STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25a002	A. BUILDING: _____ B. WING _____	C 04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING OAK ASSISTED LIVING AT VINELAND	1611 SOUTH MAIN ROAD VINELAND, NJ 08360

(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: Complaint #: NJ00163251 Census: 110 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 449	8:36-5.1(b) General Requirements (b) The assisted living residence or comprehensive personal care home shall be capable of providing at least the following services: assistance with personal care, nursing, pharmacy, dining, activities, recreational, and social work services to meet the individual needs of each resident. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00163251	A 449		

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A 449	Continued From page 1	A 449		

Based on interview and record review it was determined that the facility's administration failed to meet the social work service needs for 1 of 3 sampled residents, Resident #2. This deficient practice was evidenced by the following:

Review of Resident #2's medical record revealed that Resident #2 had an admission date of NJ Exec Order 26.4b1 and diagnoses which include NJ Exec Ord [redacted] The surveyor reviewed a facility document titled "General Service Plan" dated NJ Exec Order 26.4b1 which revealed that Resident #2 was NJ Exec Order 26.4b1 [redacted].

The facility reported event was reported on NJ Exec Order 26.4b due to the resident being served a NJ Exec Order 26.4b1. Resident #2 was being NJ Exec Order 26.4b1 from the facility due to NJ Exec Order 26.4b1 with the facility's NJ Exec Order 26.4 policy.

On 4/11/2023 at 3:24 p.m., during surveyor interview with the Director of Nursing (DON) and Executive Director (ED) it was revealed that the facility did not have a contract with a social worker or a staff social worker available to provide services for Resident #2.

Review of facility document titled "Observations...", it was revealed that on NJ Exec Order 26.4b1, Resident #2 was found to be NJ Exec Order 26.4b1 in his/her room. On NJ Exec Order 26.4b1, administration spoke to Resident #2 after staff reported the NJ Exec Order 26 [redacted] coming from his/her room. Resident #2 admitted to NJ Exec Order 26.4 in his/her apartment. Administration also found NJ Exec Order 2

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A 449	Continued From page 2 NJ Exec Order 26.4b1 . On NJ Exec Order 26.4b1, staff entered Resident #2's room and found NJ Exec Order 26 , along with NJ Exec Order 26.4b1 in a cup on the resident's table. On NJ Exec Order 26.4b1 a Managed Risk Agreement (a document that provides the resident with clear, understandable information about the possible consequences of his/her choice/actions) was put in place. On NJ Exec Order 26.4b , housekeeping staff identified NJ Exec Order 26.4b1 on the residents' carpet and NJ Exec Orde on Resident #2's toilet seat. The DON and ED stated that a meeting was held with Resident #2's family regarding finding NJ Exec Order 26.4b1 for Resident #2, due to NJ Exec Order 26.4b1 with the facility's policy and procedure titled "Smoking", which states: "1, Smoking is not permitted in any areas inside the community, including resident apartment." ... The facility failed to provide social work services to assist Resident #2 and family find NJ Exec Order 26.4b for resident.	A 449		
A1401	8:36-21.1(b)(4) Quality Improvement (b) Quality improvement activities shall include, but not be limited to, the following: 4. Evaluation of resident care services, staffing, infection prevention and control, housekeeping, sanitation, safety, maintenance of physical plant and equipment, resident care statistics, and discharge planning services;	A1401		

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A1401	Continued From page 3 This REQUIREMENT is not met as evidenced by: Complaint #: NJ00163251 Based on interview and record review it was determined that the facility failed to implement twenty-four-hour measurable interventions to ensure safety of all residents within the facility. This deficient practice was evidenced by the following: The facility reported event was reported on NJ Exec Order 26.4b1 due to the resident being NJ Exec Order 26.4b1. Resident #2 was being NJ Exec Order 26.4b1 the facility due to NJ Exec Order 26.4b1 with the facility's NJ Exec Order 26.4b1. On 4/11/2023 at 11:44 a.m., the surveyor conducted a tour of the facility and identified Resident #2's apartment, which is located on the NJ Exec Order 26.4b1 of the facility. At this time, the surveyors noted a NJ Exec Order 26.4b1 coming from Resident #2's apartment and alerted the facility's administration. At 11:48 a.m., the facility's Director of Nursing (DON), Business Office Manager (BOM), and Activity Director (AD), opened Resident #2's apartment door and verbalized they also NJ Exec Order 26.4b1. The BOM stated that she believed Resident #2 was NJ Exec Order 26.4b1 in his/her apartment's bathroom due to the NJ Exec Order 26.4b1 once the bathroom door was opened. The surveyor noted NJ Exec Order 26.4b1 on the carpet near a NJ Exec Order 26.4b1 in the resident's apartment which the facility's DON identified as NJ Exec Order 26.4b1. Upon surveyor review of Resident #2's medical record it was revealed that Resident #2 had an admission date of NJ Exec Order 26.4b1 and diagnoses	A1401		

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A1401	Continued From page 4	A1401		

which include NJ Exec Order 26.4b1 [redacted]. The surveyor reviewed a facility document titled "General Service Plan" dated NJ Exec Order 26.4b1 which revealed that Resident #2 is NJ Exec Order 26.4b1 [redacted].

At 11:51 a.m., the surveyor interviewed the DON who indicated that there were no twenty-four-hour measurable interventions in place to ensure the safety of all facility residents regarding fire safety.

At 12:00 p.m., the surveyor interviewed a Certified Medication Aid (CMA) who revealed that she was unaware of any residents that NJ Exec Order 26 in their rooms; however, she was directed to report NJ Exec Order 26.4b1 coming from Resident #2's room to administration. The CMA reported that she did not document when she NJ Exec Order 26 [redacted].

At 12:04 p.m., the surveyor interviewed a Licensed Practical Nurse (LPN) who revealed that she was aware that Resident #2 NJ Exec Order 26 in his/her apartment. The LPN stated that when she NJ Exec Order 26.4b1 from Resident #2's apartment she was instructed by facility administration to do a room check looking for NJ Exec Order 26.4b1 [redacted] The LPN stated that there is no log to document when room checks were conducted.

At 12:36 p.m., the survey team interviewed Resident #2 who stated that NJ Exec goes outside to the NJ Exec Order 26.4 area most of the time and verbalized that NJ Exec has previously NJ Exec Order 26 in his/her room, however NJ Exec denied NJ Exec Order 26.4 in his/her room within the last week. Resident #2 acknowledged that NJ Exec should not be NJ Exec Order 26 in his/her room.

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A1401	Continued From page 5	A1401		

Review of the facility document titled "Observations for [Resident #2]", it was revealed that on NJ Exec Order 26.4b1, Resident #2 was found to be NJ Exec Order 26.4b1 and NJ Exec Order 26 in his/her room. It was also revealed that on NJ Exec Order 26.4b1, facility staff entered Resident #2's room after NJ Exec Order 26.4b1 coming from Resident #2's apartment; there were no NJ Exec Order 26.4b1, or NJ Exec Order 26 found.

On NJ Exec Order 26.4b1, staff reported the NJ Exec Order 26 coming from Resident #2's room to facility administration. Administration spoke to Resident #2 who admitted to NJ Exec Order 26.4 in his/her apartment. In addition, NJ Exec Order 26.4b1 were found, one NJ Exec Order contained NJ Exec Orde and a NJ Exec Order 26.4b1. Resident #2 was educated by administration regarding NJ Exec Order 26.4b1 and the facility's policy on NJ Exec Order 26.4b Resident #2's family was notified, and meeting was scheduled for NJ Exec Order 26.4b1.

On NJ Exec Order 26.4b1, staff NJ Exec Order 26.4b1 coming from Resident #2's room; staff entered room and found NJ Exec Order 26.4b1, along with NJ Exec Order 26.4b1 in a cup on the resident's table. On NJ Exec Order 26.4b1 a Managed Risk Agreement (a document that provides the resident with clear, understandable information about the possible consequences of his/her choice/actions) was put in place after staff noted the NJ Exec Order 26.4b1 coming from resident's apartment. On NJ Exec Order 26.4b, housekeeping staff identified NJ Exec Order 26.4b1 on residents' NJ Exec Orde and NJ Exec Orde on Resident #2's toilet seat.

At 3:24 p.m., the surveyor interviewed the facility's DON and Executive Director who revealed that the facility did not implement twenty-four-hour measurable interventions to

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A1401	Continued From page 6 ensure that Resident #2 was not NJ Exec Order 26.4b1 in his/her room. The facility was unable to provide documented evidence that safety checks were being conducted throughout the day and overnight. The facility failed to implement twenty-four-hour measurable interventions to ensure the safety of all residents within the facility. At 2:00 p.m., the survey requested a removal plan regarding Resident #2 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 in his/her room. On 4/17/2023 the surveyor returned to the facility. The removal plan was implemented. During staff interviews it was revealed that there was an hourly log that was to be completed by the aide assigned to Resident #2.	A1401		