New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	**1674 DELSEA DRIVE DEPTFORD, NJ 08096**

(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
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM	H5790		

A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined that the facility failed to retain a completed copy of the Universal Transfer Form (UTF) in the medical records for 3 of 3 residents reviewed, Resident [redacted] and [redacted]. This deficient practice was evidenced by the following:

1. On 12/8/21 at 11:05 a.m., the surveyor reviewed Resident [redacted]'s closed medical record which revealed that the resident's move-in date was [redacted] with diagnoses which included [redacted] [redacted]).

The "Incident Report" (IR) dated [redacted] at 12 a.m. revealed that the resident was found on the floor and Resident [redacted] stated that he/she rolled out of bed. The CMA documented that the resident complained of [redacted] and was not touched or moved from the floor.

The hospital "Discharge Instruction (Patient)" dated [redacted] revealed that the resident

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

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H5790	Continued From page 1	H5790		

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Further surveyor review of the medical record failed to provide documented evidence that a Universal Transfer Form (UTF) was completed for Resident when the resident was transferred to the hospital on after a fall.

At 1:20 p.m., during interview with the Executive Director (ED), the surveyor requested the resident's UTF when the resident was transferred to the hospital related to fall with injury. The ED stated that she was not sure if the form was completed at the time of the resident's transfer and agreed that the form should have been completed and sent out with the resident.

Surveyor review of the "Resident Incident Procedure for Care Partners" provided by the ED revealed, "If the resident is being sent to the hospital, ... The universal transfer form must be completed and a copy must be made and left in the chart before the resident leaves the community."

2. On 12/8/21 at 10:30 a.m., the surveyor asked the Certified Medication Aide (CMA) if any residents were transferred to the hospital. The CMA replied that Resident returned from the hospital on

The surveyor reviewed the medical record (MR) of Resident who had a diagnosis which included
. The surveyor reviewed the "Nursing Progress Note (NPN)" written,
which revealed that the resident complained of a medication reaction and was transferred to the hospital and returned to the

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H5790	Continued From page 2 facility that same day. The surveyor did not observe a copy of the UTF for or in the MR. On 12/8/21 at 11:00 a.m., the surveyor interviewed Resident who stated that he/she had gone out to the hospital on and returned to the facility the same day. The resident also stated that he/she was transferred to the hospital on with complaints of and returned to the facility that same day. The resident provided the surveyor with copies of the hospital discharge instructions dated which revealed a diagnosis of an . On 12/8/21 at 2:00 p.m., the surveyor interviewed the CMA who stated that the facility did not always keep a copy of the UTF in the residents MR. On 12/8/21 at 3:00 p.m. the surveyor interviewed the Executive Director who stated that the facility should have retained a copy of the UTF in the residents' MR when the resident [Resident] was transferred to the hospital. 3. On 12/7/21 at 11:00 a.m., the surveyor reviewed the medical record of Resident which showed that Resident moved into the facility on with diagnoses which included . Further review of Resident 's medical record identified on the "Incident Report" (IR) that Resident had a fall on time uncertain (8 a.m.), was found on the floor and was sent to the hospital. However, the surveyor did not observe a copy of the Universal Transfer Form (UTF) in Resident	H5790		

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H5790	Continued From page 3 s medical record or documentation that Resident had been transferred to the hospital. On 12/8/21 at 10:25 a.m., the surveyor observed Resident asleep in bed with the bed in the low position and a positioned on the floor next to the bed. The surveyor was unable to interview Resident On 12/8/21 at 12:40 a.m., the surveyor interviewed the Home Health Aide (HHA) who explained that she was not aware of Resident having been transferred to the hospital and that the usually provided care to the resident. On 12/8/21 at 12:45 a.m., the surveyor interviewed the who informed the survey that she performed care for Resident but was not aware of any transfers or hospitalizations for Resident On 12/8/21 at 1:00 p.m., the ED informed the surveyor that Resident had been transferred to the hospital for a change in medical condition and then returned to the facility after rehab. However, the ED failed to confirm the date of transfer and failed to provide a UTF or documentation regarding such transfer.	H5790		
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint Revised report for A-0779 COMPLAINT #: NJ 00150473 CENSUS: 43	A 000		

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A 000	Continued From page 4 SAMPLE SIZE: 12 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; This REQUIREMENT is not met as evidenced by:	A 310		

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A 310	Continued From page 5	A 310		

Complaint #: NJ00150473

Based on interview and record review it was determined that the facility's Executive Director (ED) failed to enforce the policies and procedures of the facility for the following:

"Resident to Resident Abuse"- to conduct an investigation of the suspected resident to resident physical altercation that occurred on [redacted] for [redacted] of [redacted] residents reviewed, Resident [redacted] and [redacted].

"Personal care and assistance" -to conduct a General Service Plan (GSP) or Health Service Plan (HSP) with quarterly updates or as needed for residents experiencing a change in condition for [redacted] residents whose medical record was reviewed for having a GSP or HSP, Resident [redacted] [redacted]

failed to have a Registered Nurse (RN) available at all times on [redacted].

The deficient practice was evidenced by the following:

1. On 12/9/21 at 10:45 a.m., the surveyor observed Resident [redacted] sitting on a couch in his/her room watching television. The surveyor observed the resident to be oriented. According to the medical record, the resident move-in date was [redacted] with diagnoses which included [redacted] and [redacted]

During interview, the surveyor inquired of Resident [redacted] if the resident had any incident with another resident or staff member. The resident stated that he/she could not recall and denied being hit by Resident [redacted] or anyone at the facility.

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A 310	Continued From page 6 At 1:45 p.m., Resident [redacted] was observed outside the building sitting in his/her wheelchair. The surveyor observed the resident to be [redacted] and [redacted] and [redacted]). According to the "Face Sheet", the resident was admitted to the facility [redacted] with diagnoses which included [redacted] of the [redacted]. The surveyor interviewed Resident [redacted] and inquired from the resident if he/she recalled any incident with another resident. Resident [redacted] denied any incident with any resident. Surveyor review of the "Incident Report: Unusual occurrence" dated [redacted] and signed by a Registered Nurse (RN) revealed, "While leaving dining Room [Resident [redacted]] was blocking [Resident [redacted]] way to his/her room. When [Resident [redacted]] asked [Resident [redacted]] to please move [Resident [redacted] was swinging back hitting [Resident [redacted]." On 12/10/21 at 11:15 a.m., the surveyor interviewed the ED regarding the above incident. The ED stated that she was not made aware of the incident and was not getting the reports. The ED explained that she found out about the incident of resident to resident physical abuse when the ombudsman was in the building last week [[redacted]]. Surveyor review of the policy and procedure titled, "Resident to Resident Abuse" indicated, "House Manager/Executive Director or Designee is to complete an Investigation Report, including witness statements and forward to RDO and Risk Management RN within 24 hours."	A 310		

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A 310	Continued From page 7	A 310		

2. On 12/7/21 at 11:00 a.m., the surveyor reviewed the Medical Record (MR) of Resident [redacted] who moved into the facility [redacted] with a diagnosis which included [redacted]. The surveyor reviewed the "Progress Notes" (PNs) written [redacted] at 1:41 p.m., which revealed, "Late Entry for [redacted] 9:30 AM: ...resident was found on the floor by bedside." The surveyor reviewed the "General Service Plan" (GSP) dated [redacted] and did not observe any updates or interventions for falls.

3. On 12/8/21 at 10:30 a.m., the surveyor reviewed the MR of Resident [redacted] who moved into the facility in [redacted] with diagnosis which included [redacted] Surveyor review of a document titled, "INCIDENT REPORT" dated [redacted] at 12:30 p.m., revealed Resident [redacted] was "found on the floor...yelling...refused to go to the hospital no injuries." The surveyor reviewed the GSP dated [redacted] and [redacted] and did not observe any updates or interventions for falls.

4. On 12/8/21 the surveyor reviewed the MR of Resident [redacted] and observed that he/she moved into the facility in [redacted] with diagnoses which included [redacted].

On 12/8/21 at 10:30 a.m., the surveyor interviewed the Certified Medication Aide who told the surveyor that Resident [redacted] returned from the hospital with an [redacted]

On 12/8/21 at 11:00 a.m., the surveyor interviewed Resident [redacted] who stated that while in the hospital on [redacted], he/she received a [redacted] [redacted] because of [redacted].

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A 310	Continued From page 8 On 12/8/21 at 2:00 p.m., the surveyor asked the Executive Director (ED) who was responsible for the development of the HSP and she responded, "the RN." The ED further stated that the RN was available by phone and had not entered the facility to do any assessments. The surveyor reviewed the medical records of Resident [redacted] and did not observe a HSP. On 12/8/21 at 2:15 p.m., the surveyor interviewed the Homemaker Home Health Aide (HHA) who had been responsible for the care of this resident. She told the surveyor that she cared for the resident's [redacted] because she had past experience and if the resident had problems with the [redacted] she would contact the Executive Director who was also a Licensed Practical Nurse. On 12/9/21 at 1:00 p.m., the ED was not able to provide the surveyor with a copy of the training record for the Caregivers providing [redacted] [redacted] care. There were no individualized interventions developed or identified in the resident's HSP to provide directions to the staff for the resident's [redacted] care needs. The surveyor reviewed the policy titled, " Personal care and assistance" which revealed, "Purpose: To ensure each resident receives necessary services while maintaining his or her independence and personal decision making abilities...RN will conduct an initial assessment upon admission and will develop a general service plan or health service plan depending on the individual needs within 14 days...Both general service plans and health service plans will be updated quarterly and as needed based on	A 310		

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A 310	Continued From page 9 changes in the residents' physical or cognitive status." 5. On 12/7/21 at 7:30 the surveyor entered the facility and requested the presence of the RN. At that time the Executive Director (ED) stated that the RN was on vacation and should have returned to the facility today but was ill. On 12/8/21 at 9:00 a.m., the surveyor interviewed the ED requesting the presence of the RN. The ED stated that she was not sure of the status of the RN and that she would reach out to an agency for RN coverage at the facility. Later that day at 3:30 p.m., the ED told the surveyor that she contracted with an RN on [redacted] and that she would be available 24/7 via phone. The ED also stated that the former RN had resigned and that her last day at the facility was [redacted]. The ED acknowledged that the facility did not have RN coverage on [redacted], [redacted] and during the day of [redacted]	A 310		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to maintain documented evidence that Responsible Party	A 615		

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A 615	Continued From page 10 (RP) was notified of fall and change in condition for residents reviewed, Resident and This deficient practice was evidenced by the following: 1. On 12/8/21 at 11:50 a.m., the surveyor reviewed the closed medical record of Resident which revealed that the resident moved into the facility in with diagnoses which included Surveyor review of the "Incident Report" (IR) dated at 11:50 a.m., and completed by a Certified Medical Aide (CMA) identified that the resident fell out of a wheelchair and sustained a According to the CMA's documentation, the resident refused to go to the hospital for evaluation. Further surveyor review of the medical record failed to identify documented evidence that the RP was notified of the fall with injury. At 1:20 p.m., during interview with the Executive Director (ED) regarding the above concern, the ED reported to the surveyor that she had not been made aware of most incidents because the reports were not coming to her. The ED commented that the had probably been notified. 2. On 12/8/21 at 10:30 a.m., the surveyor interviewed the Certified Medication Aide (CMA) who stated that Resident went to the hospital on and returned to the facility the same day with a . On 12/8/21 at 11:00 a.m., the surveyor	A 615		

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A 615	Continued From page 11	A 615		

interviewed Resident who stated that he/she was not able to and wanted to go to the hospital. The resident further stated that he/she was transferred to the hospital via ambulance on and returned to the facility the same day.

On 12/8/21 the surveyor reviewed the medical record (MR) of Resident and observed that the resident moved into the facility in with diagnoses which included The surveyor did not observe any documentation in the MR that the family/responsible party had been notified that the resident was unable to and needed to be transferred to the hospital on

On 12/8/21 at 2:00 p.m. the surveyor interviewed the Executive Director who stated that she was unaware that the family had not been notified when Resident was transferred to the hospital.

On 12/8/21 the surveyor reviewed the facility's policy titled:
"Emergency Medical/Acute illness and Notifications" effective December 2017, which revealed,
"Purpose: To provide adequate response and notifications in resident emergencies including care of residents during periods of acute illness...
Procedure: 6. The resident's family guardian, and/or designated responsible person...shall be notified and this notification is documented in the resident's record...immediately after an occurrence or in the event of the following;
a. Resident acquires an acute illness requiring medical care...The resident is transferred from the facility.

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A 615	Continued From page 12 .	A 615		
A 693	8:36-7.1(a) Resident Assessments and Care Plans (a) Upon admission, each resident shall receive an initial assessment by a registered professional nurse to determine the resident's needs. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00150473 Based on interview and record review it was determined that the facility failed to ensure that an initial assessment was completed by a Registered Nurse (RN) upon a resident's admission to the facility in order to determine the immediate care and assistance needed for [redacted] of [redacted] residents reviewed, Resident [redacted] as evidenced by the following: On 12/8/21 at 11:50 a.m., the surveyor reviewed Resident [redacted]'s closed medical record which revealed that the resident's original move-in date was [redacted] with diagnoses which included [redacted] Four days prior to the resident moving into the facility, a partial assessment was completed by a home care provider that identified the resident required assistance with toileting; at least one person assistance with transferring; hands on assistance with grooming; assistance with dressing; and assistance with the administration	A 693		

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A 693	Continued From page 13 of medications twice a day. The surveyor's continued review of the resident's closed medical record failed to provide documented evidence of an initial assessment by an RN upon admission to the facility in order to develop and implement the necessary intervention(s) to meet the resident's needs. At 1:20 p.m., the surveyor interviewed the Executive Director (ED) regarding the resident's admission to the facility and inquired if an initial assessment had been performed by an RN. The ED stated that the resident was at the facility for a short period of time and was not sure if an initial assessment had been completed by the former RN. The ED failed to provide the surveyor with Resident [redacted]s initial assessment. Surveyor review of the policy and procedure titled, "Personal care and assistance" dated December 2017 revealed: "RN will conduct an initial assessment upon admission, and will develop a general service plan or health service plan depending on the individuals needs within 14 days."	A 693		
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	A 753		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ____ B. WING ____	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

(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 753	Continued From page 14	A 753		

by:
Based on interview and record review it was determined that the facility failed to ensure documented evidence was maintained in residents' medical records for the development and/or revision of the General Service Plan (GSP) and/or Health Service Plan (HSP) for [redacted] of [redacted] residents reviewed, Residents [redacted], [redacted] and [redacted] This deficient practice was evidenced by the following:

1. On 12/8/21 at 9:25 a.m., the surveyor reviewed Resident [redacted] medical record. According to the "Resident Information Sheet," the resident's move in date was [redacted] with diagnoses which included [redacted] [redacted]. The "Progress Notes" (PN) dated [redacted] revealed that the resident was [redacted] and oriented to [redacted] and/or [redacted] and ambulated with an assistive device.

Surveyor review of the "Incident Report" (IR) completed by a Certified Medication Aide (CMA) dated [redacted] at 0730 [a.m. or p.m. not indicated], revealed that the resident had a fall while attempting to "get something" and fell. The resident denied hitting "anything."

The IR completed by a Certified Medication Aide (CMA) dated [redacted] at 7:35 a.m., revealed that the resident fell to the floor while attempting to get out of the bed but had no injuries.

An IR dated 11/16/21 at 5:30 a.m. completed by a CMA revealed that the resident fell while exiting from the bathroom and complained of [redacted] to the [redacted] The PN written by a Licensed Practical Nurse (LPN) at 10:43 a.m. indicated that the resident later complained of [redacted] and [redacted] and was transferred to the hospital at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

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A 753	Continued From page 15 9:30 a.m. The surveyor reviewed the GSP signed and dated [redacted] which failed to provide documented evidence that the GSP had been updated with intervention(s) to address the resident's falls that occurred on [redacted] [redacted] and [redacted]. The surveyor interviewed the Executive Director (ED) and the ED stated that she was not aware the resident's GSP had not been updated. 2. On 12/8/21 at 11:50 a.m., the surveyor reviewed Resident [redacted]'s closed medical record which revealed that the resident's move-in date was [redacted]0 with diagnoses which included [redacted] Surveyor review of the "Incident Report" (IR) dated [redacted] at 11:50 a.m., and completed by a Certified Medical Aide (CMA) revealed that the resident fell out of a wheelchair and sustained a [redacted]. According to the CMA's documentation, the resident refused to go to the hospital for evaluation. The IR dated [redacted] at 12 a.m. revealed that the resident was found on the floor and identified that the resident had rolled out of bed. The CMA documented that the resident complained of [redacted] and was not touched or moved from the floor. The hospital "Discharge Instruction (Patient)" dated [redacted] revealed that the resident sustained "[redacted]." Further review of the resident's medical record	A 753		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

(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 753	Continued From page 16 failed to provide documented evidence that a General Service Plan (GSP) was developed and/or updated with intervention(s) to reflect the resident's needs after having fallen on [redacted] and [redacted] and sustaining [redacted] injuries. At 1:20 p.m., during an interview with the Executive Director (ED) regarding the above concern, the ED stated that if the GSP was not in the medical record, then it probably was not done by the former Registered Nurse (RN). 3. On 12/10/21 at 9:45 a.m., the surveyor reviewed Resident [redacted]'s closed medical record. According to the "Face Sheet," the resident's admission date was [redacted] with diagnosis which included [redacted]. The "Incident Report" dated [redacted] at 8:30 p.m., completed by a Licensed Practical Nurse (LPN) identified that she was alerted by another resident that Resident [redacted] was on the floor crying. The LPN documented that the Resident [redacted] reported that he/she had rolled out of bed. The "Universal Transfer Form" dated [redacted] completed by an Registered Nurse (RN) documented that Resident [redacted] fell and sustained [redacted]. The IRs dated [redacted] at 2:40 p.m. completed by an RN and 7:55 p.m. completed by a Certified Medication Aide revealed that the resident was found on the floor. Both documented that there were no injuries noted. At 10:55 a.m., the surveyor interviewed the Executive Director (ED) and requested the resident's General Service Plan (GSP) for review. The ED told the surveyor that the "Resident	A 753		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	**1674 DELSEA DRIVE DEPTFORD, NJ 08096**

(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 753	Continued From page 17	A 753		

Assessment Evaluation" (RAE) was also the GSP and acknowledged that the resident's RAE had not been updated with interventions to decrease further incidents of falls.

Surveyor review of the policy and procedure titled, "Personal care and assistance" dated December 2017 revealed:
"Both general service plans and health service plans will be updated quarterly and as need based on changes in the residents' physical or cognitive status."

4. On 12/7/21 at 11:00 a.m., the surveyor reviewed the Medical Record (MR) of Resident [redacted] who moved into the facility [redacted] with a diagnosis which included [redacted] The surveyor reviewed the "Progress Notes" (PNs) written [redacted] at 1:41 p.m., which revealed, "Late Entry for [redacted] 9:30 AM: ...resident was found on the floor by bedside." The surveyor reviewed the "General Service Plan" (GSP) dated [redacted] and did not observe any updates or interventions for falls.

5. On 12/8/21 at 10:30 a.m., the surveyor reviewed the MR of Resident [redacted] who moved into the facility in [redacted] with diagnosis which included [redacted] Surveyor review of a document titled, "INCIDENT REPORT" dated [redacted] at 12:30 p.m. revealed Resident [redacted] was "found on the floor...yelling...refused to go to the hospital no injuries." The surveyor reviewed the GSP dated [redacted] and [redacted] and did not observe any updates or interventions for falls.

6. On 12/8/21 the surveyor reviewed the MR of Resident [redacted] and observed that the resident moved into the facility in [redacted] with diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	**1674 DELSEA DRIVE DEPTFORD, NJ 08096**

(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 753	Continued From page 18	A 753		

which included [redacted] and [redacted]

On 12/8/21 at 10:30 a.m., the surveyor interviewed the Certified Medication Aide who told the surveyor that Resident [redacted] returned from the hospital with a [redacted].

On 12/8/21 at 11:00 a.m., the surveyor interviewed Resident [redacted] who stated that while in the hospital on [redacted], he/she received an [redacted] because of [redacted].

On 12/8/21 at 2:00 p.m., the surveyor asked the Executive Director (ED) who was responsible for the development of the Health Service Plan (HSP) and she responded, "the RN." The ED further stated that the RN was available by phone and had not entered the facility to do any assessments. The surveyor reviewed the medical records of Resident [redacted] and did not observe an HSP.

