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
	90117	A. BUILDING: _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF MORRIS PLAI	209 LITTLETON ROAD MORRIS PLAINS, NJ 07950

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00182946, NJ00182601, NJ00170697, NJ00162330 CENSUS: 72 SAMPLE SIZE: 8 SURVEY DATE: 01/27/2025 - 01/29/2025 The facility is not in substantial compliance with all 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, based on this Complaint Survey. 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		

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

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This REQUIREMENT is not met as evidenced by:
Based on record review, interview, and facility document and policy review, the Executive Director (ED) failed to ensure staff implemented the facility's policies and procedures to ensure emergency services were contacted and [NJ Exec Order 26.4b1] was initiated immediately when a resident, who desired [NJ Exec Order 26.4b1], was found [NJ Exec Order 26.4b1] which affected 1 (Resident #1) of 2 residents reviewed for [NJ Exec Orde] in the facility; to prevent [NJ Exec Order 26.4b1] for 2 (Residents #3 and #5) of 3 residents reviewed for [NJ Exec Order 26.4b1] and to ensure medication transcriptions were accurate, which affected 1 (Resident #2) of 3 residents reviewed for pharmaceutical services.

It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause, serious injury, harm, impairment, or death to residents.

Findings included:

1. A facility policy titled, "Cardiopulmonary Resuscitation (CPR)," revised 07/09/2018, indicated, "Action Steps 1. A resident who is found unresponsive, without a pulse the Team Member will: a. Validate the resident's code status (available on the [electronic health record system] and on the resident face sheet) or ([electronic health record system] on the Resident Information Sheet). b. If the resident does not have a DNR [do not resuscitate] order: i. Call/have another team member call Emergency

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A 310	Continued From page 2 Services (911) ii. The CPR Certified Team Member will start CPR iii. Utilize an AED [automated external defibrillator] if present on site, per state requirements iv. Continue CPR until Emergency Services arrive and assumes care for the resident. c. While the general rule is to provide emergency treatment to a resident in cardiac arrest, there are a few exceptions where withholding CPR would be considered appropriate (American Heart Association). i. In the event the Licensed healthcare professional (such as a Physician, Physician Extender, RN [registered nurse]) acting within established scope of practice in the jurisdiction determines that the following signs are present, CPR will not be initiated: 1. Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril (e.g. [exempli gratia, for example], exposure to infectious diseases). 2. Clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, decomposition). 3. A valid advance directive, a Physician Order for Life-Sustaining Treatment (POLST) indicating that resuscitation is not desired, or a valid Do Not Attempt Resuscitation (DNAR)/Do Not Resuscitate (DNR) order." The policy revealed the "Responsible Parties" included the "Executive Director." A facility policy titled, "Responding To Medical Emergencies," dated 06/29/2005, revealed, "It is the policy of this community to provide immediate response to emergencies and to call for emergency medical services (911) as indicated." The policy revealed, "5. The Licensed Nurse/Team Member (if there is not a licensed nurse in the community) will take the following steps when the resident is not on Hospice services: a. The Licensed Nurse/Team Member will call 911 for the following situations," which	A 310		

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included "vi. Change in level or loss of consciousness," "x. Lack of heartbeat or pulse," and "xiv. And or any other significant or potentially life threatening condition, or when a team member is in doubt." The policy revealed the "Responsible Parties" included the "Executive Director."

A facility policy titled, "Abuse, Neglect, & Exploitation-Prevention, Reporting and Investigation," revised 05/04/2016, revealed, "It is the policy of the community that: a. Every reasonable effort within its control is taken to prevent the abuse, neglect, and exploitation of residents. Team Members must not engage in, nor permit anyone else to engage in, abuse, neglect or exploitation of any resident. b. Team members of the community are mandated reporters and have a duty to report known or suspected abuse, neglect and/or exploitation to local, state, federal and/or provincial authorities in accordance with applicable law and regulation. c. In addition, team members who know of or suspect abuse, neglect or exploitation of any resident must immediately notify the Executive Director/designee, to ensure appropriate action is timely taken for the safety of the resident and those potentially impacted." The policy revealed, "Neglect: the failure to provide goods and services necessary to protect the resident from health and safety hazards." The policy revealed the "Responsible Parties" included the "Executive Director."

Resident #1's "Visual/Bedside Individual Service Plan Report" indicated the facility admitted the resident on NJ Exec Order 26.4b1. The report revealed the resident was a NJ Exec Order 26.4b1, indicating the resident wished to receive all NJ Exec Order 26.4b1 in the event of NJ Exec Order 26 or NJ Exec Order 26.4b1

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A 310	Continued From page 4 NJ Exec Order 2 A facility document titled, "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that on NJ Exec Order 26.4b1 at approximately 4:55 AM, Care Manager (CM) #1 observed Resident #1 in bed, NJ Exec Order 26.4b1 The report indicated that, at 5:07 AM, CM #1 notified the RN on call that Resident #1 was NJ Exec Order 26.4b1 and was instructed to call 911 immediately. Per the report, CM #1 was not aware of Resident #1's NJ Exec Order 26.4b1. The report indicated that emergency medical services (EMS) personnel arrived at the facility at approximately 5:15 AM and the resident was NJ Exec Order 26.4b1 . The report indicated that it was determined that CM #1 failed to follow protocol regarding responding to medical emergencies and indicated that CM #1's employment was terminated. A typed facility document titled, "Privileged and Confidential Statement of Event," dated NJ Ex Order 26.4(b)(1) and signed by CM #2, indicated that CM #2 had assisted CM #1 with providing NJ Exec Order 26.4b1 care for Resident #1, NJ Exec Order 26.4b1 and removing NJ Exec Order 26.4b1 on the resident's NJ Exec Or The statement indicated that later that shift, CM #1 told CM #2 that Resident #1 was NJ Exec Order 26.4b1 The statement indicated that CM #1 called a supervisor and a nurse, then called 911. Per the statement, CM #2 waited by the doors to let the emergency services staff in to the unit. The statement indicated that the emergency medical technicians (EMTs) arrived about 10 to 15 minutes later. The statement indicated that CM #1 asked CM #2 to open Resident #1's service plan to check the resident's the NJ Exec Order 26.4b1, which was when CM #2 saw that Resident #1's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b . Per the statement, EMS personnel asked CM #2 if NJ Exec Or had been	A 310		

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initiated and why she had not called 911 sooner. The statement indicated that CM #2 did not recall the exact times of the incident.

A typed facility document titled, "Privileged and Confidential Statement of Event," dated [NJ Exec Order 26.4b1] and signed by CM #1, indicated that she was in Resident #1's room before 2:30 AM and left before 3:00 AM and the resident was [NJ Exec Order 26.4b1] and was [NJ Exec Order 26.4b1] at that time. The statement indicated that she checked on the resident around 4:55 AM and the resident was [NJ Exec Order 26.4b1], noting their [NJ Exec Order 2] and [NJ Exec Or] were [NJ Exec Orde] The statement indicated that the resident's [NJ Exec Order 26.4b1] and the [NJ Exec Orde] of the resident's [NJ Exec O] looked [NJ Exec Order] The statement indicated she alerted CM #2 and called Assisted Living Coordinator (ALC) #5 at 4:57 AM, then Reminiscence Coordinator (RC) #10 at 5:05 AM, who instructed her to call RN #3. The statement indicated that she called RN #3 at 5:07 AM, the call dropped, so she called back at 5:08 AM and was told RN #3 would call her back. The statement indicated that RN #3 called back at 5:13 AM and told CM #1 to call 911 and '[NJ Exec Order 26.4b1]." The statement indicated that 911 was called at approximately 5:14 AM. Per the statement, when the EMS personnel arrived, CM #1 showed them where Resident #1 was. The statement indicated that an EMS member came out of Resident #1's room to inquire about Resident #1's [NJ Exec Order 26.4b1]. The statement indicated they checked an electronic tablet and saw that Resident #1 was [NJ Exec Order 26.4b]. The statement indicated that an EMS member said to call 911 first, in the future.

A typed facility document titled, "Privileged and Confidential Statement of Event," dated [NJ Exec Order 26.4b1] and signed by RC #10, indicated that

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A 310	Continued From page 6 she received a call from CM #1 at 5:05 AM on NJ Exec Order 26.4b1. The statement indicated that RC #10 asked CM #1 if they had called RN #3, and when CM #1 said she had not, RC #10 told CM #1 to call RN #3 immediately. The statement indicated that she and the Executive Director (ED) arrived at the facility on NJ Exec Order 26.4b1 at 10:15 PM and retrained care managers, including CM #1 and CM #2, about the protocol for calling 911, NJ Exec Ord location, protocol for NJ Exec Orde of a resident, and location of transfer paperwork. The statement indicated that they trained the care managers that the RN was also to be called if they noticed a NJ Exec Order 26.4b1 of a resident. A typed facility document titled, "Privileged and Confidential Statement of Event," dated NJ Exec Order 26.4b1 and signed by the ED, indicated that on NJ Exec Order 26.4b1 at 10:15 PM, she and RC #10 arrived at the facility for a meeting with the Reminiscence care managers and the assisted living care managers. The statement indicated the care managers were retrained on responding to medical emergencies and NJ Exec Order 26.4b1 policies. The statement indicated that CM #1 stated that upon her arrival to the shift, she checked on residents, including Resident #1, and everything was all right. The statement indicated CM #1 stated that she later went back to check on Resident #1 and to complete NJ Exec Order 26.4b1 care and noted Resident #1 NJ Exec Order 26.4b1. Per the statement, CM #1 called ALC #5 and RC #10 and was told to call RN #3. The statement indicated that CM #1 stated that RN #3 told them to call 911, and EMS NJ Exec Order 26.4b1 Resident #1's NJ Exec Orde at 4:30 AM. During an interview on 01/28/2025 at 12:16 PM, RN #3, who was a resident care director, stated that she would respond to a call of someone	A 310		

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being NJ Exec Order 26.4b1 if she was in the building. She stated care managers should check a resident's NJ Exec Order 26.4b1, which was on an electronic tablet that should be with the staff member, call another staff for help, and start NJ Exec Ord while the other staff member called 911 and the nurse on call. She stated that she received a call from a CM a little after 5:00 AM who stated that Resident #1 was NJ Exec Order 26.4b1 She stated that she questioned the CM how she knew the resident was NJ Exec Ord because care managers could not pronounce a resident's NJ Exec Order 2 She stated that she told CM #1 to call 911. RN #3 stated that she did not ask the CM if she had initiated NJ Exec Ord or if she knew the resident's NJ Exec Order 26.4b1. She stated that, at first, she did not know what time CM #1 had found the resident NJ Exec Order 26.4b1 She stated that she did not instruct CM #1 to start NJ Exec Ord She stated that, based on the investigation, the resident's NJ Exec Order 26.4b1 when CM #1 lifted the resident's NJ Exec Ord

During an interview on 01/28/2025 at 3:03 PM, the ED stated that during the investigation, CM #1 stated she did not start NJ Exec Ord because she knew Resident #1 was NJ Exec Order 26.4b1 The ED stated that CM #1 should have checked the resident for a pulse, summoned another staff member on duty, transferred the resident to the floor, checked their NJ Exec Order 26.4b1 started NJ Exec Ords and instructed the other staff member to call 911 and then call the nurse.

2. A facility policy titled, "Elopement and Missing Residents," revised 06/25/2018, revealed, "It is the policy of the community to respect and support the rights of residents to leave safely, be mobile, and involved in their community." The policy also revealed, "Elopement- an act or instance of leaving a safe area or safe premises."

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A 310	Continued From page 8 A facility policy titled, "Assessing and Evaluating Residents," revised 08/20/2018, revealed, "Action Steps 1. A Service and Health Assessment (SEHA) will be completed on residents at the following timeframes: a. prior to move in, b. upon move-in, as required by state/province regulation c. every six (6) months or as required by state/province regulations/law and d. upon a significant change in condition." A facility policy titled, "Individualized Service Plan [ISP]," revised 02/19/2014, revealed, "Service Plan -An individualized plan of care developed by evaluating/assessing the resident. The plan addresses advanced directives, allergies and interventions to meet the preferences, psychosocial, cognitive, physical, safety and functional needs of the resident. Action Steps 1. The Resident Care Director (RCD)/Health Care Manager (HCM) ensures that each resident has an Individualized Service Plan (ISP). a. The ISP is initiated prior to move in and updates/completed: i. Within 72 hours after Move-In ii. Every six (6) months iii. With any significant change in condition iv. Additional updates may be made with changes in needs and/or at the resident or resident's responsible party request." The policy revealed the "Responsible Parties" included the "Executive Director." Resident #3's service plan indicated the facility admitted the resident on [redacted] According to the service plan, the resident had a medical history that included diagnoses of [redacted] The service plan contained a focus area, initiated [redacted], that	A 310		

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indicated the resident was an NJ Exec Order 26.4b1 risk and exhibited NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Interventions directed staff to offer the resident activities including walking outside, gardening, group activities, or participating in the music program (initiated NJ Exec Order 26.4b1. Interventions also directed staff to observe the resident's location in the facility, direct the resident to an activity and sit with them, NJ Exec O the resident's NJ Exec Orde and indicated that the resident had NJ Exec Order 26.4b1 due to recently NJ Exec Order 26.4b1 (initiated NJ Exec Order 26.4b1.

