STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A000	A. BUILDING: _____ B. WING _____	C 10/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EVESHAM	ONE BRENDENWOOD DRIVE VOORHEES, NJ 08043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint and COVID-19 Focused Infection Control COMPLAINT #: NJ00134406 and NJ00136266 CENSUS: 133 SAMPLE SIZE: 1 SURVEY DATE: 10/23/2020 and 10/28/2020 The facility is not in compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs, based on this Complaint Survey. The facility was found to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs, based on this COVID-19 Focused Infection Control Survey. This facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 653	8:36-6.1(a)(6) Resident Care Policies (a) Written resident care policies and procedures shall be established, implemented, and reviewed at intervals specified in the policies and procedures. Each review of the policies and procedures shall be documented. Policies and procedures shall include, but not be limited to, the following:	A 653		

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

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A 653	Continued From page 1 6. Emergency medical and dental care of residents, including notification of the resident's family, guardian, or responsible person, when known, and with the resident's consent, and care of residents during periods of acute illness; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00136266 Based on record review, interviews, and facility policy review, the facility failed to follow their policy to call 911 for emergency transport for one (Resident #1) of one resident who was experiencing a life-threatening emergency. This had the potential to affect all 133 residents who resided in the facility. Findings included: The facility's "Change of Condition" policy, revised 06/2020, documented: " ...Emergent: ... 911 should be called immediately for residents experiencing life-threatening emergencies ..." Resident #1 had been admitted to the facility in [redacted] The resident's diagnoses included [redacted] Resident #1's Personal Service Plan (PSP), dated [redacted] indicated the facility would administer the resident's medication. It indicated she did not require assistance with	A 653		

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A 653	Continued From page 2	A 653		

dressing/grooming, showering/bathing, toileting, or mobility within the facility. The PSP indicated the resident was "not always oriented to time" and the facility was to schedule and coordinate non-facility services (doctor, dentist, lab services) and arrange transportation for those services.

A nurse's progress, dated [redacted] at 5:19 PM, indicated Resident #1 was sent to the hospital for evaluation of a [redacted] It indicated the resident's physician and [redacted] had been notified. Vital signs were indicated as follows: temperature [redacted] degrees Fahrenheit, blood pressure [redacted], respiratory rate [redacted] heart rate [redacted] and pulse oximeter reading [redacted]. The note indicated the resident had no shortness of breath, "or in any form of distress." It indicated the resident was sent to a hospital emergency room for evaluation and the nurse would follow up if the resident would be admitted to the hospital. The note was written by Registered Nurse (RN) #1.

A nurse's progress note, dated [redacted] at 10:32 PM, indicated Resident #1 had been admitted to the hospital with diagnoses of [redacted] The note was written by Licensed Practical Nurse (LPN) #3.

On 10/27/2020 at 11:12 AM, in a telephone interview, ambulance call center representative #1 was asked about the details of the facility's call for transport of Resident #1. She stated the facility called for an emergency transport of the resident on [redacted] at 12:45 PM and was given an estimated time of arrival (ETA) of 90 minutes. She stated an ambulance unit was dispatched at 4:30 PM (3 hours and 45 minutes

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A 653	Continued From page 3	A 653		

after the request), arrived at the facility at 4:54 PM, and arrived at the hospital at 5:19 PM (4 hours and 34 minutes after the emergency transport request).

On 10/27/2020 at 3:12 PM, ambulance call center representative 2 was interviewed by phone regarding the details of Resident #1's transport on [redacted]. She reviewed the call record, verified the above timeline, and stated the facility called them directly and did not use 911. She stated that once the facility was informed of the ETA, they could have called 911 for emergency transport. She stated there was no record the facility had called back to ask about the ambulance's response delay.

On 10/28/2020 at 10:26 AM, the above timeline for the ambulance response was reviewed with the Director of Nursing (DON). When asked if based on the nurse's progress note, was the resident in a life-threatening emergency, she stated, [redacted], it would have been a life-threatening emergency." She further stated the nurse indicated the resident was not in distress. When asked what her expectation was for how this situation should have been managed (monitoring the resident and calling 911), she stated, "I don't know if they called 911. I would have called 911."

On 10/28/2020 at approximately 11:00 AM, RN #1 was interviewed by phone. His progress note, dated [redacted] at 5:19 PM, was read to him. When asked if based on the progress note, was Resident #1 experiencing a life-threatening emergency, he stated, "No. I was there with [him/her] and [his/her] pulse [oximeter reading] was fluctuating. The resident stated [she/he] wasn't in distress or short of breath." The RN

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stated the resident, "just said [she/he] [redacted] He stated he monitored the resident all afternoon in the resident's apartment. RN #1 stated he asked the resident if she/he wanted 911 called and the resident said [she/he] was not having problems.

The following portion of the facility's "Change of Condition" policy was read to RN #1: "911 should be called immediately for residents experiencing life-threatening emergencies." When asked if he had followed the facility's policy, he stated he did not call 911 because "the resident was not in any distress."

On 10/28/2020 at 11:46 AM, in a phone interview, RN #1 was asked if the physician had ordered the resident be transferred by 911. He stated, "No. The physician ordered a transport, but not a 911 transport."

On 10/28/2020 at 12:46 PM, Resident #1's physician was interviewed by phone. She stated she had been notified of Resident #1's condition on [redacted] and knew he/she had [redacted] and was [redacted] When asked if she had ordered the resident to be sent out 911 or just transferred, she stated, "I believe 911. I knew it was at the height of COVID." When asked if she was aware the resident had waited over four hours for transport, the physician stated, "I was aware of the delay and that [RN #1] was with [the resident] and [the resident] wasn't experiencing shortness of breath, had a [redacted] and was stable." When asked if the facility should have sent the resident out 911 or if it was okay to keep the resident at the facility until the ambulance transport arrived, the physician stated she believed the facility had acted appropriately to monitor the resident onsite and not call 911 because the resident was stable

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A 653	Continued From page 5 and the RN had stayed with the resident all afternoon. On 10/28/2020 at 2:50 PM, the DON was interviewed. She was reminded she had stated earlier the resident was experiencing a life-threatening emergency and she would have called 911. The facility's "Change of Condition" policy was read to the DON: "911 should be called immediately for residents experiencing life-threatening emergencies." She was asked if the facility's policy had been followed to call 911 for Resident #1. She stated she was not at the facility at the time, but the RN who was at the facility did not see the resident as being in a life-threatening situation. She stated a person had to take into consideration the RN who was here did not believe the resident was in a life-threatening emergency because of other clinical indicators; the resident was coherent and communicating, had no shortness of breath and no cyanosis. The resident was admitted to the hospital with shortness of [redacted].	A 653		