On 12/8/21 at 2:15 p.m., the surveyor interviewed the Homemaker Home Health Aide (HHA) who had been responsible for the care of this resident. The HHA told the surveyor that she cared for the resident's [redacted] because she had past experience with this. She continued to tell the surveyor that if the resident had problems with the [redacted], that she would then contact the Executive Director who was also an Licensed Practical Nurse.

On 12/9/21 at 1:00 p.m., the ED failed to provide the surveyor with a copy of the training record for the Caregivers who rendered [redacted] [redacted]. There were no individualized interventions developed or identified in the resident's HSP to provide directions to the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

(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 753	Continued From page 19	A 753		

Continued From page 19

for the resident's [redacted] care needs.

7. On 12/7/21 at 11:00 a.m., the surveyor reviewed the medical record of Resident [redacted] which identified that the resident moved into the facility on [redacted] with diagnoses which included [redacted] and [redacted].

Surveyor review of the facility document titled "INCIDENT REPORT" (IR) dated [redacted] and at 4:15 p.m. revealed that Resident [redacted] had an unwitnessed fall in which Resident [redacted] "came down to dinner + stated (the resident) fell but got up. [redacted] that is [redacted] to (the resident's) [redacted] Further review of the IR identified the following:

1. On 8/3/21 (uncertain of time), the Resident [redacted] was found on the floor [redacted] and [redacted] and was sent to the hospital.

2. On 8/14/21 (uncertain of time), Resident [redacted] was found on the floor by a [redacted].

3. On 8/21/21 at 5:37 a.m., Resident [redacted] was found on the floor next to bedside.

The surveyor reviewed Resident [redacted]'s General Service Plan (GSP) dated [redacted] and [redacted] and did not observe any updates or interventions for falls.

On 12/7/21 ongoing review of Resident [redacted] medical record showed under the Advanced Nurse Practitioner's (ANP) service report dated [redacted] that Resident [redacted] had a history of [redacted] and was a [redacted].

On 12/8/21 at 12:00 p.m., the Executive Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	**1674 DELSEA DRIVE** **DEPTFORD, NJ 08096**

(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 753	Continued From page 20 (ED) explained to the surveyor that she was not aware of Resident █'s falls and that there was no documentation on falls or interventions to reduce the incidence of falls on Resident █'s GSP. On 12/8/21 at 1:00 p.m., the surveyor reviewed the facility "Policy and Procedure titled: Fall Risk Intervention Guidelines" and listed under Policy: Residents who have been identified as a fall risk upon assessment, returning from hospital, or experienced two (2) falls in one (1) week must have an intervention included on their Wellness Plan and daily task sheets .... Procedure: ...2. Once a resident has been identified as a fall risk, at least two interventions need to be implemented into the Wellness Plan based on the reason for the fall."	A 753		
A 765	8:36-7.4(c)(1) Resident Assessments and Care Plans (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was	A 765		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ____ B. WING ____	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

(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 765	Continued From page 21	A 765		

determined that the Registered Nurse (RN) failed to reassess a resident's change of condition upon return from a hospitalization in order to determine the resident's medical needs for 1 of 12 residents reviewed for care and services, Resident [redacted]
This deficient practice was evidenced by the following:

On 12/8/21 at 10:30 a.m., the surveyor interviewed the Certified Medication Aide (CMA) who stated that Resident [redacted] went to the hospital on [redacted] and returned to the facility the same day with an [redacted].

The surveyor reviewed the medical record of Resident [redacted] and observed that the resident moved into the facility in [redacted] with diagnoses which included [redacted] [redacted] and [redacted]

On 12/8/21 at 11:00 a.m., the surveyor interviewed Resident [redacted] who stated that he/she was not able to urinate and wanted to go to the hospital. The surveyor asked the resident if he/she was seen by the Registered Nurse (RN) and the resident replied, "no." The resident provided the surveyor with copies of the hospital discharge instructions which revealed a diagnosis of an [redacted].

The surveyor did not observe any documentation in the residents medical record that identified that the resident was assessed by the RN upon return from the hospital.

On 12/8/21 at 3:00 p.m., the surveyor interviewed the Executive Director (ED) who stated that Resident [redacted] was not assessed by the RN upon return from the hospital. The ED acknowledged that the resident had a change in condition since

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

(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 765	Continued From page 22 return to the facility with an [redacted] [redacted]. Later the same day at 3:30 p.m., the ED told the surveyor that the facility had contracted with an RN and that she would be available via phone only and would not come into the facility to assess any residents. The ED stated that the RN was on call via phone 24/7 for any emergencies or questions. The ED stated that Resident [redacted] should have been reassessed by an RN.	A 765		
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. This REQUIREMENT is not met as evidenced by: Provisions of Health Care Services Complaint #: NJ 00150473 Based on interview and record review it was determined that the facility failed to notify an Registered Nurse (RN) of incidents of falls and changes in medical condition for 4 of 12 residents reviewed, Residents [redacted] and [redacted]. This deficient practice was evidenced by the following:	A 779		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	**1674 DELSEA DRIVE DEPTFORD, NJ 08096**

(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 779	Continued From page 23 1. On 12/7/21 at 11:15 a.m., the surveyor observed Resident [redacted] in the resident's room lying across the bed with right side of the face down on the bed. The surveyors did not observe [redacted] on the resident's [redacted]. However, Resident [redacted] stated that he/she woke up a few days ago with [redacted] and did not know how it occurred. Resident [redacted] denied any staff and/or resident physical encounter. On 12/8/21 at 9:25 a.m., the surveyor reviewed Resident [redacted]s medical record and according to the "Resident Information Sheet," the resident's move in date was [redacted] with diagnoses which included [redacted] and [redacted]. The "Progress Notes" (PN) dated [redacted] revealed that the resident was [redacted] to [redacted] and [redacted] and ambulated with an assistive device. Surveyor review of the "Incident Report" (IR) completed by a Certified Medication Aide (CMA) dated [redacted] at 0730, revealed that the resident had a fall while attempting to "get something" and denied hitting "anything." The IR dated 11/16/21 at 5:30 a.m., completed by a CMA revealed that the resident fell while exiting from the bathroom and complained of [redacted] [redacted]. The PN written by a Licensed Practical Nurse (LPN) at 10:43 a.m., indicated that the resident later complained of [redacted] and [redacted] and was transferred to the hospital at 9:30 a.m. Surveyor review of the medical record failed to identify documented evidence that an RN was notified on [redacted] and [redacted]1 of the falls in order to assess Resident [redacted] nursing care	A 779		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ___ B. WING ___	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

(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 779	Continued From page 24	A 779		

needs. The resident was later transferred and admitted to the hospital on [redacted]

2. On 12/10/21 at 9:45 a.m., the surveyor reviewed Resident [redacted] closed medical record and according to the "Face Sheet", the resident's admission date was [redacted] with diagnosis which included [redacted]

The "Incident Report" dated [redacted] at 8:30 p.m., completed by a Licensed Practical Nurse (LPN), documented that she was alerted by another resident that Resident [redacted] was on the floor crying. The LPN documented that Resident [redacted] stated that he/she rolled out of bed. The RN was not notified of the [redacted] incident.

During interview with the Executive Director (ED), she acknowledged that the RN was not notified and stated that the RN should had been notified with every incident.

3. On 12/8/21 at 10:30 a.m., the surveyor interviewed the Certified Medication Aide (CMA) who stated that Resident [redacted] went to the hospital on [redacted] and returned to the facility the same day with an [redacted].

On 12/8/21 at 11:00 a.m., the surveyor interviewed Resident [redacted] who stated that he/she was not [redacted] and wanted to go to the hospital. The resident stated that he/she was transferred to the hospital via ambulance on [redacted] and returned to the facility the same day.

On 12/8/21 the surveyor reviewed the medical record of Resident [redacted] and observed that the resident moved into the facility in [redacted] with diagnoses which included [redacted], [redacted] and [redacted] The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ____ B. WING ____	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

(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 779	Continued From page 25	A 779		

surveyor did not observe any documentation in the MRs that the RN was notified of the resident's complained of [redacted] and subsequent transfer to the hospital on [redacted].

The surveyor reviewed the facility's policy titled, "Emergency Medical/Acute illness Notifications" effective December 2017, which revealed: "...Purpose: To provide adequate response and notifications in resident emergencies including care of residents during periods of acute illness... 5. In the event of a medical emergency 911 shall be called immediately. Wellness RN...must be notified."

4. On 12/7/21 at 11:00 a.m., the surveyor reviewed the medical record of Resident [redacted] which identified that Resident [redacted] moved into the facility on [redacted] with diagnoses which included [redacted].

On 12/8/21 at 10:25 a.m., the surveyor observed Resident [redacted] asleep in bed with the bed in the low position and a fall mat placed on the floor next to the bed.

Further review of Resident [redacted]'s medical record, identified on the facility document titled "Incident Report" (IR) that Resident [redacted] had a fall on [redacted] time uncertain (8 a.m.), was found on the floor [redacted] and was sent to the hospital." There was no documentation observed in Resident [redacted] medical record or IR that the Registered Nurse (RN) was notified.

On 12/8/21 at 12:40 p.m., the surveyor interviewed the Home Health Aide (HHA) who explained to the surveyor that if a resident fell, she would notify the nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	**1674 DELSEA DRIVE DEPTFORD, NJ 08096**

(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 779	Continued From page 26 On 12/8/21 at 12:55 p.m., the Executive Director (ED) informed the surveyor that nurses document by exception and there was no other documentation regarding Resident [redacted]s fall incident on [redacted]. On 12/8/21 at 1:30 p.m., the surveyor reviewed the facility policy and procedure titled "Incident Reporting." Listed under Procedure: "...Notifications must be made to RN/DON, MD, and responsible party(s) at time of incident occurrence."	A 779		
A 781	8:36-7.5(d) Resident Assessments and Care Plans (d) The resident's physician or the physician's designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident's physical or cognitive/mental condition and any intervention by the physician shall be recorded. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00150473 Based on interview and record review it was determined that the facility failed to notify the physician of incidents of falls and changes in medical condition for 5 of 12 residents reviewed, Residents #[redacted], and [redacted]. This deficient practice was evidenced by the following: 1. On 12/8/21 at 9:25 a.m., the surveyor	A 781		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	**1674 DELSEA DRIVE DEPTFORD, NJ 08096**

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A 781	Continued From page 27	A 781		

reviewed Resident s medical record and according to the "Resident Information Sheet," the resident's move-in date was with diagnoses which included and . The "Progress Notes" (PN) dated revealed that the resident was alert and oriented to and and ambulated with an assistive device.

