STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65a002	A. BUILDING: _____ B. WING _____	C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT STAFFORD	1275 ROUTE 72 MANAHAWKIN, NJ 08050

(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#: NJ00163123 CENSUS: 73 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 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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	65a002	A. BUILDING: _____ B. WING _____	C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT STAFFORD	1275 ROUTE 72 MANAHAWKIN, NJ 08050

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
COMPLAINT#: NJ00163123

Based on record review and interview, it was determined that the Administrator failed to ensure the implementation of the facility policy titled, "Urgent and Emergency Needs Response." This deficient practice was evidenced by the following:

On 8/22/2024 at 12:40 p.m., the surveyor conducted a complaint survey, and in doing so reviewed a facility document titled, "All Alarms Report (AAR)" dated 8/19/2024 and timed from 12:20 p.m., through 8/22/2024, 12:10 p.m. The AAR revealed the amount of time elapsed from the time residents pressed/activated their individual call bell pendants (a device used to alert staff that assistance is needed), to the time facility staff responded to the resident's call bell pendant alarm request for assistance.

Surveyor further review of the AAR revealed that during the above indicated time frame, there were 51 times in which it took facility staff a range of 10 minutes to 248 minutes, with a average of 37 minutes, to respond to residents request for assistance.

Surveyor review of the facility policy and procedure titled,"Urgent and Emergency Needs Response" revealed under policy the following, "... And a working response system to provide timely assistance to all residents and prompt response to meet resident's urgent or emergency needs." Under procedure included the following,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65a002	A. BUILDING: _____ B. WING _____	C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT STAFFORD	1275 ROUTE 72 MANAHAWKIN, NJ 08050

(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 310	Continued From page 2 "Each apartment is equipped with a 24-hour call system, emergency call button or pendant to alert associate to emergency or urgent needs. Associates are available on-site 24 hours, 7 days per week to respond and offer timely assistance and prompt response. Associates carry devices linked directly to the emergency call system. We strive to answer emergency call alarms within seven (7-10) minutes of a call being placed. Call reports will be printed weekly and reviewed by the Resident Care Director/Executive Director or designee. All calls beyond ten (10) minutes will be investigated and documented as to why call was not responded to within required time frame... "	A 310		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
65a002	A. Building B. Wing	10/23/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT STAFFORD	1275 ROUTE 72 MANAHAWKIN, NJ 08050

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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 10/17/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/22/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO