STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30a002	A. BUILDING: _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF WEST ORANGE	**510 PROSPECT AVENUE WEST ORANGE, NJ 07052**

(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 #: NJ00126902 CENSUS: 54 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30a002	A. BUILDING: _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF WEST ORANGE	510 PROSPECT AVENUE WEST ORANGE, NJ 07052

(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 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00126902
Based on observation, interview and record review it was determined that the Administrator failed to ensure the enforcement of the facility policy titled, "Resident Abuse Policy" for [redacted] of [redacted] residents reviewed, Resident [redacted], Resident [redacted] and Resident [redacted]. This deficient practice was evidenced by the following:

1. On 8/29/19 at 9:45 a.m., the surveyor reviewed the medical record of Resident [redacted] and observed that he/she was admitted to the facility in [redacted] with diagnoses that included [redacted].
Review of the "Progress Notes" (PNs) revealed that on [redacted] Resident [redacted] was found with [redacted]. X-ray results dated [redacted] revealed "A [redacted]." Further review of the PN did not disclose whether the resident had a [redacted] or other incident that would result in a [redacted].

2. At 10:00 a.m., the surveyor reviewed the medical record of Resident [redacted] and observed that he/she was admitted to the facility in [redacted] with diagnoses which included [redacted]. According to the PNs, on [redacted] the resident was observed with [redacted]. X-rays completed on [redacted] revealed an "[redacted]." There was no documentation that the resident sustained a [redacted] or other incident that would result in a [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30a002	A. BUILDING: _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF WEST ORANGE	510 PROSPECT AVENUE WEST ORANGE, NJ 07052

(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 310	Continued From page 2 3. At 10:15 a.m., the surveyor reviewed the medical record of Resident [redacted] and observed that he/she was admitted to the facility in [redacted] with diagnoses which included [redacted]. Further review of the PNs revealed that on [redacted] the resident complained of [redacted] to his/her [redacted]. The surveyor observed an X-ray report of the [redacted] dated [redacted] which documented, "the [redacted] cannot be excluded." There was an [redacted] report also dated [redacted] of the [redacted] which documented, [redacted] but "[redacted]" The surveyor did not observe any documented evidence in the medical record of a fall or injury to the right hand. Surveyor review of the facility policy titled, "Resident Abuse Policy" revealed documented, "All injuries will be investigated by the Registered Nurse and/or the Executive Director to determine whether or not abuse is suspected." Further review of facility records did not reveal documentation that the injuries were investigated by the Executive Director to determine whether abuse was ruled out. At 2:00 p.m., during surveyor interview the Resident Services Coordinator (RSC) stated that he/she conducts interviews with staff when there is an injury of unknown origin; however, he/she was not able to provide documentation that the facility Administrator enforced the "Resident Abuse Policy" and completed an investigation to determine whether abuse was ruled out.	A 310		
A 565	8:36-5.10(a)(3) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034	A 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30a002	A. BUILDING: _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF WEST ORANGE	510 PROSPECT AVENUE WEST ORANGE, NJ 07052

(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 565	Continued From page 3 (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: Complaint #: NJ00126902 Based on interview and record review it was determined that the facility failed to report injuries of unknown origin for suspected abuse to the Department of Health (DOH) for [redacted] of [redacted] residents reviewed, Resident [redacted], Resident [redacted] and Resident [redacted] This deficient practice was evidenced by the following: On 8/29/19 at 9:37 a.m., the Resident Services Coordinator (RSC) provided the surveyor with all the incidents that were reported to the DOH for the past year. A review of the incidents revealed that the facility did not report the following pattern of injuries of unknown origin that occurred in a short period of time to the DOH. 1. On 8/29/19 at 9:45 a.m., the surveyor reviewed the medical record of Resident [redacted] which	A 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30a002	A. BUILDING: _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF WEST ORANGE	510 PROSPECT AVENUE WEST ORANGE, NJ 07052

(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 565	Continued From page 4	A 565		

documented that he/she was admitted to the facility in [redacted] with diagnoses which included [redacted]. Review of the "Progress Notes" (PNs) revealed that on [redacted] Resident [redacted] was found with [redacted]. According to X-rays results the resident had a [redacted]. There was no documentation that the injury had been investigated to rule out abuse.

