STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C000	A. BUILDING: _____ B. WING _____	C 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVYSTONE SENIOR LIVING	7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110

(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 #: NJ00180305 CENSUS: 111 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 451	8:36-5.1(c) General Requirements (c) The assisted living residence, comprehensive personal care home, or assisted living program shall provide supervision of self-administration of medications, and administration of medications by trained and supervised personnel, as needed by residents and in accordance with this chapter. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00180305	A 451		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 451	Continued From page 1 Based on interview and record review, it was determined that the facility failed to [NJ Exec Order 26.4b1 redacted] to ensure the safe and accurate [NJ Exec Order 26.4b1 redacted] for 1 of 3 residents reviewed for [NJ Exec Order 26.4b1 redacted] Resident #2. This deficient practice was evidenced by the following: On 12/16/2024 at 10:00 a.m., during a complaint survey, the surveyor interviewed the facility's Director of Nursing (DON) related to a Facility Reportable Event received by the New Jersey Department of Health. During interview the DON stated that on [NJ Exec Order 26.4b1 redacted] at approximately 10:26 p.m., Resident #2 was [NJ Ex Order 26. 4B1 redacted]. At 12:00 p.m., the surveyor reviewed Resident #2's Medical Record (MR), which revealed a document titled, "ADMISSION RECORD," that revealed Resident #2 had [NJ Ex Order 26. 4B1 redacted] The MR also revealed a document titled, "Progress Notes" which, revealed a "Health Status Note" dated [NJ Exec Order 26.4b1 redacted], timed at 8:56 p.m., and documented by the facility's Certified Medication Aide/Tech. The Health Status Note revealed that Resident #2 was [NJ Ex Order 26. 4B1 redacted]. The surveyor also observed in the MR a "Nurse Practitioner Note" dated on [NJ Exec Order 26.4b redacted], at 12:01 p.m., which documented the resident [NJ Ex Order 26 redacted]. However, the surveyor was unable to find additional documentation related [NJ Ex Order 26. 4B1 redacted].	A 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVYSTONE SENIOR LIVING	7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110

(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 451	Continued From page 2 At 12:10 p.m., the surveyor interviewed the facility's DON, who stated that [redacted] Resident #2's [redacted] Resident #2 stating that he/she took [redacted]. In addition, the DON stated that the resident suffered a previous [redacted] earlier in the year but was unsure of the date. In the same interview, the DON stated that Resident #2 continued to [redacted]. At 12:13 p.m., the surveyor interviewed the facility's DON, who stated that Resident #2's ability to [redacted]. The once a month was when the resident turned in his/her empty [redacted] medication supply card to receive a filled supply. In the same surveyor interview, the DON stated that the facility did not have a process or policy to monitor the use of [redacted].	A 451		
A 735	8:36-7.2(e)(1-5) Resident Assessments and Care Plans (e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following: 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for	A 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVYSTONE SENIOR LIVING	7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110

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A 735	Continued From page 3 himself or herself; 3. The specific goals of treatment or services, if appropriate; 4. The time intervals at which the resident's response to treatment will be reviewed; and 5. The measures to be used to assess the effects of treatment. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00180305 Based on interview and record review, it was determined that the facility failed to ensure that a Health Service Plan (HSP) was developed and implemented for a resident individual health care needs related to a history of [redacted] for 1 out of 3 residents reviewed [redacted] Resident #2. This deficient practice was evidence by the following: On 12/16/2024 at 10:00 a.m., during a complaint survey the surveyor interviewed the facility's Director of Nursing (DON) related to a Facility Reportable Event received at the New Jersey Department of Health. During interview the DON stated that on [redacted] at approximately 10:26 p.m., Resident #2 was [redacted]. At 10:23 a.m., the surveyor interviewed the facility's DON who stated that Resident #2's	A 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 735	Continued From page 4 [redacted] on [redacted] was not the [redacted] Resident #2 experienced and that Resident #2 experienced an [redacted] around [redacted]. During continued surveyor interview, the DON stated that an [redacted] was not created for Resident #2 following his/her [redacted]. At 12:00 p.m., the surveyor reviewed Resident #2's Medical Record (MR) which revealed a document titled, "ADMISSION RECORD" that documented Resident #2 had an [redacted]. The MR also revealed a document titled, "Progress Notes" which revealed a "Nurse Practitioner Note" dated on [redacted] at 12:01 p.m., the note revealed that the resident had [redacted]. During continued surveyor MR review, the surveyor was unable to locate a HSP following Resident #2's [redacted]. Surveyor review of an undated facility "Policy and Procedures" titled, "HEALTH CARE SERVICES" revealed, "The assisted living Residence shall assure that the resident receives health care services, as defined at the NJAC 8:36-1.3, under the direction of the registered professional nurse, in accordance with the health care plan...The registered nurse shall be responsible for developing nursing practice policies and procedures and the coordination of all health care services required in the resident's health care plan ...Written policies and procedures shall insure, but not be limited to the following: 1. Assessment of the resident's health care needs will be at least semi-annually, except that those residents who have a care plan shall be reassessed quarterly."	A 735		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVYSTONE SENIOR LIVING	7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110

