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
	25392	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
V CARE ASSISTED LIVING PROGRAM	2015 FERRY AVENUE CAMDEN, NJ 08104

(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: Initial- 2015 and 2101 Ferry Avenue Camden, NJ 08104 Census: 0 Sample Size: 0 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 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures;	A 517		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/28/25

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A 517	Continued From page 1 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure that 7 of 10 staff members, whose personnel records were reviewed, received the required annual staff education. This deficient practice was evidenced by the following: On 3/5/25 at 9:40 a.m., the owner of the Assisted Living Program (ALP) provided the surveyor with	A 517		

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A 517	Continued From page 2 the personnel records for 10 staff members hired for the ALP. At 9:58 a.m., the surveyor reviewed the personnel files. The review of the personnel files revealed that 7 of the 10 staff members sampled had no documentation for the required, annual staff education. The findings were as follows: 1. 7 of 10 staff members had no documentation for staff education regarding the concepts of assisted living (AL). 2. 7 of 10 staff members had no documentation for staff education regarding dementia. 3. 7 of 10 staff members had no documentation for staff education regarding pain management. At 12:01 p.m., the surveyor interviewed the ALP's consultant and inquired about the missing staff education regarding the AL concepts, dementia, and pain management. The consultant reported that pain management and dementia topics were not included in the annual staff in-service. Furthermore, the consultant stated that the AL concepts were discussed during the in-service; however, the training on the AL concepts was not documented, therefore it could not be confirmed that it was part of the staff education. The surveyor reviewed an undated facility policy titled, "EMPLOYEE PERSONNEL POLICIES" which indicated, " ... PROCEDURE GUIDLINE ... 5. Orientation programs and in-service training classes are conducted to assist employees in understanding our personnel policies and procedures ... 9. Records shall be maintained of each meeting and a copy shall be filed with the administrator ..."	A 517		

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A1517	8:36-23.5(a) Assisted Living Programs (a) The assisted living program provider shall have written policies and procedures for arranging resident transportation to and from health care services provided outside of the program site, and shall provide reasonable plans for security and accountability for the resident and his or her personal possessions. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to develop a policy and procedure for resident transportation as evidenced by the following: On 3/5/25 at 9:50 a.m., the surveyor reviewed the program policy and procedure manual. During review, the surveyor identified that there was no transportation policy and procedure reflected in the manual. At 10:08 a.m., the surveyor interviewed the Administrator and Owner regarding resident transportation procedure. The Owner stated that the facility did not have a contracted transportation service. The Administrator stated that the program provided residents with help arranging transportation to medical appointments and shopping through various public transportation services. At 11:08 a.m., the surveyor requested a copy of the transportation policy and procedure from the Administrator and Owner. At 12:56 p.m., the Owner stated that the facility did not have a transportation policy.	A1517		

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A1527	8:36-23.6(a)(4) Assisted Living Programs (a) The assisted living program provider and each program site shall conspicuously post a notice that the following information is available to residents and the public at the program site and at the assisted living program provider's main office during normal business hours: 4. Business hours and telephone number of the assisted living program provider main office; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the Administrator failed to ensure that the program business hours and main office phone numbers were posted at each program site as evidenced by the following: On 3/5/25 the Department of Health conducted an initial inspection of the program site. According to the submitted application the facility requested licensure approval for the opening of a main office building 2015, and a second program site building 2101. At 2:29 p.m., the surveyors toured building 2101 in the company of the Owner and Administrator. Upon entrance to the building, the surveyor observed that there was no signage or postings to reflect that the building was a program site. At 2:33 p.m., the surveyor interviewed the Owner in the presence of the Administrator regarding the signage and postings and set up for the 2101 building. The Owner stated that they have an area in the building where they can post signage.	A1527		

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A1527	Continued From page 5 At 2:35 p.m., the Owner showed the surveyor a building owned social worker office with a window area for postings. The surveyor observed that there was no program set up in the office, no postings related to the program, and no business hours of operation posted.	A1527		
A1529	8:36-23.6(a)(5) Assisted Living Programs (a) The assisted living program provider and each program site shall conspicuously post a notice that the following information is available to residents and the public at the program site and at the assisted living program provider's main office during normal business hours: 5. The toll-free hot line number of the Department; telephone numbers of county agencies dealing with senior service issues; and the telephone number of the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly; This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the program Administrator failed to ensure that the Department of Health (DOH) and Ombudsman (OMB) telephone numbers were posted and available to residents at each program site as evidenced by the following: On 3/5/25 the Department of Health conducted an initial inspection of the program site. According to the submitted application the facility requested licensure approval for the opening of a main office building 2015, and a second program site	A1529		

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A1529	Continued From page 6 building 2101. At 2:29 p.m., the surveyors toured building 2101 in the company of the Owner and Administrator. Upon entrance to the building, the surveyor observed that there was no signage or postings to reflect that the building was a program site. In addition, the surveyor observed that there was no designated area for signage and posting of the DOH and OMB phone numbers made available for use by residents who required assistance. During tour of building 2102, the surveyor interviewed the owner regarding program setup and posting area. The Owner stated that when residents were admitted to the program then building 2101 program site would be setup and have all required postings. Reference: A1527, 8:36-23.6(a)(4)	A1529		
A1531	8:36-23.6(a)(6) Assisted Living Programs (a) The assisted living program provider and each program site shall conspicuously post a notice that the following information is available to residents and the public at the program site and at the assisted living program provider's main office during normal business hours: 6. The names of, and a means to formally contact, the administration of the assisted living program provider. This REQUIREMENT is not met as evidenced by:	A1531		

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A1531	Continued From page 7 Based on observation and interview it was determined that the program Administrator failed to ensure a notice with contact name and phone numbers for administration staff was posted and available at each program site as evidenced by the following: At 2:29 p.m., the surveyor toured the second building 2101 program site for licensure approval. During the tour, the surveyor did not observe any signage or notice posted with the Administrator's name or contact information. At 2:33 p.m., the surveyor interviewed the Owner in the presence of the Administrator regarding the program postings. The Owner stated that when residents were admitted to the program then all mandatory signage would be posted. Reference: A1527, 8:36-23.6(a)(4), A1529, 8:36-23.6(a)(5)	A1531		
A1589	8:36-23.13(d)(2) Assisted Living Programs (d) For those residents who do not self-administer medications, the assisted living program shall provide an appropriate and safe medication storage area, either in a common area or in the resident's housing unit, for the storage of medication. 2. The common storage area shall be used only for the storage of medications and medical supplies. This REQUIREMENT is not met as evidenced	A1589		

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A1589	Continued From page 8 by: Based on interview and observation, it was determined that the facility failed to ensure appropriate and safe medication and medical supplies storage in a common area at the facility. On 3/5/25, the survey team conducted an initial survey for an Assisted Living Program (ALP) that would be in two buildings: Building #1 and #2 which share the same parking lot. At 9:05 a.m., the surveyors entered Building #1, where the ALP's Main Office is located. At 9:23 a.m., the surveyors interviewed the ALP's owner and inquired about the layout of the ALP between the two buildings. The owner stated that Building #1 had 50 apartments and Building #2 had 86 apartments that would be eligible for the ALP, once approved. At 2:29 a.m., the surveyors toured Building #2 with the owner and the ALP's Administrator. The surveyor observed that there was no secure medication storage area, or a medication fridge located in Building #2. At 2:30 a.m., the surveyor interviewed the owner and inquired about where the medication storage was for the ALP in Building #2. The owner stated that there was no medication fridge or medication cart in Building #2 at the time of the survey. The surveyor reviewed an undated facility policy titled, "MEDICATION STORAGE IN THE ASSISTED LIVING FACILITY" which indicated, "POLICY Medications are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier, in accordance with federal and state laws and	A1589		

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A1589	Continued From page 9 regulations. PROCEDURE GUIDELINE 1. The medication supply and medication storage areas are accessible ONLY to authorized personnel ..."	A1589		

POC #2 received 4/15/25
Accepted 4/17/25

[redacted]

V Care Assisted Living Program **Plan of Correction**
Identification Number 25392
2015 and 2101 Ferry Ave.
Camden, NJ 08104

Initial Survey dated 03/05/2025
Date Plan of Correction submitted 03/21/2025

St. A 517-8:36-5.6(b)(1-7) Failure to ensure all staff members received the required annual staff education with supporting documentation in each employee file on all required topics including ..."concepts of assisted living", "dementia" and "pain management".

1. How corrective plan will be accomplished for those residents found to be affected by deficient practice.
As this was an initial survey and there are currently no residents in the program, no residents were affected.

2. How will the program identify residents with the potential to be affected.
Once the program is approved, opened, and has admitted residents, the mandatory education inservices provide important information that all potential residents would be affected by.

3. Measures put in place to ensure the deficient practice will not re-occur.

- Both orientation and annual education outlines will specifically include overview concepts of Assisted Living, care of the resident with Alzheimers and related dementias, and pain management.
- Detailed inservices will be created to ensure consistency of content.
- Documentation of inservices attended will be present in each active employee file.

All in service's were completed on 04/04/2025 with 100% compliance.

4. How will the program monitor that the practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date.)

- Monitoring will be ongoing by use of spreadsheet and reviewed every 6 months.
- Person Responsible will be Director of Nursing (DON) or designee.

Completion date: 04/04/25

Accepted 4/17/25 [redacted]

St. A 1517-8:36-23.5(a) Failure of program to have written policy and procedure for arranging resident transportation to and from health care services provided outside the program site and shall provide reasonable plans for security and accountability for the resident and his or her personal possessions.

.1 How corrective plan will be accomplished for those residents found to be affected by deficient practice.
As this was an initial survey and there are currently no residents in the program, no residents were affected.

2. How will the program identify residents with the potential to be affected.
Once the program is approved, opened, and has admitted residents, all residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not re-occur.