Resident #3's "Progress Notes" revealed a note, dated NJ Exec Order 26.4b1 at 4:18 PM, that indicated the resident was brought back to the facility from the corner of the driveway. The note indicated the resident stated they were waiting for someone to pick them up.

Resident #3's "Progress Notes" revealed a note, dated NJ Exec Order 26.4b1 at 2:22 PM, that indicated that a meeting was held with the resident's family member and indicated that the resident had attempted to NJ Exec Orde three times on the previous NJ Exec Order 26.4 NJ Exec Order 26.4b1), but that staff intervened.

Resident #3's "Progress Notes" revealed a note, dated NJ Exec Order 26.4b1 at 3:46 PM, that indicated the resident had NJ Exec Order 2 the door open and went to NJ Exec Order 26.4b

Resident #3's "Progress Notes" revealed a note, dated NJ Exec Order 26.4b1 at 2:48 PM, that indicated the resident pulled the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 onto the NJ Exec Order 26.4b1 in the back of the NJ Exec Order 26.4b1 unit. The note indicated the resident had sustained a NJ Exec Order 26.4b to their NJ Exec Order 26.4b1.

A facility document titled, "Reportable Event

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Record/Report," dated NJ Exec Order 26.4b1 revealed that, on NJ Exec Order 26.4b1, Lead Care Manager (LCM) #7 was alerted to a NJ Exec Order 26.4b1 and responded to the door at 3:41 PM. The report indicated LCM #7 observed the door was "disengaged." The report indicated that staff conducted a search of the NJ Exec Order 26.4b1 unit and noted that Resident #3 was NJ Exec Order 26.4b1. Per the report, staff alerted additional facility staff to start searching the perimeter of the facility's property. The report indicated Registered Nurse (RN) #3 called Resident #3's family member at approximately 4:05 PM. The report indicated that at 4:10 PM, Resident #3's family member called the facility to notify them that they had Resident #3 and were on the way back to the facility. The report indicated Resident #3's family member stated that Resident #3 was NJ Exec Order 26.4b1.

A typed letter from the ED and addressed to the state survey agency, signed by the ED and dated NJ Exec Order 26.4b1, revealed that upon investigation by the facility, they were able to determine that Resident #3 had NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1 on a NJ Exec Order 26.4b1 and then NJ Exec Order 26.4b1. The letter did not indicate that the facility had determined how Resident #3 was able to NJ Exec Order 26.4b1 through the NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 unit.

An undated facility document titled, "Privileged and Confidential Statement of Event," signed by LCM #7, revealed that, on NJ Exec Order 26.4b1, LCM #7 was standing close to the NJ Exec Order 26.4b1 to the assisted living community because Resident #3 had been NJ Exec Order 26.4b1. The statement indicated the NJ Exec Order 26.4b1 toward Resident #3's room, and LCM #7 went to the door and saw the alarm cover off and the door closed. The statement indicated LCM #7 looked outside

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in the NJ Exec Order 26.4b1 came back to the kitchen and told a nurse that they dic NJ Exec Order 26.4b Resident #3.

An undated facility document titled, "Privileged and Confidential Statement of Event," signed by Care Manager (CM) #8, revealed that CM #8 was in a common area and saw Resident #3 trying to NJ Exec Order 26.4b1. The statement indicated that another CM was there, and the resident went back toward their room. Per the statement, CM #8 then heard the NJ Exec Order 26.4b1 and indicated that another CM went to the door and did not see Resident #3. The statement indicated that staff checked all the rooms and could not find Resident #3, a CM checked outside and still did not see Resident #3, and then the ED was notified.

Resident #3's service plan revealed no interventions were initiated on NJ Exec Order 26.4b1 when the resident NJ Exec Order 26.4b1

During an interview on 01/28/2025 at 5:05 PM, the ED stated that once a resident started NJ Exec Order 26.4b1 the facility would identify them as an NJ Exec Order 26.4b1 risk. The ED stated that an update to the assessment and care plan should take place.

3. Resident #5's service plan revealed the facility admitted the resident on NJ Exec Order 26.4b1. According to the service plan, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 The service plan identified a focus area, initiated NJ Exec Order 26.4b1, that indicated the resident was an NJ Exec Order 26.4b1 risk and exhibited

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SUNRISE ASSISTED LIVING OF MORRIS PLAI	209 LITTLETON ROAD MORRIS PLAINS, NJ 07950

(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 12 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Interventions indicated the resident would be engaged in person-centered activities during moments of NJ Exec Order 26.4b1 Resident #5's "NJ [New Jersey] 3.0 SEHA [Service Evaluation and Health Assessment] - V 9 [Version 9]," dated NJ Exec Order 26.4b1, revealed that Resident #5 had NJ Exec Order 26.4b1 in relation to NJ Exec Order 26.4b1 and that staff should provide Resident #5 with NJ Exec Order 26.4b1 as needed to ensure that they did not compromise their safety. Resident #5's "Progress Notes" revealed a note, dated NJ Exec Order 26.4b1 at 3:16 PM and electronically signed by Registered Nurse (RN) #3, that indicated Resident #5 was seen with a clear plastic bag containing their sneakers and hearing aid charger while verbalizing they were going home. The note indicated Resident #5 was redirected back to their room and that their adjustment to their new environment was slow, but they were encouraged to attend activities and engage with their peers. Resident #5's "Progress Notes" revealed a note, dated NJ Exec Order 26.4b1 at 10:17 AM and electronically signed by RN #3, that indicated Resident #5 began NJ Exec Order 26.4b1 of their room around 2:30 AM while stating they wanted to go outside and take a walk. The note indicated the resident was assisted back to bed but that Resident #5 was back in their wheelchair NJ Exec Order 26.4b1 in their room by 3:16 AM. The note indicated that Resident #5 was referred to NJ Exec Order 26.4b1 and that Resident #5 was NJ Exec Order 26.4b1 Per the note, staff would continue to NJ Exec Order 26.4 Resident #5 when they NJ Exec Order 26.4b1	A 310		

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A 310	Continued From page 13 Resident #5's "Progress Notes" revealed a note, dated NJ Exec Order 26.4b1 at 2:19 PM and electronically signed by RN #3, that revealed Resident #5 NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 at 1:57 PM. The note revealed Resident #5 NJ Exec Order 26.4b1 but remained on the NJ Exec Order 26.4b1 The note indicated Resident #5 was observed at a NJ Exec Order 26.4b1 . Per the note, Resident #5 stated, NJ Exec Order 26.4b1 The note indicated that the resident was NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 of the building "NJ Exec Order 26.4b1" and another resident observed the resident NJ Exec Order 26.4b1 in their wheelchair up the NJ Exec Order 26.4b1 towards a road and notified staff. A facility document titled, "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that an NJ Exec Order 26.4b1 occurred on NJ Exec Order 26.4b1 involving Resident #5. The report indicated Lead Care Manager (LCM) #9 observed Resident #5 sitting in their wheelchair on the NJ Exec Order 26.4b1 at the NJ Exec Order 26.4b1 for the facility. The report indicated LCM #9 brought Resident #5 NJ Exec Order 26.4b1. An undated typed letter from the ED to the state survey agency revealed that, on NJ Exec Order 26.4b1 at approximately 1:30 PM, LCM #9 assisted Resident #5 with NJ Exec Order 26.4b1 care in their room. The letter indicated that the resident then went NJ Exec Order 26.4b1 . Per the letter, Resident #5 did not notify staff that they were NJ Exec Order 26.4b1 and was observed by another resident NJ Exec Order 26.4b1 their wheelchair up an NJ Exec Order 26.4b1. The letter indicated that at approximately 1:57 PM, another resident notified LCM #9, who went outside and observed the resident in their wheelchair on the NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 and brought the	A 310		

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A 310	Continued From page 14 resident back inside the facility. During an interview on 01/28/2025 at 12:16 PM, RN #3 stated a resident would be considered an [redacted] risk based on assessment and observation of certain behaviors. RN #3 stated staff usually communicated with each other by word of mouth if a resident was [redacted]. RN #3 stated that even if a resident did not [redacted], the facility staff would want to investigate an attempt to [redacted] RN #3 stated that, if a resident made a [redacted] or made an [redacted], it may not trigger the facility staff to have a meeting. She stated that once a resident had successfully [redacted] then the care team would have a meeting to discuss changes to the resident's care plan. Review of Resident #5's service plan revealed no interventions were initiated on [redacted] or [redacted], when the resident exhibited [redacted]. During an interview on 01/28/2025 at 5:05 PM, the ED stated that once a resident started verbalizing [redacted] or began exhibiting [redacted], the facility would identify them as an [redacted] risk. The ED stated that an update to the assessment and care plan should take place. 4. A facility policy titled, "New Resident Move-In Process," revised 07/15/2013, revealed, "3. A History and Physical (Physician's Report) and Physician's Move-In Orders must completed [sic] (within 30-90 days before Move-In) and be received by the Health Care Coordinator or Wellness Nurse to ensure that [facility name] is able to arrange medical support for any known health conditions." The policy revealed, "B. The	A 310		

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A 310	Continued From page 15 Health Care Coordinator or Wellness Nurse reviews the Service Evaluation and Health Assessment, the Physician's Report and Physician's Move-In Orders. The information is used to arrange ordering, delivering and administration of medication; support services; special equipment and appointments." Resident #2's service plan indicated the facility admitted the resident on NJ Exec Order 26.4b1 According to the service plan, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 [redacted] Resident #2's service plan included a focus area, initiated on NJ Exec Order 26.4b1, that indicated the resident was unable to NJ Exec Order 26.4b1 their medications. Interventions directed staff to assist the resident with their medications with their preferred beverage. A facility document titled, "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that Resident #2 returned to the facility from a rehabilitation center on NJ Exec Order 26.4b1 with orders for staff to administer NJ Exec Order 26.4b1 and two sprays of NJ Exec Order 26.4b1 [redacted] one time a day. The Reportable Event Record/Report revealed that, on NJ Exec Order 26.4b1, the Advanced Practice Nurse (APN) reviewed Resident #2's discharge documents and noticed that NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 missing on Resident #2's transcribed orders. The Reportable Event Record/Report revealed that the nurse on duty on NJ Exec Order 26.4b1 immediately transcribed and ordered the medications from the pharmacy. Per the Reportable Event Record/Report, Resident #2	A 310		

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A 310	Continued From page 16 missed four doses of their ordered [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1]. An undated document titled, "Addendum," revealed that Registered Nurse (RN) #3 was re-educated by the Regional Resident Care Director regarding transcribing and confirming new orders per facility protocol. During an interview on 01/27/2025 at 1:44 PM, RN #3 stated that when a new resident moved in, the nurses received the resident's medication prescriptions and entered them into the medication administration record. She stated that if a licensed practical nurse (LPN) or RN entered the orders, then another RN checked the orders for accuracy. RN #3 stated they could not recall if Resident #2 missed any medications and did not recall a time when orders were not transcribed into the computer system. RN #3 did not remember a time when [NJ Exec O] or [NJ Exec Order 26.4b1] orders were not transcribed and did not recall receiving any training regarding transcribing orders. During an interview on 01/28/2025 at 10:24 AM, the ED stated she expected nurses to transcribe prescriptions into the computer when a resident moved in or returned from another facility. The ED noted it was determined that RN #3 was the nurse responsible for not transcribing all of Resident #2's prescriptions when the resident returned to the facility. The ED stated RN #3 was retrained after the incident by the regional office to ensure another RN checked orders for missing prescriptions or other errors. The ED stated she was unaware of any changes to the transcription process since the incident involving Resident #2's medications.	A 310		

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A 389	Continued From page 17	A 389		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 16. The right to be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility document and policy review, the facility failed to ensure residents' right to be free from [NJ Ex Order 26.4(] was honored, as evidenced by a failure to ensure emergency services were contacted and [NJ Exec Order 26.4b1] was initiated immediately when a resident, who desired [NJ Exec Order 26.4b] measures, was found [NJ Exec Order 26.4b1] which affected 1 (Resident #1) of 2 residents reviewed for [NJ Exec Orde] in the facility. It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. Findings included: A facility policy titled, "Cardiopulmonary Resuscitation (CPR)," revised 07/09/2018, indicated, "Action Steps 1. A resident who is found unresponsive, without a pulse the Team	A 389		

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A 389	Continued From page 18 Member will: a. Validate the resident's code status (available on the [electronic health record system] and on the resident face sheet) or ([electronic health record system] on the Resident Information Sheet). b. If the resident does not have a DNR [do not resuscitate] order: i. Call/have another team member call Emergency Services (911) ii. The CPR Certified Team Member will start CPR iii. Utilize an AED [automated external defibrillator] if present on site, per state requirements iv. Continue CPR until Emergency Services arrive and assumes care for the resident. c. While the general rule is to provide emergency treatment to a resident in cardiac arrest, there are a few exceptions where withholding CPR would be considered appropriate (American Heart Association). i. In the event the Licensed healthcare professional (such as a Physician, Physician Extender, RN [registered nurse]) acting within established scope of practice in the jurisdiction determines that the following signs are present, CPR will not be initiated: 1. Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril (e.g. [exempli gratia, for example], exposure to infectious diseases). 2. Clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, decomposition). 3. A valid advance directive, a Physician Order for Life-Sustaining Treatment (POLST) indicating that resuscitation is not desired, or a valid Do Not Attempt Resuscitation (DNAR)/Do Not Resuscitate (DNR) order." The policy revealed the "Responsible Parties" included the "Executive Director." A facility policy titled, "Responding To Medical Emergencies," dated 06/29/2005, revealed, "It is the policy of this community to provide immediate response to emergencies and to call for	A 389		

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A 389	Continued From page 19 emergency medical services (911) as indicated." The policy revealed, "5. The Licensed Nurse/Team Member (if there is not a licensed nurse in the community) will take the following steps when the resident is not on Hospice services: a. The Licensed Nurse/Team Member will call 911 for the following situations," which included, "vi. Change in level or loss of consciousness," "x. Lack of heartbeat or pulse," and "xiv. And or any other significant or potentially life threatening condition, or when a team member is in doubt." The policy revealed the "Responsible Parties" included the "Executive Director." A facility policy titled, "Abuse, Neglect, & Exploitation-Prevention, Reporting and Investigation," revised 05/04/2016, revealed, "It is the policy of the community that: a. Every reasonable effort within its control is taken to prevent the abuse, neglect, and exploitation of residents. Team Members must not engage in, nor permit anyone else to engage in, abuse, neglect or exploitation of any resident. b. Team members of the community are mandated reporters and have a duty to report known or suspected abuse, neglect and/or exploitation to local, state, federal and/or provincial authorities in accordance with applicable law and regulation. c. In addition, team members who know of or suspect abuse, neglect or exploitation of any resident must immediately notify the Executive Director/designee, to ensure appropriate action is timely taken for the safety of the resident and those potentially impacted." The policy revealed, "Neglect: the failure to provide goods and services necessary to protect the resident from health and safety hazards." The policy revealed the "Responsible Parties" included the "Executive Director."	A 389		

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A 389	Continued From page 20 Resident #1's "Visual/Bedside Individual Service Plan Report" indicated the facility admitted the resident on [redacted]. The report revealed the resident was a [redacted], indicating the resident wished to [redacted] in the event of [redacted]. A facility document titled, "Reportable Event Record/Report," dated [redacted], revealed that on [redacted] at approximately 4:55 AM, Care Manager (CM) #1 observed Resident #1 in bed, [redacted] The report indicated that, at 5:07 AM, CM #1 notified the RN on call that Resident #1 was [redacted] and was instructed to call 911 immediately. Per the report, CM #1 was not aware of Resident #1's [redacted]. The report indicated that emergency medical services (EMS) personnel arrived at the facility at approximately 5:15 AM and the resident was [redacted] The report indicated that it was determined that CM #1 failed to follow protocol regarding responding to medical emergencies and indicated that CM #1's employment was terminated. A typed facility document titled, "Privileged and Confidential Statement of Event," dated [redacted] and signed by CM #2, indicated that CM #2 had assisted CM #1 with providing [redacted] care for Resident #1, [redacted] and removing [redacted] on the resident's [redacted] The statement indicated that later that shift, CM #1 told CM #2 that Resident #1 was [redacted] The statement indicated that CM #1 called a supervisor and a nurse, then called 911. Per the statement, CM #2 waited by the doors to let the emergency services staff in to the unit. The statement indicated that the emergency medical	A 389		

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technicians (EMTs) arrived about 10 to 15 minutes later. The statement indicated that CM #1 asked CM #2 to open Resident #1's service plan to check the resident's the [redacted], which was when CM #2 saw that Resident #1's [redacted]. Per the statement, EMS personnel asked CM #2 if [redacted] had been initiated and why she had not called 911 sooner. The statement indicated that CM #2 did not recall the exact times of the incident.

A typed facility document titled, "Privileged and Confidential Statement of Event," dated [redacted] and signed by CM #1, indicated that she was in Resident #1's room before 2:30 AM and left before 3:00 AM and the resident was [redacted] and was [redacted] at that time. The statement indicated that she checked on the resident around 4:55 AM and the resident was [redacted] The statement indicated that the resident's [redacted] and the [redacted] of the resident's [redacted] looked [redacted] The statement indicated she alerted CM #2 and called Assisted Living Coordinator (ALC) #5 at 4:57 AM, then Reminiscence Coordinator (RC) #10 at 5:05 AM, who instructed her to call RN #3. The statement indicated that she called RN #3 at 5:07 AM, the call dropped, so she called back at 5:08 AM and was told RN #3 would call her back. The statement indicated that RN #3 called back at 5:13 AM and told CM #1 to call 911 and '[redacted]." The statement indicated that 911 was called at approximately 5:14 AM. Per the statement, when the EMS personnel arrived, CM #1 showed them where Resident #1 was. The statement indicated that an EMS member came out of Resident #1's room to inquire about Resident #1's [redacted]. The statement indicated they checked an electronic

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tablet and saw that Resident #1 was [NJ Exec Order 26.4b]. The statement indicated that an EMS member said to call 911 first, in the future.

A typed facility document titled, "Privileged and Confidential Statement of Event," dated [NJ Exec Order 26.4b1] and signed by RC #10, indicated that she received a call from CM #1 at 5:05 AM on [NJ Exec Order 26.4b1]. The statement indicated that RC #10 asked CM #1 if they had called RN #3, and when CM #1 said she had not, RC #10 told CM #1 to call RN #3 immediately. The statement indicated that she and the Executive Director (ED) arrived at the facility on [NJ Ex Order 26.4(b)(1)] at 10:15 PM and retrained care managers, including CM #1 and CM #2, about the protocol for calling 911, code status location, protocol for [NJ Exec Orde] of a resident, and location of transfer paperwork. The statement indicated that they trained the care managers that the RN was also to be called if they noticed a [NJ Exec Order 26.4b1] of a resident.

A typed facility document titled, "Privileged and Confidential Statement of Event," dated [NJ Exec Order 26.4b1] and signed by the ED, indicated that on [NJ Exec Order 26.4b1] at 10:15 PM, she and RC #10 arrived at the facility for a meeting with the Reminiscence care managers and the assisted living care managers. The statement indicated the care managers were retrained on responding to medical emergencies and [NJ Exec Order 26.4b1] policies. The statement indicated that CM #1 stated that upon her arrival to the shift, she checked on residents, including Resident #1, and everything was all right. The statement indicated CM #1 stated that she later went back to check on Resident #1 and to complete [NJ Exec Order 26.4b1] care and noted Resident #1 was [NJ Exec Order 26.4b1]. Per the statement, CM #1 called ALC #5 and RC #10 and was told to call RN #3. The statement indicated

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that CM #1 stated that RN #3 told them to call 911, and EMS [NJ Exec Order 26.4b1] Resident #1's [NJ Exec Orde] at 4:30 AM.

An EMS run report, dated [NJ Exec Order 26.4b1], revealed the EMS company was dispatched at 5:19 AM, arrived at the facility at 5:23 AM. The report indicated that "according to staff, the patient was in [NJ Exec Order 26.4b1] around 4 am [4:00 AM] and 911 was not called until 5:30 am [5:30 AM] when the patient had [NJ Exec Order 26.4b1]. Per the report, Resident #1's time of [NJ Exec Orde] was called at 5:40 AM.

During an interview on 01/28/2025 at 2:29 PM, ALC #5 stated it was the facility's policy to call a nurse first if a resident was [NJ Exec Order 26.4b1] She stated that when she spoke with CM #1 about Resident #1, she reminded her that she was not the person CM #1 should have called, she should have called a nurse first.

During an interview on 01/29/2025 at 8:52 AM, RC #10 stated that she received a call from CM #1 at around 4:57 AM stating that Resident #1 was [NJ Ex Order 26.4(b)(1)] She stated that she did not check to see if CM #1 had checked the resident's [NJ Exec Ord] or started [NJ Exec Ord] because she wanted to make sure RN #3 was notified. She stated that she asked CM #1 if she had notified nursing staff, and when CM #1 said they had not, she instructed CM #1 to call RN #3. She stated that RN #3 instructed CM #1 to call 911.

During an interview on 01/28/2025 at 12:16 PM, RN #3, who was a resident care director, stated that she would respond to a call of someone being [NJ Exec Order 26.4b1] if she was in the building. She stated care managers should check a resident's [NJ Exec Order 26.4b1], which was on an

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	90117	A. BUILDING: _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF MORRIS PLAI	209 LITTLETON ROAD MORRIS PLAINS, NJ 07950

(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 389	Continued From page 24 electronic tablet that should be with the staff member, call another staff for help, and start [NJ Exec Ord] while the other staff member called 911 and the nurse on call. She stated that she received a call from a CM a little after 5:00 AM who stated that Resident #1 was [NJ Exec Order 26.4b1] She stated that she questioned the CM how she knew the resident was [NJ Exec Ord] because care managers could not pronounce a resident's [NJ Exec Order] She stated that she told CM #1 to call 911. RN #3 stated that she did not ask the CM if she had initiated [NJ Exec Ord] or if she knew the resident's [NJ Exec Order 26.4b1]. She stated that, at first, she did not know what time CM #1 had found the resident [NJ Exec Order 26.4b1] She stated that she did not instruct CM #1 to start [NJ Exec Ords] During an interview on 01/28/2025 at 3:03 PM, the ED stated that during the investigation, CM #1 stated she did not start [NJ Exec Ord] because she knew Resident #1 was [NJ Exec Order 26.4b1] The ED stated that CM #1 should have checked the resident for a pulse, summoned another staff member on duty, transferred the resident to the floor, checked their [NJ Exec Order 26.4b1], started [NJ Exec Ords] and instructed the other staff member to call 911 and then call the nurse.	A 389		
A 751	8:36-7.3(b) Resident Assessments and Care Plans (b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced	A 751		

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A 751	Continued From page 25	A 751		

by:
Based on interview, record review, and facility policy review, the facility failed to revise residents' service plans after the residents exhibited NJ Exec Order 26.4b1 or expressed a [redacted] to [redacted] the facility for 2 (Resident #4 and Resident #5) of 3 residents reviewed for elopement.

It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause, serious injury, harm, impairment, or death to residents.

Findings included:

A facility policy titled, "Individualized Service Plan [ISP]," revised 02/19/2014, revealed, "Service Plan -An individualized plan of care developed by evaluating/assessing the resident. The plan addresses advanced directives, allergies and interventions to meet the preferences, psychosocial, cognitive, physical, safety and functional needs of the resident. Action Steps 1. The Resident Care Director (RCD)/Health Care Manager (HCM) ensures that each resident has an Individualized Service Plan (ISP). a. The ISP is initiated prior to move in and updates/completed: i. Within 72 hours after Move-In ii. Every six (6) months iii. With any significant change in condition iv. Additional updates may be made with changes in needs and/or at the resident or resident's responsible party request." The policy revealed the "Responsible Parties" included the "Executive Director."

1. Resident #4's service plan indicated the facility admitted the resident on NJ Exec Order 26.4b1. According to the service plan, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 to

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A 751	Continued From page 26 NJ Exec Order 26.4b1 [redacted] Resident #4's "Progress Notes," revealed a note, dated NJ Exec Order 26.4b1 at 4:29 PM and electronically signed by Registered Nurse (RN) #3, that indicated Resident #4 was in their room NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted]" The note indicated that Resident #4 walked out of their room and went towards an emergency exit door at the front of the facility but was stopped by staff. The note indicated that the resident wanted to find a particular person. The note indicated that a call was placed to the Regional Resident Care Director for feedback in addressing Resident #4's behavior and indicated that the resident presented a NJ Exec Order 26.4b1 assessed by the team. Resident #4's "Progress Notes" revealed a note, dated NJ Exec Order 26.4b1 at 7:06 PM, which indicated the resident stated that there was a NJ Exec Order 26.4b1 [redacted]. The note indicated the resident NJ Exec Order 26.4b1 behaviors. Resident #4's "Progress Notes" revealed a note, dated NJ Exec Order 26.4b1 at 11:15 AM, which indicated the resident NJ Exec Order 26.4b1 [redacted]. Resident #4's "Progress Notes" revealed a note, dated NJ Exec Order 26.4b1 at 9:17 AM and electronically signed by RN #4, that indicated that, on NJ Exec Order 26.4b1 at 4:15 PM, Resident #4 was NJ Exec Orde in a hallway NJ Exec Order 26.4b1 [redacted], with an NJ Exec Orde activated. The note indicated that Resident #4 was unable to provide a statement as to what happened. Per the note, Resident #4 was NJ Exec Order 26.4b1 [redacted] but was	A 751		

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A 751	Continued From page 27	A 751		

NJ Exec Order 26.4b1 . The note indicated that Resident #4 NJ Exec Order 26.4b1 . The note indicated changes were made to Resident #4's service plan.

Resident #4's service plan revealed that a focus statement addressing NJ Exec Order 26.4b1 risk and NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 was not initiated until NJ Exec Order 26.4b1. Resident #4's service plan was not revised immediately following the documented instances of NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 to indicate the resident was at risk or to direct staff regarding how to intervene should the resident NJ Exec Order 26.4 the facility.

During an interview on 01/28/2025 at 12:16 PM, RN #3 stated that Resident #4 exhibited NJ Exec Order 26.4b1 prior to the NJ Exec Order 26.4b1 when they were found in the hallway with an NJ Exec Order 26.4b1.

During an interview on 01/28/2025 at 5:05 PM, the Executive Director (ED) stated that once a resident began verbalizing an intent to NJ Exec Orde behaviors, the facility would identify them as an NJ Exec Order 26.4b1 risk. The ED stated an update to the care plan should take place.

2. Resident #5's service plan revealed the facility admitted the resident on NJ Exec Order 26.4b1 According to the service plan, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1

Resident #5's "NJ [New Jersey] 3.0 SEHA [Service Evaluation and Health Assessment] - V 9

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A 751	Continued From page 28	A 751		

[Version 9]," dated [NJ Exec Order 26.4b1], revealed that Resident #5 had [NJ Exec Order 26.4b1] in relation to [NJ Exec Order 26.4b1] and that staff should provide Resident #5 with [NJ Exec Order 26.4b1] as needed to ensure that they did not compromise their [NJ Exec Order 2]

Resident #5's "Progress Notes" revealed a note, dated [NJ Exec Order 26.4b1] at 3:16 PM and electronically signed by Registered Nurse (RN) #3, that indicated Resident #5 was seen with a clear plastic bag containing their [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(] while verbalizing they were [NJ Ex Order 2]. The note indicated Resident #5 was [NJ Exec Order 26.4b1] back to their room and that their [NJ Exec Order 26.4b1] to their new environment was [NJ Exec Orde] but they were encouraged to attend activities and engage with their peers.

Resident #5's "Progress Notes" revealed a note, dated [NJ Exec Order 26.4b1] at 10:17 AM and electronically signed by RN #3, that indicated Resident #5 began [NJ Ex Order 26.4(b)(1)] outside of their room around 2:30 AM while stating they [NJ Exec Order 26.4b1] and take a walk. The note indicated the resident was assisted back to bed but that Resident #5 was back in their wheelchair [NJ Exec Order 26.4b1] in their room by 3:16 AM. The note indicated that Resident #5 was [NJ Ex Order 26.4(b)(1)] to their new environment. Per the note, staff would continue to redirect Resident #5 when they [NJ Exec Order 26.4b1]

Resident #5's "Progress Notes" revealed a note, dated [NJ Exec Order 26.4b1] at 2:19 PM and electronically signed by RN #3, that revealed Resident #5 [NJ Exec Order 2] on [NJ Exec Order 26.4b1] at 1:57 PM. The note revealed Resident #5 [NJ Exec] the facility but [NJ Exec Order 26.4b1] The note indicated Resident #5 was observed at a [NJ Exec Order 26.4b1]. Per the note,

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A 751	Continued From page 29 Resident #5 stated, NJ Exec Order 26.4b1 ." The note indicated that the resident was NJ Exec Order 26.4b1 of the building "NJ Exec Order 26.4b1" and another resident observed the resident NJ Exec Order 26.4b1 in their wheelchair up the NJ Exec Order towards a road and notified staff. Resident #5's service plan revealed that a focus area addressing NJ Exec Order 26.4b1 risk and NJ Ex Order 26.4(b)(1) or NJ Exec Order 26.4b1 was not initiated until NJ Exec Order 26.4b1. Resident #5's service plan was not revised immediately on NJ Exec Order 26.4b1 after the resident NJ Exec Order 26.4b1 the facility or on NJ Exec Order 26.4b1 when staff observed the resident NJ Exec Order 26.4b1 and the resident NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. During an interview on 01/28/2025 at 5:05 PM, the Executive Director (ED) stated that once a resident began verbalizing an intent to NJ Exec Order , the facility would identify them as an NJ Exec Order 26.4b1 risk. The ED stated an update to the care plan should take place.	A 751		
A 925	8:36-11.2 Pharmaceutical Services The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations.	A 925		

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A 925	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on interview and facility document and policy review, the facility failed to administer medications as ordered for 1 (Resident #2) of 3 residents reviewed for pharmaceutical services. Findings included: A facility policy titled, "New Resident Move-In Process," revised 07/15/2013, revealed, "3. A History and Physical (Physician's Report) and Physician's Move-In Orders must completed [sic] (within 30-90 days before Move-In) and be received by the Health Care Coordinator or Wellness Nurse to ensure that [facility name] is able to arrange medical support for any known health conditions." The policy revealed, "B. The Health Care Coordinator or Wellness Nurse reviews the Service Evaluation and Health Assessment, the Physician's Report and Physician's Move-In Orders. The information is used to arrange ordering, delivering and administration of medication; support services; special equipment and appointments." Resident #2's service plan indicated the facility admitted the resident on NJ Exec Order 26.4b1. According to the service plan, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 [redacted] Resident #2's service plan included a focus area, initiated on NJ Exec Order 26.4b1, that indicated the resident was NJ Exec Order 26.4b1 their medications. Interventions directed staff to assist the resident with their medications with their preferred beverage.	A 925		

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A 925	Continued From page 31 A facility document titled, "Reportable Event Record/Report," dated [NJ Exec Order 26.4b1], revealed that Resident #2 returned to the facility from a rehabilitation center on [NJ Exec Order 26.4b1] with orders for staff to administer [NJ Exec Order 26.4b1] one tablet daily and two sprays of [NJ Exec Order 26.4b1] one time a day. The Reportable Event Record/Report revealed that, on [NJ Exec Order 26.4b1] the Advanced Practice Nurse (APN) reviewed Resident #2's discharge documents and noticed that [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] were missing on Resident #2's transcribed orders. The Reportable Event Record/Report revealed that the nurse on duty on [NJ Exec Order 26.4b1] immediately transcribed and ordered the medications from the pharmacy. Per the Reportable Event Record/Report, Resident #2 missed four doses of their ordered [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1]. An undated document titled, "Addendum," revealed that Registered Nurse (RN) #3 was re-educated by the Regional Resident Care Director regarding transcribing and confirming new orders per facility protocol. During an interview on 01/27/2025 at 1:44 PM, RN #3 stated that when a new resident moved in, the nurses received the resident's medication prescriptions and entered them into the medication administration record. She stated that if a licensed practical nurse (LPN) or RN entered the orders, then another RN checked the orders for accuracy. RN #3 stated they could not recall if Resident #2 missed any medications and did not recall a time when orders were not transcribed into the computer system. RN #3 did not remember a time when [NJ Exec O] or [NJ Exec Order 26.4b1] were not transcribed and did not recall receiving	A 925		

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A 925	Continued From page 32 any training regarding transcribing orders. During an interview on 01/28/2025 at 10:24 AM, the ED stated she expected nurses to transcribe prescriptions into the computer when a resident moved in or returned from another facility. The ED noted it was determined that RN #3 was the nurse responsible for not transcribing all of Resident #2's prescriptions when the resident returned to the facility. The ED stated RN #3 was retrained after the incident by the regional office to ensure another RN checked orders for missing prescriptions or other errors. The ED stated she was unaware of any changes to the transcription process since the incident involving Resident #2's medications.	A 925		

SUNRISE
SENIOR LIVING

Sunrise Senior Living
Plan of Correction

Name of Facility: Sunrise of Morris Plains
Address of Facility: 209 Littleton Road. Morris Plains, NJ 07950.
License number: 90117
Inspection date(s): January 27-29, 2025.
Name and Title of Legal Entity Representative Signing the Plan of Correction:
Andrea Martinez, Executive Director
Signature of Sunrise Representative: NJ Exec Order 26.4b1
Date of Submission: April 4, 2025

Regulation	Target Date by Which Correction will be completed	Plan of Correction
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;	4/7/2025	Resident # NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 Resident # 2 Moved out of facility NJ Exec Order 26.4b1 Resident #3 Moved out of the facility on NJ Exec Order 26.4b1 Resident #5 Moved out of the facility NJ Exec Order 26.4b1 All residents in the facility have the potential to be affected. Upon receiving the survey report on 1/29/2025, community Executive Director and Resident Care Director, RN, began re-training sessions on 1/30/2025 of Care Coordinators, CNAs, HHAs, CMAs, LPNs, RNs. The following policies were reviewed: *'Assessing and Evaluating Residents', Individualized Service Plan', 'Responding to Medical Emergencies, and 'Cardiopulmonary Resuscitation', and 'Elopement and Missing Residents'*. Immediate re-training was also conducted on 1/16/2025. ED or designee will ensure training on these policies with new team members upon hire. ED or designee will ensure re-education is provided as necessary, particularly in response to policy updates. This Plan of Correction to ensure the accuracy of resident's Code Status orders, and 'Responding to Medical Emergencies 'will be discussed and evaluated quarterly for two quarters by the ED or designee and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violations does not occur again. QAPI meeting initiated on 1/30/2025 by the ED with the coordinators.

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
A 389 8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 16. The right to be free from physical and mental abuse and/or neglect;	4/7/2025	Resident #1 NJ Ex Order 26.4(b)(1) Reported to DOH on 1/16/2025. All residents in the facility with 'DNR' orders have the potential to be affected. 1/30/2025, Resident Care Director, RN, reviewed all resident's code status orders for accuracy. On 1/30/2025, Executive Director and Resident Care Director, RN, began re-training sessions for the care staff (CNAs, HHAs, CMAs, LPNs, RNs) on Resident 'Code Status' orders. If as resident is found unresponsive and without a pulse, the team member will validate the resident's code status; available on the tablet through POC/eMAR and paper chart. Review of Policies included in the training sessions: CPR, Responding to Medical Emergencies, General Service Plans. Our facility uses an eMAR and Point of Care (POC) to document medication administration and care provided to residents. Each resident's code status is displayed on the eMAR and POC screens (DNR or Full Code). This information is readily available to all Team Members. In addition, all residents have a 'move-in' record (face sheet) in front of their chart that specifies their code status. All residents with signed and current 'DNR' or 'POSLT' have the paper order available that is in front of their chart. ED or designee, and RCD or RN designee will review the 'Assessment and Orders-Code Status' during weekly Interdisciplinary meetings for 4 weeks. This Plan of Correction to ensure the accuracy of resident's Code Status orders will be discussed and evaluated quarterly for two quarters by the ED or designee and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violations does not occur again. QAPI meeting initiated on 1/30/2025 by the ED with the department coordinators.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
A 751 8:36-7.3(b) Resident Assessments and Care Plans (b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.	4/7/2025	Resident #3 Moved out of the facility on [redacted] Resident #4 Moved out of the facility on [redacted]. Resident #5 Moved out of the facility [redacted] All residents in the facility that present with risk factors of elopement have the potential to be affected. RN reviewed care plans for accuracy with interventions. Appropriate updates were made to the resident's medical record. On 1/30/2025, ED completed training on 'Assessing and Evaluating Residents', 'Health and General Service Plan'. RN and ED or designee will review, discuss and document plan of care for residents with elopement risk factors during weekly 'Interdisciplinary' meetings for 4 weeks, or until needs resolve. This removal plan is to ensure the accuracy of proper interventions for each resident who shows risk factors for elopement and will be evaluated quarterly for two quarters by the Executive Director or designee at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended, and a new removal plan and training will be implemented and evaluated to verify the violations does not occur again. QAPI meeting initiated on 1/30/2025.
A 925 8:36-11.2 Pharmaceutical Services The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter	4/7/2025	Resident #2 moved out [redacted] All residents receiving medication administration assistance in the facility have the potential to be affected. On 1/30/2025 RN reviewed residents who were re-admitted and new admissions in the last 14 days. This audit focused on the medication reconciliation for accuracy. Resident Care Director, RN completed audit to include the following steps: 1. Receiving the written orders from prescriber. 2. Fax written orders to the preferred pharmacy. 3. Transcribe orders in PCC. 4. Review entered orders with the pharmacy and the original written orders for accuracy. 5. Resident Care Director, RN, or RN designee will review each re-admission for medication reconciliation accuracy. Training conducted for nurses (LPNs, and RNs) focusing on the critical steps to take when entering orders for residents who are re-admitted to the facility. This training aimed to enhance the understanding and execution of proper entry procedures to improve patient safety. Steps include: 1. Receiving the written orders from prescriber. 2. Fax written orders to the preferred pharmacy. 3.

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
and all applicable State and Federal laws and regulations.		Transcribe orders in PCC. 4. Review entered orders with the pharmacy and the original written orders for accuracy. 5. Resident Care Director, RN, or RN designee will review each re-admission for medication reconciliation accuracy. The Resident Care Director, RN, or RN designee will review each re-admission for medication reconciliation accuracy. RN, Care Coordinators and ED or designee will review and discuss plan of care for residents returning to the community during weekly Interdisciplinary meetings. The accuracy of medication reconciliation will be discussed first quarter period by the Executive Director or designee at the Quality Assurance and Performance Improvement (QAPI) committee to verify it is still effective. If not effective, it will be amended, and a new corrective plan and training will be implemented and evaluated to verify the violations does not occur again.

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.