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OASIS AT THE Crescent

Ivy Stone Senior Living
NJ#15C000
7999 Route 130 North
Pennsauken, New Jersey 08110

Complaint Survey dated 12/16/2024

St- A 451 8:36-5.1(c) General Requirements (c) The assisted living residence, comprehensive personal care home, or assisted living program shall provide supervision of self-administration of medications, and administration of medications by trained and supervised personnel, as needed by residents and in accordance with this chapter.	
1. Immediate Correction of Deficiency	As stated, the DON revoked Resident 2's [redacted]. Currently resident who are [redacted] are only checked once a month at refill time. We immediately put a policy in place to check [redacted] residents bi-weekly.
2. Residents with the potential to be affected	Residents who are considered [redacted] are negatively impacted by this.
3. Measures put in place to ensure the deficient practice will not re-occur	We will be setting up a bi-weekly (every other week) assessment for each [redacted] resident to ensure they are taking their meds as intended and that they understand what each does and the prescribed timing. The assessment will be done by the DON or their designee in the privacy of an office. Nurse Practitioner made aware of discrepancy, needs, recommendations during audit. Residents received notice of new policy). Residents received education on this process of every other week checks. DON or designee were in-serviced on this process to check. Documentation in done currently on paper form.
4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date)	The DON and ADON will do a monthly audit of all self-medicating residents to ensure this is carried out correctly. Any issue will be brought up in weekly Clinicals.
Completion Date	March 15, 2025

St- A 735 8:36-7.2(e) (1-5) Resident Assessments & Care Plans (c) Based on the health care assessment; a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following: 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services, if appropriate; 4. The time intervals at which the resident's response to treatment will be reviewed; and 5. The measures to be used to assess the effects of treatment.	
1. Immediate Correction of Deficiency	This [redacted] and [redacted] care plan did not reflect that. We immediately put into effect that resident with [redacted] their HSP will be updated to reflect details.
2. Residents with the potential to be affected	Residents with a [redacted] could be negatively impacted due to lack of documentation and HSP in place.
3. Measures put in place to ensure the	DON or designee will do an audit of all residents to see who has a [redacted] or an occurrence while residing here and will update/create a HSP to address steps moving

Accepted 2/21/25

OASIS AT THE Crescent

deficient practice will not re-occur	forward. Each HSP will include the residents' preferences and input so we have created a unified goal. Staff will be in-serviced on self-med audits and care plan updates in accordance to events.
4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date)	DON or designee will do monthly audits to make sure we address all residents with a *NJ Ex Order 26. 4B1* [redacted] and will discuss at weekly Clinicals. Any issue found, an evaluation will take place and a plan will be put in place. ED will also be in attendance at monthly Clinicals to oversee.
Completion Date	March 15, 2025

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
15C000 Y1	A. Building B. Wing Y2	2/21/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
IVYSTONE SENIOR LIVING	7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110

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 A0451	Correction	ID Prefix A0735	Correction	ID Prefix	Correction
Reg. # 8:36-5.1(c)	Completed	Reg. # 8:36-7.2(e)(1-5)	Completed	Reg. #	Completed
LSC	03/15/2025	LSC	03/15/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/16/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
15C000 Y1	A. Building B. Wing Y2	2/21/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
IVYSTONE SENIOR LIVING	7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110

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 A0451	Correction	ID Prefix A0735	Correction	ID Prefix	Correction
Reg. # 8:36-5.1(c)	Completed	Reg. # 8:36-7.2(e)(1-5)	Completed	Reg. #	Completed
LSC	03/15/2025	LSC	03/15/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/16/2024	☐ YES ☐ NO