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
	50a004	A. BUILDING: ______ B. WING ______	01/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSIST LIVING OF E BRUNSWICK	**190 SUMMERHILL ROAD EAST BRUNSWICK, NJ 08816**

(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: Standard CENSUS: 103 SAMPLE SIZE: 12 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 783	8:36-7.5(e) Resident Assessments and Care Plans (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of residents' records, it was determined that the facility failed	A 783		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/01/16

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A 783	Continued From page 1 to ensure 4 of 5 residents consistently had annual physical examinations (PEs) that documented and certified that each resident's needs did not exceed the care that the facility was able to provide. This was evidenced by the following: Review of residents' medical records confirmed that there was no documentation to confirm that the residents' physicians certified that the four (4) residents were appropriate for assisted living (AL) setting and that their needs did not exceed the care that the facility could provide. On 1/5/16, 11:30 a.m., the surveyor made the health care coordinator/registered professional nurse (HCC/RN) aware of the findings. She told the surveyor that doctors came to see and examine the residents "a couple of times a year" for different reasons, including complaint of pain, high blood pressure, and other medical problems. This was confirmed upon review of the physicians' visit notes and exam notes which indicated the reason for the visit. The physicians' notes did not, however, indicate that the visits were for annual PEs nor did they contain medical certification that each residents' needs did not exceed what the Assisted Living facility could provide. These were evidenced by the following: 1. Resident #1 was admitted on 5/6/14 with diagnoses that included Hypertension (HTN), Osteoarthritis, Chronic Obstructive Lung Disease (COPD), and a history of fractures of the hip and elbow. Review of the resident's medical record revealed no documentation of certification that the resident's needs did not exceed that which the AL could provide.	A 783		

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A 783	Continued From page 2 2. Resident #2 was admitted on 2/9/12 with diagnoses that included Dementia, Hypertension (HTN), Congestive Heart Failure (CHF), and Muscle Weakness. The resident's medical record did not include documentation of PE/H&P for 2015, as well as the certification from the resident's physician for 2013, 2014, and 2015 that confirmed that the resident did not require more care than the facility was capable of providing. 3. Resident #3 was admitted on 1/24/11 with diagnoses that included Dementia, Depression, and Hyperthyroid. The resident's medical record revealed a facility's completed annual PE and certification form for 2015 and 2012. There was, however, no annual PE and certification for 2013 and 2014 documented in the medical record. The HCC/RN presented a physician's visit and exam note dated 4/30/14 that did not include documentation confirming that the physician certified that the resident was appropriate for AL settings and that the resident's care needs did not exceed what the AL facility was capable of providing. 4. Resident #4 was admitted on 9/12/12 with diagnoses that included Hypertension (HTN), Diabetes Mellitus (DM), Cerebral Palsy (CP), and Asthma. The resident's medical record did not include documentation of the resident's PE/H&P for 2015. Additionally, there was no documentation of an annual physician's certification confirming that the resident's needs did not exceed what the facility was capable of providing.	A 783		
A 891	8:36-10.5(a) Dining Services	A 891		

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A 891	Continued From page 3	A 891		

(a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.

This REQUIREMENT is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain kitchen flooring that was smooth and easily cleanable. The facility also failed to maintain a sanitary environment in the kitchen in accordance with N.J.A.C. 8:24.

This requirement was not met, as evidenced by the following:

During the building tour on 1/5/16 with the facility's Food Service Director (FSD) at 10:03 a.m. an inspection of the kitchen was performed. This inspection identified the kitchen's seamless flooring was in disrepair in the following locations:

1) The surveyor observed the seamless flooring near the dish washing machine and under a floor mat that had a 9" by 6" section of seamless flooring that was missing. The remaining edges were lifting upward and breaking apart.

2) The Surveyor observed that adjacent to the dish washing machine tray line, there were multiple gouges, cracks and a 3" by 3" section of seamless flooring missing and lifting upward and breaking apart.

