STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30830	A. BUILDING: _____ B. WING _____	C 02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW WOODBURY LAKE	752 COOPER STREET WOODBURY, 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 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00150667, NJ 00150410, NJ 00150534, NJ 00152165, NJ 00152194 CENSUS: 70 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

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined that the Executive Director (ED) failed to follow the facility's policy and procedures to conduct a thorough and complete investigation of an allegation of [redacted] assault by not identifying and assessing all residents that had the potential to be affected, and by not interviewing all staff and residents that may have had knowledge of the allegation, and in not doing so, failed to protect residents from possible continued abuse while the investigation was underway. The New Jersey Department of Health received a Facility Reportable Event (FRE) on [redacted] of an allegation of [redacted] abuse against Resident [redacted], of [redacted] Residents reviewed for abuse. This deficient practice was evidenced by the following:

On 2/10/22 at 10:00 a.m., the surveyor conducted an entrance conference with the ED and requested the investigative report of the allegation of [redacted] abuse concerning Resident [redacted]. The ED stated that on [redacted] at 3:30 p.m., she received a call from the township police and was informed that there was an active investigation of a suspected case of [redacted] assault which involved Resident [redacted]. The ED further stated that while Resident [redacted] was in the hospital, staff identified [redacted]g and ordered an exam by the [redacted] Assault Nurse Examiner (SANE), and it was their professional opinion that Resident [redacted] had been [redacted] assaulted.

The ED also stated that on [redacted] at 8:00 p.m.,

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A 310	Continued From page 2	A 310		

the facility had contractors that worked overnight in the facility to replace carpets during renovations. Further, the ED stated that the renovations at the facility were suspended on [redacted] and remained suspended during the survey. According to the ED, the facility investigation concluded that it was unclear how Resident [redacted] sustained injuries. The surveyor asked the ED if other residents were affected or assessed for any [redacted] or injuries of unknown origin. The ED replied, "no."

The surveyor reviewed the medical records of Resident [redacted], who moved into the facility in [redacted] with diagnosis which included [redacted]. According to a document titled, "Service Plan" dated [redacted] the resident required the assistance of one assist with baths and extensive assistance with dressing and toileting. The surveyor reviewed the "Progress Note" (PN) dated [redacted], timed at 7:56 p.m., which revealed that Resident [redacted] was transferred to the hospital for [redacted].

At 12:10 p.m., on 2/10/22 the surveyor interviewed the Licensed Practical Nurse (LPN) about the allegation of [redacted] abuse against Resident [redacted]. The LPN stated that she was not aware of an active investigation of [redacted] abuse and that the ED and/or the Corporate Nurse (CN) did not ask her any questions in regards to allegation of abuse.

On 2/10/22 at 3:00 p.m., the surveyor interviewed Staff Member (SM #1) who stated that she cared for the Resident [redacted] from [redacted] during the 2:00 p.m. to 10:00 p.m. shift and that she provided incontinence care and did not see any [redacted] areas on the residents'

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A 310	Continued From page 3	A 310		

[redacted]. SM #1 also stated that she was present on [redacted] when the resident was transferred to the hospital, and the resident was transferred to the hospital in a [redacted] because of having had a [redacted] prior to the transfer. SM #1 stated that she and another staff member provided incontinence care.

On 2/11/22 at 4:15 a.m., the surveyor interviewed SM #2 who was a Certified Medication Aide (CMA) and worked on [redacted] from 10:00 p.m. to 6:00 a.m., during the overnight shift while the contractors were at the facility. SM #2 stated that she was unaware of any alleged [redacted] abuse toward any resident. She also stated that the contractors left around midnight on [redacted]. SM#2 also stated that the ED did not interview her regarding any allegation of [redacted] abuse for any resident.

At 12:40 p.m., on 2/11/22 the surveyor interviewed SM #3, who was a facility Home Health Aide (HHA). SM #3 stated that she cared for Resident [redacted] on [redacted] and did not see any [redacted] on the resident. SM #4 further stated that the resident required extensive assistance, including incontinence care, and she did not see any [redacted] on the resident's skin.

At 1:30 p.m., on 2/11/22 the surveyor interviewed the CN and asked if other residents were assessed for [redacted] or injuries. The CN replied, "No." The CN went on to say that the facility was in shock based on the allegations of [redacted] assault against Resident [redacted].

On 2/24/22 the surveyor reviewed the Police report dated [redacted], and titled, "Supplemental Report," which revealed the following: [redacted]

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A 310	Continued From page 4 exam on the victim... advised there was evidence of a [redacted] Assault within the last three days." The surveyor reviewed the facility's policy titled, "Reporting Abuse, Neglect, or Financial Exploitation" which revealed, "...A thorough investigation of all allegations must take place and thorough documentation must be completed by the Executive Director."	A 310		