- Transportation policy and procedure was drafted to include stipulation that driver or aide safely mobilize resident into health provider office waiting room where staff can monitor resident and personal possessions for security and safety. Policy draft was submitted to program executive committee as of March 17, 2025.
- Transportation policy and procedure was adopted at V Care Assisted Living Program as of March 20, 2025.
- Policy and procedure will be reviewed with the Administrative Assistant, Director of Nursing (DON) or designee who may be involved with securing transportation for a program resident.

4. How will the program monitor that the practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date.)

- Each transport will use the form in the adopted Transportation policy and procedure, allowing no less time than 72 hours for transportation to be arranged.
- Review will be quarterly (once first transport is arranged) of each Transport Form for completeness, initialed by DON or designee.
- Person responsible is the DON or designee.

Completion date: 04/04/25 Accepted 4/17/25 [redacted]

St. A 1527-8:36-23.6(a)(4) Failure to ensure that signage of business hours and main business phone numbers were available to residents and the public posted at each program site.

1. How corrective plan will be accomplished for those residents found to be affected by deficient practice.
As this was an initial survey and there are currently no residents in the program, no residents were affected.

2. How will the program identify residents with the potential to be affected.
Once the program is approved, opened, and has admitted residents, all residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not re-occur.
Signage of business hours and main business phone numbers are available to residents and the public posted at each program site.

4. How will the program monitor that the practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date.)

- All signage will be posted in a permanent manner.
- Person responsible: Administrator

Completion date: 03/14/25 Accepted 4/17/25 [redacted]

St. A 1529-8:36-23.6(a)(5) Failure to ensure that signage indicating building was a program site, that Department of Health (DOH) and Ombudsman (OMB) phone numbers were posted and available to the residents at each program site.

1. How corrective plan will be accomplished for those residents found to be affected by deficient practice.
As this was an initial survey and there are currently no residents in the program, no residents were affected.

2. How will the program identify residents with the potential to be affected.
Once the program is approved, opened, and has admitted residents, all residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not re-occur.

- Signage with Program name is posted at each of the building sites.
- Department of Health and Ombudsmen phone numbers are posted for residents and the public in a permanent manner at each of the building sites.

4. How will the program monitor that the practice is being corrected and will not re-occur? (Including frequency of monitoring, person responsible, and a completion date.)

- Signage is posted in a permanent manner.
- Person responsible: Program administrator

Completion date: 03/14/25 Accepted 4/17/25 [redacted]

St. A 1531-8:36-23.6(a)(6) Failure to ensure that a notice of name of administrator and phone number were posted at each program site to residents and public during normal business hours.

1. How corrective plan will be accomplished for those residents found to be affected by deficient practice.
As this was an initial survey and there are currently no residents in the program, no residents were affected.

2. How will the program identify residents with the potential to be affected.
Once the program is approved, opened, and has admitted residents, all residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not re-occur.
Name of Program administrator and contact information will be posted permanently at each site.

4. How will the program monitor that the practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date.)

- Administrator name and contact info will be posted permanently at each site.
- Responsible person: Program Administrator

Completion date: 03/14/25

Accepted 4/17/25 [redacted]

St. A 1589-8:36-23.13(d)(2) Failure to ensure appropriate and safe medication and medical supply storage container or refrigerator at each site.

1. How corrective plan will be accomplished for those residents found to be affected by deficient practice.
As this was an initial survey and there are currently no residents in the program, no residents were affected.

2. How will the program identify residents with the potential to be affected.
Once the program is approved, opened, and has admitted residents, all residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not re-occur.

- A secure medication storage cart was set up in building 2. A cart was present in building 1.
- A medication refrigerator was installed in building 2. A medication refrigerator was present in building 1.

4. How will the program monitor that the practice is being corrected and will not re-occur? (Including frequency of monitoring, person responsible, and a completion date.)

- The medication storage cart and refrigerator are permanent parts of the building site and will remain at each site.
- Person responsible: Program Administrator.

Completion date: 03/14/25 Accepted 4/17/25 NJ Ex Order 26.4(b)

Program Administrator Signature:_____

Name of Program Administrator: NJ Ex Order 26.4(b)(1) L.P.N., CALA

Date: March 21, 2025

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
25392 Y1	A. Building B. Wing Y2	4/17/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
V CARE ASSISTED LIVING PROGRAM	2015 FERRY AVENUE CAMDEN, NJ 08104

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 A0517	Correction	ID Prefix A1517	Correction	ID Prefix A1527	Correction
Reg. # 8:36-5.6(b)(1-7)	Completed	Reg. # 8:36-23.5(a)	Completed	Reg. # 8:36-23.6(a)(4)	Completed
LSC	04/04/2025	LSC	04/04/2025	LSC	03/14/2025
ID Prefix A1529	Correction	ID Prefix A1531	Correction	ID Prefix A1589	Correction
Reg. # 8:36-23.6(a)(5)	Completed	Reg. # 8:36-23.6(a)(6)	Completed	Reg. # 8:36-23.13(d)(2)	Completed
LSC	03/14/2025	LSC	03/14/2025	LSC	03/14/2025
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	
3/5/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO