on 4/12/22.

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8.36-7.5(c)

(c)Registered Professional Nurse shall be called at onset of illness, injury or change in condition of any residents nursing care needs or medical needs and for needed nursing care intervention or medical care.

1.How the corrective action will be accomplished for those residents found to been affected by the deficient practice: **The resident ([redacted]) was moved to apartment [redacted] ([redacted]) and continues to reside in the building. The resident ([redacted]) presently resides in the building. The Resident ([redacted]) continues to reside in the facility.**

2.How the facility will identify other residents having the potential to be affected by the same deficient practice: **All residents have the potential to be affected by the same deficient practice.**

3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: **All falls will be reported to RN immediately on the day of the fall and documented in the nurses notes. The RN will complete an assessment of the resident within 72hours and document in the nurse's notes. All LPN's will be in-serviced on policy and procedure following falls.**

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of systemic changes: **DON and ED will review the Nursing Notes and Communication logs daily to ensure all Fall Policies are followed.**

The facility will be in compliance by 4/22/22.

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8:36-4.1(a)(16)Resident Rights

(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:
16. The right to be free from physical and mental abuse and/or neglect;

1.How the corrective action will be accomplished for those residents found to been affected by the deficient practice: : **The resident ([redacted]) was moved to apartment [redacted] ([redacted]) and continues to reside in the building. The Resident ([redacted]) continues to reside in the building. Resident ([redacted]) no longer resides in the building. In-service to entire staff to review Resident Rights and understanding to report resident to resident contact immediately to the RN.**

2.How the facility will identify other residents having the potential to be affected by the same deficient practice: **All residents have the potential to be affected by the same deficient practice.**

3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: **All resident that show recurring behaviors of potential abuse will be required to have 1:1 until it is determined that he/she can reside safely in community without one. All resident to resident contact will be reported to the DOH regardless of opinions, proof of injury or significance of contact.**

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of systemic changes: **DON and ED will review the Nursing Notes and Communication logs daily to ensure all Residents Right and Abuse policies are followed.**

The facility will be in compliance on 5/2/22.

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