Surveyor review of the "Incident Report" (IR) completed by a Certified Medication Aide (CMA) dated at 7:35 a.m., revealed that the resident had a fall while attempting to get out of bed and fell to the floor. The resident sustained no injuries. However, there was no documented evidence in the medical record that the physician was notified of the above incident. There was not documented evidence in the resident's medical record that the physician was notified of the fall on

At 1:45 p.m., during interview with the Executive Director (ED) regarding above concern, she acknowledged that the physician was not notified and stated that the RN should have notified the physician.

2. On 12/8/21 at 11:50 a.m., the surveyor reviewed Resident 's closed medical record which revealed that the resident's move in date was with diagnoses which included

Surveyor review of the "Incident Report" (IR) dated at 11:50 a.m., and completed by a Certified Medical Aide (CMA) revealed that the resident fell out of a wheelchair and sustained a " to the According to the documentation, the resident refused to go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ____ B. WING ____	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

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A 781	Continued From page 28	A 781		

to the hospital for evaluation.

The IR dated [redacted] at 12 a.m., revealed that the resident was found on the floor and identified that the resident had rolled out of bed. The CMA documented that the resident complained of [redacted] and was not touched or moved from the floor.

The hospital "Discharge Instruction (Patient)" dated [redacted] revealed that the resident sustained a [redacted], [redacted] fall. [redacted], [redacted] and [redacted].

Further surveyor review of the medical record failed to identify documented evidence that the physician was notified of the [redacted] and [redacted] incidents with injury and the resident's transfer to the hospital on [redacted].

At 1:20 p.m., during interview with the Executive Director regarding Resident [redacted]'s concern, the ED stated that she was not aware of the incidents and that it was the Registered Nurse's (RN) responsibility to notify all parties of incidents/accidents.

3. On 12/8/21 the surveyor reviewed the medical record (MR) of Resident [redacted] who moved into the facility in [redacted]0 with diagnosis which included [redacted] and [redacted]. Surveyor review of a document titled, "INCIDENT REPORT" (IR) dated [redacted] at 12:30 p.m., revealed that Resident [redacted] was "found on the floor...yelling...refused to go to the hospital no injuries." Further review of the IR revealed that the Physician was not notified that the resident was found on the floor yelling. The surveyor reviewed Resident [redacted] progress notes (PNs) and did not observe any documentation on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	**1674 DELSEA DRIVE DEPTFORD, NJ 08096**

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A 781	Continued From page 29	A 781		

that the Physician was notified that the resident was found on the floor.

4. On 12/8/21 the surveyor reviewed the MR of Resident and observed that the resident moved into the facility in with diagnoses which included and

On 12/8/21 at 10:00 a.m., the surveyor interviewed the Certified Medication Aide (CMA) who stated that Resident was transferred to the hospital for complaints of on and returned to the facility the same day with an .

On 12/8/21 at 11:00 a.m., the surveyor interviewed Resident who stated that he/she went to the hospital on because of a medication reaction and returned to the facility the same day. The resident further stated that on that the resident was transferred to the hospital for and returned to the facility the same day.

The surveyor did not observe any documentation in Resident MR that the Physician was notified that the resident was transferred to the hospital on and .

On 12/8/21 at 3:00 p.m., the surveyor interviewed the Executive Director (ED) who stated that the Registered Nurse should have informed the Physician of the occurrence and documented the occurrence in the residents' MR. The ED further stated that she had not reviewed IRs in the past.

The surveyor reviewed the policy titled, "INCIDENT REPORTING" which revealed, "Notifications must be made to MD and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

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A 781		A 781		

Continued From page 30

responsible party(s)...Progress note to be placed in resident's chart of incident and subsequent outcome."

5. On 12/7/21 at 11:00 a.m., the surveyor reviewed the medical record of Resident [redacted] which showed that Resident [redacted] moved into the facility on [redacted] with diagnoses which included [redacted] and [redacted].

On 12/8/21 at 10:25 a.m., the surveyor observed Resident [redacted] asleep in bed with the bed in the low position and a [redacted] positioned on the floor next to the bed.

Further review of Resident [redacted]'s medical record, showed on the facility document titled "Incident Report" (IR) that Resident [redacted] had a fall on [redacted] time uncertain (8 a.m.), was found on the floor [redacted] and was sent to the hospital. There was no documentation observed in Resident [redacted]s medical record or IR that the Medical Doctor (MD) was notified.

On 12/8/21 at 11:25 a.m., surveyor interviewed with the ED who explained that there was no documentation recorded in the electronic medical record for Resident [redacted] regarding falls or MD notification.