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A 891	Continued From page 4 The Surveyor asked the FSD about the status of the seamless flooring that was in disrepair. The FSD told the surveyor, "Maintenance is getting quotes to repair the flooring." The Surveyor asked the facility's Maintenance Coordinator (MC) to provide a copy of proposals to repair the kitchen's seamless flooring. The MC told the surveyor that they hadn't received estimates yet. The kitchen's seamless flooring was in disrepair in several locations. This presents an infection control issue in violation of Chapter XII of the New Jersey Sanitary Code.	A 891		
A 935	8:36-11.4(b) Pharmaceutical Services (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and review of pertinent documents including the medication administration records (MARs), it was determined that the facility failed to administer a transdermal patch for Resident #3 in accordance	A 935		

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A 935	Continued From page 5	A 935		

with the manufacturer's specifications and cautionary warnings.

This deficient practice was evidenced by the following:

Review of Resident #3's MAR on 1/5/16 at 10:30 a.m. revealed the following: "Exelon 4.6 mg/24 hr patch TD24 - apply 1 patch in the morning to dry clean skin. DX: Dementia. May cause dizziness. For external Use only. Alternate site with each change. Remove old patch before applying. Do not use same area for 2 weeks. Fold in half to discard. Wash hands after handling." This order was confirmed upon reconciliation with the physician's order sheet (POS).

The MAR for Resident #3 identified that the Exelon patch, a cognitive enhancer prescribed to treat and manage Dementia, was not being administered in accordance with the manufacturer's specifications or the cautionary warning printed on the MAR. The site of application of the Exelon patch needs to be rotated every day and the same site not repeated for 14 days. The resident's MAR identified that the site of application of the Exelon patch was only being rotated every five (5) days. The MAR was already pre-numbered with sites "#1, 2, 3, and 4" which was then repeated. These four (4) sites of patch application were also reflected on the back side of the MAR which indicated: Patch sites: 1. Left Front 2. Right Front 3. Left Back 4. Right Back." This resulted in the Exelon patch being applied to the same site every 5 days rather than every 14 days as specified by the manufacturer. There was an attached body diagram noted on the back of the resident's MAR that had fourteen (14) suggested sites for patch application however this diagram was not being

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A 935	Continued From page 6 utilized. At 10:30 a.m. in the medication administration room of the assisted living (AL) unit, the health care coordinator (HCC)/registered professional nurse (RN) present was made aware of the findings. She told the surveyor that she was unaware that the medication patch was only being applied to four (4) different sites. The surveyor showed the RN/HCC the sheet with the diagram that had the 14 recommended sites for application which was included in the binder of the resident's MAR. The HCC/RN stated that the 14 site diagram should have been followed. The surveyor asked the HCC/RN if the consultant pharmacist was aware of the problem. She responded that she was not sure if this problem had been identified by the consultant pharmacist. Review of the resident's medical record confirmed the following: - Resident #3's physician originally ordered the Exelon Patch on 10/09/14. - The surveyor reviewed the available MARs from 3/15 - 11/15 which identified that the Exelon patch was being erroneously applied to only the four (4) different sites. The site of application was not being rotated every 14 days - The consultant pharmacist's review of the resident's medication regimen revealed that in 8/26/15, the consultant pharmacist noted this error and recommended the following: "Exelon Patch Rotation Form-suggested to be put in place as not to repeat same site of patch more >/x in 14 days." There was no evidence that the facility acted on the consultant pharmacist's recommendation.	A 935		

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A 973	Continued From page 7	A 973		
A 973	8:36-11.6(a)(5) Pharmaceutical Services (a) The facility or program shall designate a pharmacist who shall direct pharmaceutical services and provide consultation to the physician, facility, or program staff, and residents, as needed. The pharmacist shall assist the facility or program with, at a minimum, the following: 5. At least quarterly, inspecting all common areas of the facility or program where medications are stored or administered, documenting any problems and proposing solutions to these problems, and maintaining records of such inspections. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined that the facility failed to ensure that the consultant pharmacist was inspecting the medication storage areas of the unit on a quarterly basis. This deficient practice was evidenced by the following: Upon review of the medication administration record (MAR) on 1/6/16 at 10:30 a.m., it was discovered that Resident #3's medication patch was being administered incorrectly. This prompted the surveyor to question the health care coordinator (HCC)/registered professional nurse (RN) regarding the required quarterly consultant pharmacist's notes/reports that included residents' medication regimen reviews, as well as	A 973		