2. At 10:00 a.m., the surveyor reviewed the medical record of Resident [redacted] and observed that he/she was admitted to the facility in [redacted] with diagnoses which included [redacted]. According to the 8/1/19 PN the resident was observed with [redacted]. [redacted] completed on [redacted] revealed an "[redacted]." There was no documentation in the medical record that the injury had been investigated to rule out abuse.

3. At 10:15 a.m., the surveyor reviewed the medical record of Resident [redacted] and observed that he/she was admitted to the facility in [redacted] with diagnoses which included [redacted]. Further review of the PNs revealed that on [redacted] the resident complained of pain to his/her right hand. The surveyor observed an X-ray report of the [redacted] dated [redacted] which documented, "the presence of [redacted] cannot be excluded." Additionally, there was an X-ray report also dated [redacted] of the [redacted] which documented, [redacted] however there was [redacted]." The surveyor did not observe any documented evidence in the medical record that the injury had been investigated to rule out abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30a002	A. BUILDING: _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF WEST ORANGE	**510 PROSPECT AVENUE WEST ORANGE, NJ 07052**

(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 565	Continued From page 5 At 2:00 p.m. the RSC confirmed that the [redacted] sustained by Resident [redacted], Resident [redacted] and the [redacted] sustained by Resident [redacted] were not reported to the DOH although abuse had not been ruled out by the investigation.	A 565		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
30a002 Y1	A. Building B. Wing Y2	10/11/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF WEST ORANGE	510 PROSPECT AVENUE WEST ORANGE, NJ 07052

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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 09/30/2019	ID Prefix A0565 Reg. # 8:36-5.10(a)(3) LSC	Correction Completed 09/30/2019	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
8/29/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: F9C612

Arden Courts
Memory Care Community

Kristin Moran, Administrator
Arden Courts of West Orange
510 Prospect Avenue
West Orange, NJ 07052

September 30, 2019

Complaint Survey visit Plan of Correction

Tag A310

- How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: All residents will be ensured the development, implementation, and enforcement of all policies and procedures, including resident rights;
- How the facility will identify other residents having the potential to be affected by the same practice: All residents have a potential to be affected.
- What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Executive Director, and Resident Services Coordinator have been educated to follow the enforcement of the facility policy entitled, “Resident Abuse Policy” as deemed necessary to rule out any abuse after investigation is done for an injury of unknown origin. All staff in-serviced on the facility policy entitled, “Resident Abuse Policy.” All staff in-serviced on the state regulation pertaining to abuse reporting.
- 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 the systemic change: Executive Director and/or Resident Services Coordinator will monitor all occurrences or injuries of unknown origin and to follow the “Resident Abuse Policy” as deemed necessary to rule out any abuse. Occurrences or injuries of unknow origin will be reviewed during the daily morning meeting to ensure timely and required follow up actions occur.

Timeframe in place is immediately 9/30/2019 and on-going.

Tag 565

- How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: All residents will be ensured the facility will notify the Department of Health immediately by telephone at 609-633-9034 or (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the

following: Injuries of unknown origin and 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

- How the facility will identify other residents having the potential to be affected by the same practice: All residents have a potential to be affected.
- What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Executive Director, Resident Services Coordinator and all staff have been educated to ensure and enforce the facility will notify the Department of Health immediately by telephone at 609-633-9034 or (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: Injuries of unknown origin and 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.
- 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 the systemic change: Executive Director and/or Resident Services Coordinator will monitor notifications to the New Jersey Department of Health on all occurrences of injuries of unknown origin daily or weekly as needed and reviewed during daily morning meeting to ensure timely and required follow up actions occur.

Timeframe in place is immediately 9/30/2019 and on-going