On 12/8/21 at 1:30 p.m., the surveyor reviewed the facility policy and procedure titled "Incident Reporting." Under Procedure:
...Notifications must be made to RNDON, MD, and responsible party(s) at time of incident occurrence. ...Progress note to be Documented in EMAR of incident and subsequent outcome."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

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A 793	Continued From page 31	A 793		
A 793	8:36-8.2 Nursing Services A facility shall have at least one registered professional nurse available at all times. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00150473 Based on observation and interview, it was determined the facility failed to ensure a Registered Professional Nurse (RN) was available to the facility at all times. The facility failed to have an RN available from 12/6/21 through 12/8/21. This deficient practice was evidenced by the following: On 12/7/21 at 7:30 a.m., the surveyor entered the facility and requested the presence of the RN. At that time the Executive Director (ED) stated that the RN was on vacation and should have returned to the facility today but was ill. On 12/8/21 at 9:00 a.m., the surveyor interviewed the ED requesting the presence of the RN. The ED stated that she was not sure of the status of the RN and that she would reach out to an agency for RN coverage at the facility. Later that day at 3:30 p.m., the ED told the surveyor that she contracted with an RN on 12/8/2021 and that she would be available 24/7 via phone. The ED also stated that the former RN had resigned and that her last day at the facility was 12/5/21. The ED acknowledged that the facility did not have RN coverage on 12/6/21, 12/7/21 and during the day of 12/8/21.	A 793		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

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A1011	Continued From page 32	A1011		
A1011	8:36-11.7(k) Pharmaceutical Services (k) Controlled dangerous substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts, N.J.S.A. 24:21-1 et seq. and all other Federal and State laws and regulations concerning the procurement, storage, dispensation, administration, and disposition of same. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation and policy, it was determined that the facility failed to ensure that the Controlled Substances shift-to-shift signature log used to ensure accountability of controlled substances was conducted according to facility policy on 2 of 2 sampled medication Carts. This deficient practice was evidenced by the following: 1. On 12/7/21 at 8:59 a.m., following a narcotic count with CMA #1, the surveyor reviewed the "Controlled Substance/MAR Change of Shift Audit" maintenance record for Medication Cart █. Upon review, the surveyor noticed that there was no "off going signature" for 12/7/21. Further review showed that there were thirty-five missing on coming and off going signature blanks from 9/29/21 to 12/7/21. Following review of the narcotics maintenance record, the surveyor asked the Certified Medication Aide (CMA #1) what the procedure was for shift-to-shift Controlled substance counts. CMA #1 explained to the surveyor that the	A1011		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	**1674 DELSEA DRIVE DEPTFORD, NJ 08096**

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A1011	Continued From page 33	A1011		

oncoming staff member performed a count of each controlled substance with the outgoing staff member on all shifts and then both staff members wrote their signature to confirm that the count was performed and correct. Further, CMA #1 informed the surveyor that sometimes staff forget to sign.

2. On 12/7/21 at 12:00 p.m., the surveyor reviewed the "Controlled Substance/MAR Change of Shift Audit" maintenance record for Medication Cart ██ which also showed missed signatures for oncoming and outgoing controlled substance count. Further surveyor review identified fifty oncoming and outgoing missed staff member signatures from 10/15/21 to 12/7/21.

The surveyor asked CMA #2 to explain the procedure for Controlled Substance counts and CMA #2 informed the surveyor that staff coming on duty count with staff going off duty "and then we sign off" indicating the narcotic count was correct. Also, CMA #2 informed the surveyor that staff forget to write their signature.

3. On 12/7/21 at 12:40 p.m., the ED explained that the Registered Nurse was in charge of the CMA's and she was not aware of the missing signatures in the Controlled Substance maintenance record.

On 12/7/21 at 1:30 p.m., the surveyor reviewed the facility policy and procedure titled "Inventory of Controlled Substances" and listed under " ...Procedure: ...2. The Care Partner responsible for medication administration conducts a change of shift count at the beginning and end of each shift:
a. The Care Partner Responsible going off duty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: ____ B. WING ____	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	1674 DELSEA DRIVE DEPTFORD, NJ 08096

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A1011	Continued From page 34 looks at the Declining Inventory Sheet calling the resident name, drug, dose, and count to the oncoming Care Partner Responsible. b. The CMA/Care Partner Responsible coming on duty counts the pills to match with the count by the outgoing. c. Both Care Partners sign the Narcotic Count Sheet. All narcotic logs shall be retained in accordance with State Regulations.	A1011		
A1339	8:36-18.6(a) Infection Prevention and Control Services (a) The facility shall develop policies and procedures for the collection, storage, and handling of regulated medical waste. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00150473 Based on observation, interview, and record review, it was determined that the facility failed to ensure appropriate collection, storage and handling of regulated medical waste as evidenced by the following: On 12/7/21 at 8:15 a.m., during entrance into Building ██, in the vestibule on the right-hand side, the surveyor observed a red bin labeled "Infectious waste. (IW)" dated 1-21-21. The red IW bin contained an overflow of used "COVID-19 Ag CARDs" sticking out of the bin. In addition, the surveyor observed that the IW lid was not secured on top of the bin leaving the medical waste retrievable to passers by. At 10:30 a.m., the surveyor interviewed the	A1339		

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	35a000	A. BUILDING: ______ B. WING ______	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL SENIOR LIVING AT DEPTFORD	**1674 DELSEA DRIVE DEPTFORD, NJ 08096**

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A1339	Continued From page 35 Executive Director (ED) regarding the overflowing IW bin. The ED stated that she was not aware that the IW lid was not secured and overflowing. The ED identified that the RN had been responsible for monitoring the IW bin. The ED informed the surveyor that Maintenance would now be responsible for monitoring and removal of IW. Surveyor review of the "Infection Control Plan" titled, "Infectious Waste/ Medical Waste Disposal" provided by the ED revealed: "Infectious waste destined for disposal will be placed in closeable, leak proof containers or bags."	A1339		