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A 973	Continued From page 8 the quarterly medication storage inspections conducted. The HCC/RN initially stated that she was not sure if those were available. The HCC/RN was unable to provide any evidence of the requested documentation until the next day, 1/6/16. The HCC/RN provided two (2) quarterly medication reviews (for 11/15 and 8/15), but no quarterly inspection records. On 1/6/16, the HCC/RN was again requested to provide documentation of the medication storage inspections conducted by their consultant pharmacist. The HCC/RN, however, was unable to provide one. Refer to tag: 8:36-11.4(b)	A 973		
A1047	8:36-14.3(d) Emergency Services and Procedures (d) Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable NFPA requirements and N.J.A.C. 5:70. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observations and review of pertinent	A1047		

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A1047	Continued From page 9 documentation, it was determined the facility failed to perform and document a monthly visual examination on the tag attached to the fire extinguisher for 17 of 17 fire extinguishers inspected as required by code and NFPA requirements. Evidence of this includes the following: During the building tour on 1/5/16 and 1/6/16 in the presence of the facility's Executive Director (ED) and Maintenance Coordinator MC) the surveyor inspected 17 fire extinguishers located in various locations in the building. This inspection identified that 17 fire extinguishers were last annually inspected October 2015 as per information documented on the tags attached to to the fire extinguisher. The surveyor observed the following, On 1/5/16 (day one), 1. At 10:09 a.m., the surveyor observed two wet chemical "Class K" type fire extinguishers in the kitchen that had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. Along the tour at 10:49 a.m., the surveyor made a request to the ED to provide a copy of the Vendor's annual fire extinguisher inspection work acknowledgement ticket. At 11:15 a.m., the ED provided a copy from a vendor who inspected the fire extinguishers. A review identified the Vendor annually inspected 21 fire extinguishers on 1/28/15. On 1/6/16 (day two), 2. At 9:37 a.m., the surveyor observed one ABC type fire extinguisher in the third floor "Penthouse" boiler room which had no evidence of a monthly visual examination performed and/or	A1047		

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A1047	Continued From page 10 documented on the inspection tag for November 2015. 3. At 9:39 a.m., the surveyor observed one ABC type fire extinguisher in the third floor "Penthouse" boiler room which had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. 4. At 9:44 a.m., the surveyor observed one ABC type fire extinguisher inside the Main electrical room which had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. 5. At 9:51 a.m., the surveyor observed one ABC type fire extinguisher across from Resident apartment #244 which had no evidence, of a monthly visual examination performed and documented on the inspection tag for November 2015. 6. At 9:54 a.m., the surveyor observed one ABC type fire extinguisher next to Resident apartment #249 which had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. 7. At 10:10 a.m., the surveyor observed one ABC type fire extinguisher next to the second floor electrical room which had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. 8. At 10:14 a.m., the surveyor observed one ABC type fire extinguisher next to the second floor Activities storage closet which had no evidence of a monthly visual examination performed and	A1047		

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A1047	Continued From page 11 documented on the inspection tag for November 2015. 9. At 10:27 a.m., the surveyor observed one ABC type fire extinguisher near the Assisted Living Coordinates office which had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. 10. At 10:29 a.m., the surveyor observed one ABC type fire extinguisher near Resident apartment #205 which had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. 11. At 10:57 a.m., the surveyor observed one ABC type fire extinguisher in the Service corridor next to the commercial laundry room which had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. 12. At 11:02 a.m., the surveyor observed one ABC type fire extinguisher in the corridor next to Resident apartment #105 which had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. 13. At 11:04 a.m., the surveyor observed one ABC type fire extinguisher in the corridor across from the Executive Directors office which had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. 14. At 11:10 a.m., the surveyor observed one ABC type fire extinguisher inside the first floor	A1047		

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A1047	Continued From page 12 Dispensary room which had no evidence of a monthly visual examination performed and documented on the inspection tag for November 2015. 15. At 11:25 a.m., the surveyor observed two ABC type fire extinguishers in the "Reminiscence" (Memory Impaired) unit dining rooms which had no evidence of a monthly visual examination performed and documented on the inspection tags for November 2015. At 12:05 p.m., the surveyor reviewed the Facility's 2015 "Monthly Fire Extinguisher Checklist which identified the facility had inspected the portable fire extinguishers on the following dates, 1/5/15, 2/2/15, 3/4/15, 4/2/15, 5/1/15, 6/17/15, 7/7/15, 8/7/15, 9/4/15, 10/1/15, 11/1/15 and 12/1/15. Although the facility documented in the Monthly Fire Extinguisher Checklist an inspection on 11/1/15, there was no evidence of the inspection documented on the tags attached to the extinguishers. According to NFPA 10- 4-3.4, at least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguisher.	A1047		

Sunrise Senior Living
Plan of Correction- New Jersey

Name of Community: Sunrise East Brunswick
Address of Community: 190 Summerhill Road East Brunswick, NJ 08816
License number: 50a004
Inspection date(s): 1/6/2016
Name/Title of Sunrise Representative Signing the Plan of Correction: Karin Smith, ED
Signature of Sunrise Representative: Karin Smith
Date of Submission: 1/26/2016; revised 3/25/2016

Regulation Number (list the full, legal citation number from the regulatory report; do not re-type the regulation summary)	Target Date by Which Each Action Step was or will be Completed	Corrective Action for the Affected Residents	Corrective Action for Other Residents	Systemic Correction to Prevent Recurrence	Monitoring Plan
A783	1/6/2016 and ongoing	All residents affected have the same attending physician. The attending physician will complete the Sunrise annual form along with is electronic record to indicate the annual PE as well as the certification that the resident's needs do not exceed what we can provide in an assisted living setting.	All residents have the potential to be affected by this deficient practice have been identified and the annual PE and certification has been updated.	The annual PE's will be examined by the RCD /RN on a monthly basis to ensure the certifications are present now and ongoing. We have a tickler in place to ensure each PE/certification is completed timely.	The CALA and RCD (Resident Care Director) will monitor and ensure adherence to the regulation.
A891		We have obtained the estimate to replace the kitchen flooring. We expect the floor to be replaced by 5/31/2016.	No Specific resident was cited.	Once replaced, the kitchen flooring will be inspected by the Dining Service Coordinator on a monthly basis to ensure the flooring remains free from cracks and gaps.	The CALA and the Dining Service Coordinator will monitor and ensure adherence to the regulation.
A935	1/6/2016	We obtained a schematic that identifies areas of the body appropriate for application of the medication patch. This schematic will be used to ensure the same spot is not repeated for 14	Resident #3 is the only resident affected by this deficient practice.	The wellness staff has been in-serviced as to the use of the schematic form and manufacturer's specifications for this medication. The RCD/RN will continue to ensure the medication	The CALA and RCD will ensure this medication is monitored and administered appropriately

		days as per the manufacturer's specification.		**is properly administered. RCD will ensure that the community will follow-up on the consultant pharmacist's recommendations.**	
A973	**1/6/2016**	**The consultant pharmacist performs quarterly reviews of the medication storage areas and units. The reports do not specifically state that he performed the quarterly checks although the reports indicate comments regarding items identified in the carts and his recommendations. Moving forward the pharmacist will document the quarterly inspection and the RCD/RN will initial the inspection as acknowledgement and initial any changes that have been made.**	**No Specific resident was cited.**	**Previous quarterly 2015 pharmacist inspections will be reviewed by the RCD/RN to ensure all comments regarding the medication storage and units have been addressed and acknowledged with initials.**	**The CALA and RCD will monitor and ensure adherence to the regulation.**
A1047	**1/6/2016**	**Fire extinguishers will be inspected and maintained monthly and the examination will be recorded on the tag that is affixed to the extinguisher.**	**No Specific resident was cited.**	**The MC (Maintenance Coordinator) will ensure the monthly checks are completed and documented according the regulation.**	**The CALA and MC will monitor and ensure adherence to the regulation.**

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.