STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	080470	A. BUILDING: _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE DAY OF LAUREL SPRINGS	1361 CHEWS LANDING ROAD LAUREL SPRINGS, NJ 08021

(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
M 000	Initial Comments Type of Survey: Complaints and COVID-19 Focused Infection Control Survey conducted on July 11 and 12, 2023. Complaint #: NJ00156232, NJ00156463 Census: 67 Sample Size: 3 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 197	8:43F-2.6(d) Licensure Procedures The license shall not be assignable or transferable and shall be immediately void if the facility ceases to operate, if the facility's ownership changes, or if the facility is relocated to a different site. This REQUIREMENT is not met as evidenced by: NJ00156232, NJ00156463 Based on observation and interview, it was	M 197		

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M 197	Continued From page 1 determined that the facility was closed and was not in operation at the approved licensed site. This deficient practice was evidenced by the following: On 7/11/23 at 9:00 a.m., the surveyors arrived at the address listed for the facility and observed the parking lot was empty and the facility doors were locked. The surveyor called the facility and there was no answer. According to the facility website, the hours of operation were 8:00 a.m., to 4:30 p.m. On 7/11/23 at 9:26 a.m., the surveyor called the emergency contact number listed with the Department of Health (DOH) and was informed the facility was closed and moved to another location. On 7/11/23 at 10:08 a.m., the surveyor interviewed the Administrator (ADM) of the closed location at the new location, who explained the previous location was temporarily closed down due to decreased staffing and on 6/19/23 had decided to merge with a sister facility on 6/19/23 under the new locations license. In addition, all the participants were moved to the new location on 6/19/23. On 7/11/23 at 12:00 p.m., the surveyor reviewed the facility policy and procedure manual and "Document 1.3, last Revision Date: 12/2022" listed under number "6. In the event that the center...is relocated, the centers license will not be reassigned or transferred to a new location and is considered void. The process for obtaining new licensure will be followed...." The facility was no longer operating at the approved licensed location.	M 197		

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M 197	Continued From page 2 Reference: M-0255, 8:43F-3.4(a)(1)	M 197		
M 255	8:43F-3.4(a)(1) Administration (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed by written confirmation within 72 hours of the following: 1. Unanticipated interruption or cessation of program services for three hours or more (excluding closure for inclement weather). This REQUIREMENT is not met as evidenced by: NJ00156232, NJ00156463 Based on observation and interview, on 7/11/23 and 7/12/23, it was determined that the facility failed to notify the Department of Health (DOH) of a cessation of services at the licensed facility location. In addition, the facility failed to notify the DOH of closure and transfer of participants, of transition to new location, and of merger with a sister facility. This deficient practice was evidenced by the following: On 7/11/23 at 9:00 a.m., the surveyors arrived at	M 255		

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M 255	Continued From page 3	M 255		

the address listed for the facility and observed the parking lot was empty and the facility doors were locked.

On 7/11/23 at 10:08 a.m., the Administrator (Adm) explained to the surveyor the facility was temporarily closed due to low staffing, so the facility merged with a sister facility at another location on 6/19/23. In addition, all the participants and some staff were transferred to the new location on 6/19/23.

On 7/11/23 at 11:55 a.m., the Adm stated the Regional Director (RD) notified the home corporate office and they would notify the DOH of changes.

On 7/11/23 at 2:42 p.m., the surveyor interviewed the RD by telephone who explained the facilities merged due to staffing issues and she sent email notification to the home corporate office for them to notify the DOH. The surveyor requested a copy of the notification to the home corporate office and the RD stated she would have to locate the notification.

On 7/12/23 at 11:30 a.m., the RD explained the notification of relocation and merger of the two facilities to the home corporate office was a phone call and she was not sure of what date.

On 7/12/23 at 12:35 p.m., the Adm stated all participants' families and gaurantors were notified of the merger and move to the new location and there was no cessation in services. Additionally, the Adm explained the closure was temporary due to the lack of staffing and the facility was not turning in their license.

On 7/12/23 at 5:05 p.m., the RD was not

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M 255	Continued From page 4 available for surveyor interview, so the Adm explained the RD notified the Regulatory and Contract Analyst (RCA) and she, the RCA notifies the DOH. On 7/12/23 the facility was unable to provide a documented record of notification to the DOH of facility closure and transfer of participants, or of transfer to new location, and or of merger with a sister facility on 6/19/23. In addition, as of 7/12/23 there was no record of notification to the DOH. On 7/13/23 post survey at 11:14 a.m., the surveyor interviewed the RCA by telephone who explained she discussed with the RD about how the facilities could be merged on 6/21/23, but was not made aware or notified that the facility closed and transferred operations to another location on 6/19/23. The RCA stated there were no notifications to the DOH of the merger. The facility failed to notify the DOH of closure, transfer, and merger of operations on 6/19/23. Reference: M-0197, 8:43F-2.6(d)	M 255		
M 403	8:43F-6.2(a) General Services Adult day health service facilities shall provide at least one full-time, or full-time equivalent, direct care staff member for every nine participant equivalents, calculated on the basis of the daily census. Additional staff shall be provided as needed, based on the acuity of the participants. The facility shall have adequate staff capability to provide services and supervision to the participants at all times.	M 403		

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M 403	Continued From page 5	M 403		

This REQUIREMENT is not met as evidenced by:
NJ00156232, NJ00156463

Based on interview, and record review, it was determined that the facility failed to meet the minimum staffing requirement to provide direct care services and supervision to 32 participants of the program on 07/05/2022. This deficient practice was evidenced by the following:

On 07/11/2023 at 9:00 a.m., the surveyors arrived at the address listed for the facility to conduct a complaint survey, and observed the parking lot was empty and the facility lights were turned off and the facility was closed. The facility had the hours of operation posted, which showed 8:00 a.m.- 4:00 p.m. The surveyors called the facility, but there was no answer.

On 07/11/2023 at 9:26 a.m., the surveyors called the emergency contact on file for the facility and spoke to the Regional Director (RD). The RD stated the facility was temporarily closed due to lack of staff following the COVID19 pandemic, but members and staff moved to a sister facility five miles away.

The surveyors arrived at the sister facility at 9:10 a.m.

On 07/11/2023 at 10:08 a.m. during the entrance conference, the surveyor interviewed the Center Director (CD), who stated the Nurse Manager (NM) and the Activity Manager (AM) at the 'Laurel Springs' facility resigned, and the CD from their sister facility resigned, so leadership merged the

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M 403	Continued From page 6 two facilities and temporarily closed their 'Laurel Springs' location. The surveyor review of the daily census provided by the Administrator from 07/01/2022 - 07/13/2022 revealed the following: On 07/05/2022 the census listed 32 participants (prts) and four Direct Care Staff (DCS) were required, however, the facility had three DCS to provide care and supervision to prts. On 07/18/2023 at 1:48 p.m., the surveyor interviewed the Regional Director (RD), who stated on 07/05/2022, she filled in at the facility from 8:00 a.m. to 9:00 a.m., until the on-call nurse arrived, and then she left the facility leaving 3 DCS to provide care and supervision to prts. The surveyor reviewed the "Member Care Policies and Procedures" for "Staffing Pattern", which showed, "1. The staff-to-member ratio shall be maintained at a minimum of one staff to nine members (1:9), or according to current regulatory requirements and as determined by the needs of a member's care...4. The center director, volunteers, consultants, or any staff who do not provide direct care to members may not be included in the staffing ratio...8. The center will maintain written staffing schedules and will be provided in order to ensure the member's continuity of care....". The facility failed to ensure that the minimum required number of full-time DCS were scheduled as required for the 32 prts that attended the facility on 07/05/2022.	M 403		

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M 419	Continued From page 7	M 419		
M 419	8:43F-6.3(d) General Services The facility shall maintain written staffing schedules. Staffing schedules shall be implemented to ensure continuity of care. This REQUIREMENT is not met as evidenced by: NJ00156232, NJ00156463 Based on interview and record review, it was determined that the facility failed to maintain a staffing schedule that ensures adequate staffing and continuity of care. The facility failed to provide a written staffing schedule from 07/14/2022-07/27/2022 and 06/27/2023-07/11/2023 that reflected and documented all staff members on duty providing direct care to participants, the hours/days worked, and coverage for sick and vacation time. This deficient practice was evidenced by the following: On 07/12/2023 at 9:12 a.m., staffing schedules were requested from 07/14/2022-07/27/2022 and 06/27/2023-07/11/2023. The Center Director (CD) provided staffing schedules for July 2022 and July 2023 for the Program Assistants (PAs) and Registered Nurses (RNs) that reflected their weekly work hours. Review of the July 2022 staffing schedules revealed the facility had two RNs and one PA from 07/01/2022-07/13/2022, and three PAs from 07/14/2022 - 07/29/2022. The July 2023 staffing schedules for the RNs and PAs were prefilled for	M 419		

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M 419	Continued From page 8	M 419		

the whole month even though there were 14 business days left in the month. All aforementioned staffing schedules for the PAs and RNs did not reflect the staff that actually worked.

On 07/12/2023 at 1:30 p.m., the surveyor asked the Center Director (CD) if she had the staff schedule that included all the employees who provided direct care to Participants (prt) from 07/01/2022-07/13/2022, and the CD provided a "Master Staff Schedule." Review of the "Master Staff Schedule" revealed a list of staff names with titles, scheduled days to work, and their required work hours, not the actual worked schedules. The CD stated the "Master Staff Schedule" was the staffing schedule, but it did not reflect the scheduled staff that actually worked. The CD offered to request payroll documents for all staff to confirm which staff actually worked and provided direct care during the requested timeframes.

On 07/17/2023 at 2:32 p.m., the CD emailed the payroll records to the surveyor. Review of documents showed the Nurse Manager (NM) took a vacation from NJ ex order 26.4b1, and a per diem Registered Nurse (RN) staff filled in. There was no indication that the NM went on vacation or that a per-diem RN staff person provided coverage on the calendar sheets, or the "Master Staff Schedule" provided by the CD.

The surveyor reviewed the facility's "Member Care Policies and Procedures" on "Staffing Pattern", which showed, "the center will maintain written staffing schedules and will be provided in order to ensure the member's continuity of care".

The CD did not have written staffing schedules

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M 419	Continued From page 9 that they maintained available to provide to the Department of Health surveyor on the day of survey.	M 419		

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M197 8:43F-2.6(d) Licensure Procedures

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

   When the Laurel Springs center was temporarily closed due to staffing issues, members and caregivers were personally called and managed care transfer request letters were sent out. There was no lapse of services as the last session at Laurel Springs was on Friday June 16th, 2023. All members and all staff transferred to Washington Township beginning Monday June 19th, 2023.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

   All participants have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.

   The license shall not be transferred and will be immediately void if the facility ceases to operate. The Washington Township center is adequately staffed at the 1:9 ratio with full-time, part-time and seasonal staff so that this deficient practice will not occur again. The center director reviews staffing daily to ensure compliance. The center staff will continue to be provided with an annual Inservice covering compliant staffing ratios.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

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If the facility ownership changes or if the facility is relocated to a different site, the facility will notify the New Jersey Department of Health by phone immediately followed by written communication within 72 hours. The Regional Director will monitor for compliance annually. Center Administration will be educated on policies and procedures upon hire and continued annually.

accepted 10/30/23 LM

This Plan of Correction will be completed as of September 1st, 2023

M255 8:43F-3.4(a)(1)

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   On July 12th, 2023 Regulatory and Contract Analyst notified the Department of Health of Active Day of Laurel Springs temporary closure.
2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
   All Participants have the potential to be affected by this deficient practice.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.

   The facility will notify the New Jersey Department of Health immediately by telephone followed by written communication within 72 hours whenever an unanticipated interruption or cessation of services extends beyond three hours. In addition, annual training regarding this policy will occur for all Center Directors and Regional Directors in order to prevent this from occurring again.

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4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

   The Regional Director will monitor for compliance annually.

   This Plan of Correction will be completed as of September 1st, 2023.

accepted 10/30/23

M403 8:43F-6.2(a)

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

   Starting on 7/13/2023 and ongoing, the center director ensured Active Day adult day health service facility provided at least one full-time, or full-time equivalent, direct care staff member for every nine participant equivalents, calculated on the basis of the daily census. The Center Director confirmed that adequate staffing levels were met by reviewing the daily written staffing schedule and reviewing the daily member call outs on a daily basis.
2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

   All members had the potential to be affected by this deficient practice.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

   The Center Director will evaluate staffing ratios daily by reviewing member call outs and estimating how many members are to be in attendance the day before. The Center Director will make staffing changes accordingly by calling per diem staff for coverage and/or borrowing appropriate staff from other

Active Day Centers. The facility shall have adequate staff capability to provide services and supervision to the participants at all times. The center director will evaluate the daily census as members are dropped off and will compare this information with staffing levels daily to ensure compliance.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e what program will be put into place to monitor the continued effectiveness of the systemic changes.

On a corporate level, the Active Day Home Office has put into place quarterly staffing level audits and staffing ratio matrices that clearly depict compliant staffing levels.

Please note: The surveyor review of the daily census provided by the center director indicated 32 participants on July 5th, however, the facility had 29 participants on this day.

10/30/23

M419

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

In addition to electronically recording all staff on duty, the facility shall maintain written staffing schedules. The written staffing schedules will be implemented to ensure continuity of care and document all staff members on duty providing direct care to participants. It will include hours/days worked and coverage for sick and vacation time. This form was taken from another Active Day Center. All staff were provided with verbal instruction on signing in and out on these written staffing schedules on 8/25/2023. The written staffing schedule was implemented on 8/28/2023.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

   All participants have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

   The addition of maintaining written staffing schedules with electronic staffing records will ensure member continuity of care. The written staffing schedules will be kept in the center. Each employee will sign in and sign out daily. This was implemented as of 8/28/2023. Any PRN staff will be directed by the Center Director or alternate to sign in on the form on such days they are working in the center. The center director or alternate will monitor the written staffing schedules for accuracy daily.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e what program will be put into place to monitor the continued effectiveness of the systemic changes.

   The center will maintain written staffing schedules in addition to electronic staffing records that will be maintained and available to provide to the New Jersey Department of Health Surveyor as needed for future surveys. This written staffing schedule will be monitored daily by the Center Director.

This Plan of Correction will be completed as of September 1st, 2023.

10/30/23

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
080470 Y1	A. Building B. Wing Y2	7/12/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE DAY OF LAUREL SPRINGS	1361 CHEWS LANDING ROAD LAUREL SPRINGS, NJ 08021

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 M0197	Correction	ID Prefix M0255	Correction	ID Prefix M0403	Correction
Reg. # 8:43F-2.6(d)	Completed	Reg. # 8:43F-3.4(a)(1)	Completed	Reg. # 8:43F-6.2(a)	Completed
LSC	09/01/2023	LSC	09/01/2023	LSC	09/01/2023
ID Prefix M0419	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43F-6.3(d)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/01/2023	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	
7/12/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO