STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	922TYU	A. BUILDING: _____ B. WING _____	C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT ARLINGTON SENIOR LIVING	2 HILLSIDE DRIVE MOUNT ARLINGTON, NJ 07856

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Standard with Complaint Complaint #: NJ 00166243, NJ 00177380, NJ 00157990 Census: 79 Sample Size: 14 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		

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

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that th facility failed to develop and implement a policy and procedure for Certified Medication Aide training and oversight by a Registered Nurse as evidenced by the following: On 10/8/24 at 12:35 p.m., the surveyor interviewed the AHWD/LPN regarding RN medication review and CMA training. The AHWD/LPN stated that she was not aware of any CMA competency binder or where to locate the CMA competencies. In addition, the AHWD stated that the Director of Nursing (DON) resigned in August of 2024 and the Regional RN covered the facility. At 1:34 a.m., the surveyor interviewed the Regional Director of Health and Wellness (RHWD)regarding CMA medication review and training. The RHWD stated that she was not aware of where to find the CMA review of medication and training records. In addition, the RHWD stated that the traveling RN that covered the facility was not available and she was unable to notify the RN to find out where the CMA medication review and training were located. On 10/9/24 at 2:30 p.m., the surveyor requested the CMA delegation/RN oversight and training policy and procedure from the RHWD. At 2:55 p.m., the surveyor also requested the CMA delegation/RN oversight and training policy	A 310		

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A 310	Continued From page 2 from the Executive Director (ED). The ED stated that he was new to the facility and was not aware of all policy and procedures. On 10/10/24 the facility was unable to provide the surveyor with a policy and procedure for CMA training on medication administration and RN oversight. Reference: 8:36-11.5(b)(3)(i-v) 8:36-11.5(b)(5)	A 310		
A 355	8:36-4.1(a)(1) Resident Rights comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, 1. The right to receive personalized services and care in accordance with the resident's individualized general service and/or health service plan; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00177380 Based on interview, record review, and review of pertinent facility documents it was determined that the facility failed to provide personalized services and care in accordance with the	A 355		

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A 355	Continued From page 3	A 355		

resident's General Service Plan (GSP) for 4 of 14 residents, Residents #2, #3, #4, and #5. This deficient practice was evidenced by the following:

On 10/8/24, the surveyor reviewed the closed Medical Record (MR) of Resident #2, who was admitted to the facility with a diagnosis of [redacted]. The surveyor reviewed Resident #2's GSP, initiated on [redacted], which indicated that Resident #2 had [redacted]. The GSP indicated, [redacted]. The GSP also indicated that Resident #2 [redacted]. The surveyor reviewed Resident #2's physician orders and did not observe an order for a [redacted].

Further, the surveyor reviewed two Progress Notes (PN) written by the former Director of Nursing (DON). One PN dated [redacted] documented, [redacted] LPN [Licensed Practical Nurse] ... [redacted]. [Resident #2] [redacted] Resident was taken to [a local hospital] for evaluation." The second PN, dated [redacted], documented that the DON spoke with Resident #2's Power of Attorney (POA), who informed the DON that Resident #2 [redacted] and four[redacted]

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A 355	Continued From page 4 At 1:00 p.m., the surveyor interviewed the Assistant Director of Health and Wellness (ADHW) regarding Resident #2's NJ ex order 26.4b1 [redacted]. During the interview, the surveyor inquired about Resident #2's NJ ex order 26.4b1. The ADHW stated that Resident #2 NJ ex order 26.4b1 [redacted]. Further, the surveyor inquired the reason Resident #2 NJ ex order 26.4b1 [redacted] even though the resident's GSP stated that the resident had NJ Ex Order 26.4(b)(1). The ADHW stated that the NJ Ex Order 26.4(b)(1) by the former DON, and that she did not know why the NJ ex order [redacted] On 10/9/24 at 1:59 p.m., the surveyor interviewed the concierge on duty to inquire if any of the residents on the 'NJ ex order 26.4b1 NJ ex order 26.4b1" list NJ ex order 26.4b1 [redacted]. The Concierge stated that Resident #3 NJ ex order 26.4b1 [redacted] Resident #4 NJ ex order 26.4b1 [redacted] and Residents #5 and #6 would sometimes NJ Ex Order 26.4(b)(1). The concierge stated that she would NJ Ex Order 26.4(b)(1) [redacted] every so often NJ Ex Order 26.4(b)(1) the residents. The surveyor reviewed the MR for Resident #3, who was admitted to the facility with a diagnosis of NJ Ex Order 26.4(b)(1). The surveyor reviewed the resident's GSP, last revised on NJ ex order 26.4b1, which indicated the resident NJ ex order 26.4b1 [redacted] The surveyor also reviewed the MR for Resident #4, who was admitted to the facility with a NJ ex order 26.4b1 [redacted]. The surveyor reviewed the resident's GSP, last revised on NJ ex order 26.4b1 which indicated the resident had a	A 355		

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A 355	Continued From page 5	A 355		

NJ ex order 26.4b1 [redacted]

Additionally, the surveyor reviewed Resident #5's MR, NJ ex order 26.4b1 [redacted] The surveyor reviewed the resident's GSP, last revised on NJ ex order 26.4b which indicated that the resident NJ ex order 26.4b1 [redacted].

At 2:22 p.m., the surveyor interviewed the Regional Director of Health and Wellness (RDHW) and the Business Office Manager (BOM) to inquire if there was a system in place to ensure the safety of residents at risk for NJ Ex Order 26.4(b)(1) [redacted] when NJ Ex Order 26.4(b [redacted] The RDHW stated that staff would NJ Ex Order 26.4(b)(1) every couple of minutes to check on residents NJ Ex Order 26.4(b)(1). In addition, the BOM stated that some residents at risk for NJ Ex Order 26.4(b)(1) [redacted] would sit in one specific chair that was in the concierge's view, and that sometimes staff would NJ Ex Order 26.4(b)(1) with the residents. The surveyor inquired the reason residents at risk for NJ Ex Order 26.4(b)(1) were permitted to NJ Ex Order 26.4(b)(1) [redacted], and the RDHW stated that all the residents on the NJ Ex Order 26.4(b)(1) risk list without NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(1), and that they were only put on the list because they had a diagnosis of NJ Ex Order 26.4(b)(1) [redacted]

The surveyor reviewed the facility policy titled, "Resident Safety Equipment Policy," which indicated, "Any resident assigned a safety device, due to Wandering/Elopement Risk Evaluation Tool, will wear the bracelet, anklet, token, pendant on their person ... If residents are viewed leaving the community by the front desk staff, and they are known to be at risk, the Director of

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A 355	Continued From page 6 Nursing or Director of Resident Care should be notified immediately." Reference- 8:36-4.1(a)(22) A-0401	A 355		
A 401	8:36-4.1(a)(22) 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: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00177380 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to enforce the resident's right to live in safe conditions for 5 of 14 residents, Residents #2, #3, #4, #5, and #6. This deficient practice was evidenced by the following: 1. On 10/8/24, the surveyor reviewed the closed Medical Record (MR) of Resident #2, who was admitted to the facility in NJ ex order 26.4b1 with diagnoses of NJ ex order 26.4b1 [redacted] The surveyor reviewed Resident #2's GSP, NJ ex order 26.4b1 , which indicated that	A 401		

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A 401	Continued From page 7 Resident #2 had NJ ex order 26.4b1 The GSP indicated, NJ ex order 26.4b1 ..NJ ex order 26.4b1 NJ ex order 26.4b1 The GSP also indicated that Resident #2 NJ ex order 26.4b1 The surveyor reviewed Resident #2's physician orders and did not observe an order for NJ Ex Order 26.4(b)(1). Further, the surveyor reviewed two Progress Notes (PN) written by the former Director of Nursing (DON). One PN dated NJ ex order 26.4b1 documented, NJ ex order 26.4b1 ... [Resident #2] NJ ex order 26.4b1 [he/she] NJ ex order 26.4b1 ..NJ ex order 26.4b1 ." The second PN, dated NJ ex order 26.4, documented that that the DON spoke with Resident #2's Power of Attorney (POA), who informed the DON that Resident #2 NJ ex order 26.4b1 At 1:00 p.m., the surveyor interviewed the Assistant Director of Health and Wellness (ADHW) to inquire about Resident #2's NJ ex order 26.4b1, and the ADHW stated that a former LPN performed a nighttime medication pass and noticed that Resident #2 NJ ex order 26.4b1. The ADHW stated that	A 401		

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A 401	Continued From page 8 staff then NJ Ex Order 26.4(b)(1) and notified [redacted] and Resident #2's family. The ADHW stated that Resident #2 NJ ex order 26.4b1 [redacted] During this interview, the surveyor also inquired if Resident #2 NJ ex order 26.4b1, and the ADHW stated that Resident #2 NJ ex order 26.4b1 [redacted]. Further, the surveyor inquired the reason Resident #2 did not have NJ Ex Order 26.4(b)(1) even though his/her service plan stated that the resident would. The ADHW stated that the service plan was completed by the former DON, and that she did not know why the service plan mentioned NJ Ex Order 26.4(b)(1). On 10/9/24 at 1:59 p.m., the surveyor interviewed concierge to inquire if any of the residents on the, "Residents at Risk of Elopement," list went outside unattended. Concierge stated that Resident #3 NJ ex order 26.4b1 [redacted], Resident #4 NJ ex order 26.4b1 [redacted] and Residents #5 and #6 NJ ex order 26.4b1 [redacted]. The surveyor then inquired what the protocol was for NJ Ex Order 26.4(b)(1) residents who NJ Ex Order 26.4(b)(1). Concierge stated that she would NJ Ex Order 26.4(b)(1) every so often to monitor the residents, and that if there was a resident she was worried about, she would have the resident sit in one specific chair that is visible from the front desk. 2. The surveyor reviewed the MR for Resident #3, who was admitted to the facility in NJ ex order 26.4b1 [redacted] with a diagnosis of NJ ex order 26.4b1. The surveyor reviewed the resident's, NJ ex order 26.4b1 NJ ex order 26.4b1" dated [redacted], which indicated the	A 401		

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A 401	Continued From page 9	A 401		

resident NJ ex order 26.4b1 . The surveyor also reviewed the resident's GSP, last revised on NJ ex order 26.4b1, which indicated the resident NJ ex order 26.4b1

3. The surveyor also reviewed the MR for Resident #4, who was admitted to the facility in NJ ex order 26.4b1 with a diagnosis of NJ ex order 26.4b1 The surveyor reviewed the resident's, NJ ex order 26.4b1 ," dated NJ ex order 26.4b1, which indicated the resident NJ ex order 26.4b1 . The surveyor also reviewed the resident's GSP, last revised on NJ Ex Order 26.4b1, which indicated the resident had a NJ ex order 26.4b1

4. Additionally, the surveyor reviewed the MR for Resident #5, who was admitted to the facility in NJ ex order 26.4b1 with NJ ex order 26.4b1 . The surveyor reviewed the resident's, 'NJ ex order 26.4b1 " dated NJ ex order 26.4b1, which indicated the resident NJ ex order 26.4b1 . The surveyor also reviewed the resident's GSP, last revised on NJ ex order 26.4, which indicated the resident had a NJ ex order 26.4b1

5. The surveyor also reviewed the MR for Resident #6, who was admitted to the facility in NJ ex order 26.4b1 with a diagnosis of NJ ex order 26.4b1 . The surveyor reviewed the resident's, NJ ex order 26.4b1 ," dated NJ ex order 26.4b1, which indicated the resident NJ ex order 26.4b1

At 2:22 p.m., the surveyor interviewed the Regional Director of Health and Wellness (RDHW) and the Business Office Manager

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A 401	Continued From page 10	A 401		

(BOM) to inquire if there was a system in place to ensure the safety of residents at risk for NJ Ex Order 26.4(b)(1) who would NJ Ex Order 26.4(b)(1). The RDHW stated that staff would NJ Ex Order 26.4(b)(1) every couple of minutes to check on residents that were at risk for NJ Ex Order 26.4(b)(1) In addition, the BOM stated that some residents at risk for NJ Ex Order 26.4(b)(1) would sit in one chair that was in the concierge's view, and that sometimes staff would sit outside with the residents. The surveyor then inquired the reason residents at risk for NJ Ex Order 26.4(b)(1) were permitted to go outside unattended without continuous supervision/monitoring, and the RDHW stated that all the residents on the NJ Ex Order 26.4(b)(1) risk list without NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(1), and that they were only put on the list because they NJ ex order 26.4b1 .

On 10/10/24 at 2:03 p.m., the surveyor interviewed Resident #2's Emergency Point of Contact/Power of Attorney (POA) regarding Resident #2's NJ ex order 26.4b1 Resident #2's POA stated that Resident #2 NJ ex order 26.4b1 Resident #2's POA stated that Resident #2 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Resident #2's POA stated that the resident was admitted to NJ Ex Order 26.4(b)(1)

The surveyor reviewed the facility policy titled, "Resident Safety Equipment Policy," which indicated, "Any resident assigned a safety device, due to Wandering/Elopement Risk Evaluation Tool, will wear the bracelet, anklet, token, pendant on their person ... If residents are viewed leaving the community by the front desk staff, and they are known to be at risk, the Director of Nursing or Director of Resident Care should be

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A 401	Continued From page 11 notified immediately." On 11/1/24, the facility submitted a revised removal plan that addressed [NJ Ex Order 26.4(b)(1)] concerns, including continuous monitoring of residents at risk for [NJ Ex Order 26.4(b)(1)] and direct staff supervision when outside of the facility. In addition, facility will provide staff training on [NJ Ex Order 26.4(b)(1)] risks and procedures.	A 401		
A 511	8:36-5.5(a) General Requirements (a) The facility or program shall develop and implement written job descriptions to ensure that all personnel are assigned duties based upon their education, training, and competencies and in accordance with their job descriptions. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to ensure that a written job description was developed and implemented to ensure an employee possessed the necessary education and competency to perform their assigned duties for 1 of 10 employee files reviewed, Employee #4 as evidenced by the following; On 10/9/2024 at 1:20 p.m., the surveyor reviewed Employee #4's file, a Home Health Aide (HHA) provided by the facility's Business Office Manager (BOM). According to the employee file, Employee #4 was employed at the facility on [NJ Ex Order 26.4(b)] Surveyor review of the employee file did not observe a job description in the employee's file.	A 511		

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A 511	Continued From page 12 At 2:30 p.m., the surveyor interviewed the BOM who stated that all employee files should have a signed job description.	A 511		
A 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures; 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19.	A 517		

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A 517	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and review of employee files, it was determined that the facility failed to ensure that 8 of 10 facility employees received the required annual mandatory staff education for Employees #'s 2, 3, 4, 5, 6, 7, 9, and 10. This deficient practice was evidenced by the following: On 10/9/2024 at 1:20 p.m., the surveyor reviewed ten (10) employee files provided by the facility's Business Office Manager (BOM) which revealed 8 of the 10 employees did not have documentation that all required educations were completed. 1. Employee #2 had a Date of Hire (DOH) of NJ ex order 26.4b1, had no documentation for the required education related to Resident Rights or Abuse and Neglect. 2. Employee #3 had a DOH of NJ ex order 26.4b1 and had no documentation for the required education related to Emergency Drill, Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Emergency Training, Alzheimer Dementia, and Pain management.	A 517		

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A 517	Continued From page 14 3. Employee #4 had a DOH of [NJ ex order 26.4b1] and had no documentation for the required education related to Emergency Drill, Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Emergency Training, Alzheimer Dementia, and Pain management. 4. Employee #5 had a DOH of [NJ ex order 26.4b1] and had no documentation for the required education related to Emergency Drill and Emergency Training. 5. Employee #6 had a DOH of [NJ ex order 26.4b1] and had no documentation for the required education related to Resident Rights, Abuse and Neglect, and Emergency Training. 6. Employee #7 had a DOH of [NJ ex order 26.4b1] and had no documentation for the required education related to Emergency Drill, Resident Rights, and Emergency Training. 7. Employee #9 had a DOH of [NJ ex order 26.4b1] and had no documentation for the required education related to Resident Rights, Abuse and Neglect, and Emergency Training. 8. Employee #10 had a DOH of [NJ ex order 26.4b1] and had no documentation for the required education related to Emergency Drill, Resident Rights, Infection Control, Abuse and Neglect, and Emergency Training. At 1:29 p.m., the surveyor interviewed the facility's Assistant Health and Wellness Director who stated that the facility's BOM was in charge of the facility's employee files and ensuring required educations were completed. At 2:30 p.m., the surveyor interviewed the BOM	A 517		

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A 517	Continued From page 15 pertaining to documentation of completion of the required education. The BOM stated that she was not aware of all the required educations and believed that some educations were located in the facility's online education system or were in possession of other department managers. The BOM was unable to provide the surveyor with the above-mentioned training for the above employees.	A 517		
A 539	8:36-5.7(a)(2) General Requirements (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 2. A description of the services which the assisted living residence, comprehensive personal care home or assisted living program is capable of providing; This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that a printed policy and procedure manual was available on the premises for surveyor review. This deficient practice was evidenced by the	A 539		

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A 539	Continued From page 16 following: On 10/8/24 at 10:38 p.m., the surveyor interviewed the Executive Director regarding the facility policy and procedures and waivers. The ED stated that he started at the facility on [NJ ex order 26.4b] and was not aware of all the facility's policy and procedures and waivers. In addition, the ED stated that the Regional Health and Wellness Director (RHWD) would assist the surveyor with requested policy and procedures. At 1:34 p.m., the surveyor interviewed the RHWD regarding the facility policy and procedure manual for surveyor review. The RHWD stated that there was no policy and procedure manual and that she would print out the policy and procedures upon surveyor request from online. On 10/9/24 at 2:30 p.m., the RHWD stated a second time that the facility policy and procedures were electronic and online and that there was no printed manual for surveyor review.	A 539		
A 547	8:36-5.7(a)(6) General Requirements (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 6. Policies and procedures for the maintenance of personnel records for each employee, including at least his or her name,	A 547		

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A 547	Continued From page 17 previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description, records of orientation and inservice education, and evaluation of job performance; This REQUIREMENT is not met as evidenced by: Based on interview and review of employee files, it was determined that the facility failed to ensure that employee's NJ Ex Order 26.4(b)(1) records were maintained for 6 of 10 employees reviewed, Employee #'s: 1, 2, 4, 5, 6, and 7. This deficient practice was evidenced by the following: On 10/9/2024 at 1:20 p.m., while conducting a complaint and standard survey, the surveyor reviewed ten employee files provided by the facility's Business Office Manager (BOM) which revealed 6 out of the 10 employee files reviewed did not contain and NJ Ex Orde 1. Employee #1 had a Date of Hire (DOH) of NJ ex order 26.4b1, had no documentation of a NJ Ex Orde. 2. Employee #2 had a DOH of NJ ex order 26.4b1, had no documentation of a NJ Ex Orde. 3. Employee #4 had a DOH of NJ ex order 26.4b1, had no documentation of a NJ Ex Order 4. Employee #5 had a DOH of NJ ex order 26.4b1, had no documentation of a NJ Ex Orde. 5. Employee #6 had a DOH of NJ ex order 26.4b1, had no documentation of a NJ Ex Orde. 6. Employee #7 had a DOH of NJ ex order 26.4b1, had no documentation of a NJ Ex Order	A 547		

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A 547	Continued From page 18 At 2:30 p.m., the surveyor interviewed the facility's BOM pertaining to the above-mentioned employee [NJ Ex Orde]s, the BOM stated the [NJ Ex Orde]s should have been in the employees files.	A 547		
A 553	8:36-5.7(b) General Requirements (b) The facility shall have a policy and procedure that addresses how policy and procedure manuals will be made available to residents, guardians, designated responsible individuals, prospective applicants, and referring agencies. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to develop, implement, and enforce a facility policy and procedure that addresses how policy and procedure manuals will be made available to residents, guardians, designated responsible individuals, prospective applicants, and referring agencies. This deficient practice was evidenced by the following: On 10/8/2024 at 10:22 a.m., during the entrance conference of a standard and complaint survey, the surveyor interviewed the facility's Assistant Health and Wellness Director (AHWD) who stated that the facility's Traveling Clinical Health and Wellness Nurse was pulling the requested facility policies. During continued surveyor interview, the AHWD stated that she did not have access to the facility's policy and procedure manual as it was located in the Executive Director office. In addition, the AHWD stated that the facility's staff would have to ask for the policy.	A 553		

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A 553	Continued From page 19 On 10/9/2024 at 11:45 a.m., the surveyor interviewed the facility's Certified Medication Aide (CMA, CMA#), who stated that she could get the facility's policy and procedure manuals were located in the facility's Wellness Office and Executive Director Office. During continued surveyor interview, CMA # , who stated she was unable to get the policies herself and would have to ask for it. At 1:20 p.m., the surveyor reviewed the policy and procedures given to the survey team and did not observe a policy related to the facility's policy and procedure manual. At 2:28 p.m., the surveyor interviewed the facilities Regional Health and Wellness Director (RHWD) who stated the facility's policy and procedures are located online and that all employees could access the manual through any facility computer. In addition, the RHWD stated that the facility did not like policy and procedure binders. At that time the surveyor requested the facility's policy on policy and procedure manuals. On 10/10/2024 at 11:07 a.m., the RHWD stated that the facility did not have a policy on policy and procedure manuals.	A 553		
A 581	8:36-5.11(a)(4) General Requirements (a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public: 4. Business hours of the facility;	A 581		

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A 581	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post a notice of the facility's business hours of the facility in a conspicuous place that can be viewed by the facility residents and the public. This deficient practice was evidenced by the following: On 10/8/2024 at 10:46 a.m., while conducting a complaint and standard survey, the surveyor toured the facility and did not observe a posting that contained the facility's business hours. On 10/9/2024 at 10:07 a.m., the surveyor interviewed the facility's Regional Health and Wellness Director (RHWD) who stated that the facility did not have the facility business hours posted in the facility.	A 581		
A 585	8:36-5.11(a)(6) General Requirements (a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public: 6. The toll-free hot line number of the Department; telephone numbers of county agencies and of the State of New Jersey Office of the Ombudsman; This REQUIREMENT is not met as evidenced by: Based observation and interview, it was determined that the facility failed to conspicuously	A 585		

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A 585	Continued From page 21 post a notice that the informed the facility's resident and public of the toll-free hot line telephone number of the New Jersey Department of Health (NJDOH). This deficient practice was evidenced by the following: On 10/8/2024 at 10:46 a.m., while conducting a complaint and standard survey, the surveyor toured the facility and did not observe a posting that contained the NJDOH toll-free hot line telephone number. On 10/9/2024 at 10:07 a.m., the surveyor interviewed the facility's Regional Health and Wellness Director (RHWD) who stated that the facility did not have the NJDOH toll-free hot line telephone number posted and that she would post the toll-free hot line telephone number. Surveyor review of the facility's policy titled, "Required Posting", with an effective date of 8/1/2023, revealed, "POLICY STATEMENT Five Star communities post and publicize appropriate information in a manner that is continuously accessible to all residents, families, and concerned parties ... IV. PROVISION(S) AND PROCEDURE(S) A. information posted in the community includes, without limitation:..6. The Toll-free hotline numbers of the state agency, county agencies and office of the Ombudsman..."	A 585		
A 587	8:36-5.11(a)(7) General Requirements (a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public: 7. The names of, and a means to formally	A 587		

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A 587	Continued From page 22 contact, the owner and/or members of the governing authority. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post the means to formally contact, the owner and/or members of the governing authority in a conspicuous place that can be viewed by the facility residents and the public. This deficient practice was evidenced by the following: On 10/8/2024 at 10:46 a.m., while conducting a complaint and standard survey, the surveyor toured the facility and did not observe a posting that contained the facility's formal contact information such as the owner and/or members of the governing authority. On 10/9/2024 at 10:07 a.m., the surveyor interviewed the facility's Regional Health and Wellness Director (RHWD) who stated that the facility did not have a posting with the means to formally contact, the owner and/or members for the governing authority. Surveyor review of the facility's policy titled, "Required Posting", with an effective date of 8/1/2023, revealed, "POLICY STATEMENT Five Star communities post and publicize appropriate information in a manner that is continuously accessible to all residents, families, and concerned parties ... IV. PROVISION(S) AND PROCEDURE(S) A. information posted in the community includes, without limitation :.. 7. The names of and means to formally contact the	A 587		

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A 587	Continued From page 23 owner and/or members of the governing body...,"	A 587		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that facility failed to comply with the provision of Chapter 24, N.J.A.C. 8:24. "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines": N.J.A.C. 8:24-4.6(a), 8:24-4.6(b), 8:24-3.3k(1-5), and 8:24-4.1, which placed the highly susceptible population/residents' health and safety at risk for foodborne. This deficient practice was evidenced by the following: 1. 8:24-4.6(a) Equipment food-contact surfaces and utensils shall be clean. On 10/8/2024 at 10:58 a.m., while conducting a standard and complaint survey, the surveyor toured the facility with the facility Food Service Director (FSD), the surveyor observed the	A 891		

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A 891	Continued From page 24 facility's ice machine that appeared to have dark gray and brown fluffy substance adhered to the inner of rim of the ice machine, leading to where the ice is held within the machine. At 11:03 a.m., the surveyor used a white clean paper towel and wiped the inner rim of the ice machine which left a large amount of dark colored substance on the paper towel. At that time, the surveyor interviewed the facility's FSD, in reference to the substance in the ice machine and on the paper towel, the FSD stated that the ice machine needed to be cleaned. At 11:11 a.m., during the continued tour of the facility's kitchen, the surveyor noted a waffle maker that had tan, brown, and black substances adhered to the facility's waffle maker. At that time, during surveyor interview, the facility's FSD stated that the waffle maker needed to be cleaned and requested a facility kitchen staff to clean the waffle maker. 2. 8:24-4.6(b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease On 10/8/2024 at 11:22 a.m., during a tour of the facility's kitchen, the surveyor observed nine sauce pots and frying pans hanging on a rack above the facility's three-compartment-sink that had black and brown substances encrusted on to the pans. At 11:35 a.m., the surveyor observed three large saucepans and four rectangular pans that had black and brown substances encrusted on to the pans and saucepans. At that time, the surveyor interviewed the facility FSD who stated that he will	A 891		

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A 891	Continued From page 25 discard the above mentioned pans and saucepans. 3. 8:24-3.3k(1-5) (k) During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: " 1. In the food with their handles above the top of the food and the container, except as specified in (k)2 below; 2. In food that is not potentially hazardous, with their handles above the top of the food within containers of equipment that can be closed, such as bins of sugar, flour, or cinnamon; 3. On a clean portion of the food preparation table or cooking equipment only if the in-use utensil and the food-contact surface of the food preparation table or cooking equipment are cleaned and sanitized at a frequency specified under N.J.A.C. 8:24-4.6 and 4.7; 4. In running water of sufficient velocity to flush particulates to the drain, if used with moist food such as ice cream or mashed potatoes; 5. In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous; or...." On 10/8/2024 at 11:28 a.m., during a tour of the facility's kitchen, the surveyor observed a large clear container storage container with dry rice. A paper cup and a metal cup located inside the rice in the storage container. At that time, the surveyor interviewed the facility's FSD who stated that the paper and metal cup shouldn't have been located inside of the rice. The FSD removed the paper and metal cup from the rice. 4. 8:24-4.1 (a) Materials that are used in the construction of utensils and food-contact surfaces	A 891		

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A 891	Continued From page 26 of equipment shall not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe; durable, corrosion-resistant, and nonabsorbent, sufficient in weight and thickness to withstand repeated ware washing; finished to have a smooth, easily cleanable surface; and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 10/8/2024 at 11:35 a.m., during a tour of the facility's kitchen, the surveyor observed two red, two white, one green, and one tan cutting board with multiple scoring, scratch, and chipping marks. At that time, the surveyor interviewed the facility's FSD who stated that he would throw the cutting boards away.	A 891		
A 937	8:36-11.5(a) Pharmaceutical Services (a) The administration of medications is within the scope of practice and remains the responsibility of the registered professional nurse. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure a Registered Nurse (RN) delegated appropriate medication task to Certified Medication Aides (CMA) within the approved scope of practice for 1of 14 residents, Resident #1 as evidenced by	A 937		

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(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 937	Continued From page 27 the following: On 10/9/24 at 10:00 a.m., the surveyor reviewed the medical record (MR) of Resident #1 who moved in to the facility in NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4b1 In addition, the surveyor reviewed the resident's MAR dated from NJ ex order 26.4b1 and observed that the CMAs initialed and signed out Resident #1's NJ ex order 26.4b1 At 12:20 p.m., the surveyor interviewed the Assistant Health and Wellness Director (AHWD) who was a Licensed Practical Nurse (LPN) regarding Resident #1's NJ ex order 26.4b1 administered by the CMAs. The AHWD/LPN stated that she NJ ex order 26.4b1 At 12:25 p.m., the surveyor interviewed the Regional Health and Wellness Director (RHWD)who was the Registered Nurse (RN) that covered the facility on the day of survey. The RHWD/RN confirmed that CMAs were not authorized to administer NJ Ex Order 26.4(b)(1) On 10/10/24 at 3:06 p.m., the surveyor notified the Executive Director (ED) that the CMA's administered the NJ ex order 26.4b1 which was not in the CMAs approved scope of practice without a waiver. The surveyor reviewed the facility policy and procedure titled, "Medication Management" which revealed "Delegation of Medication ...or Medication Administration to other qualified	A 937		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	922TYU	A. BUILDING: _____ B. WING _____	C 10/10/2024

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A 937	Continued From page 28 personnel is done in accordance with specific state laws and regulations. ..." Reference: A0941, 8:36-11.5(b)(3)(i-v)	A 937		
A 941	8:36-11.5(b)(3)(i-v) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C. 13:37-6.2 to certified medication aides, as defined in this chapter. 3. The certified medication aide shall not: i. Administer any injection other than pre-drawn properly packaged and labeled insulin as described in (b)1 above; ii. Calculate a medication dosage; iii. Pre-pour medications for more than one resident at a time; iv. Contact prescribers for changes in medication, to clarify an order, or contact the pharmacist for questions regarding a dispensed medication; or v. Administer bolus doses of enteral feedings, or stop and/or start an existing enteral feeding pump or gravity-fed system.	A 941		

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A 941	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure that the Certified Medication Aides (CMA) were authorized by an approved waiver to administer injectable medication other than insulin in accordance with state requirements for 1 of 14 residents, Resident #1 as evidenced by the following: On 10/8/24 at 11:40 a.m., the surveyor inspected the medication storage cart with CMA #1. The surveyor observed that NJ ex order 26.4b1 for Resident #1 NJ ex order 26.4b1 . The surveyor then reviewed the resident's NJ ex order 26.4b1 located on top of the medication cart and observed that the NJ Ex Order 26.4(b)(1 was last initialed as administered on NJ Ex Order 26.4(b by a CMA. The surveyor interviewed CMA #1 during inspection of the medication storage cart regarding what staff NJ ex order 26.4b1 to Resident #1. CMA #1 stated that she was NJ ex order 26.4b1 and NJ ex order 26.4b1 . In addition, the CMA stated that the NJ ex order 26.4b1 was administered by all staff who were assigned to medication administration, including herself. At 1:34 p.m., the surveyor interviewed the Regional Health and Wellness Director (RHWD) regarding procedures for CMA medication administration. The RHWD stated that she was the covering Registered Nurse (RN) for another Regional (RN) who was absent from the facility. In addition, the RHWD stated that there were no	A 941		

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A 941	Continued From page 30 facility medication waivers. On 10/9/24 at 10:00 a.m., the surveyor reviewed the medical record (MR) of Resident #1 who moved in to the facility in NJ Ex Order 26.4(b)(1) with diagnoses that NJ ex order 26.4b1 In addition, the surveyor reviewed the resident's MAR dated from NJ ex order 26.4b1 and observed that the CMAs initialed and signed out Resident #1's NJ ex order 26.4b1 At 10:34 a.m., the surveyor interviewed CMA #2 regarding administration of Resident #1's NJ ex order 26.4b1. CMA #2 stated that she administered Resident #1's NJ ex order 26.4b1 At 12:20 p.m., the surveyor interviewed the Assistant HWD (AHWD) who was a Licensed Practical Nurse LPN) and the RHWD/RN regarding Resident #1's NJ Ex Order 26.4(b)(1) being administered by the CMAs. The AHWD/LPN stated that she was not aware that CMAs were not authorized to administer the medication. The RHWD stated that CMAs were not authorized to administer NJ ex order 26.4b1 . At 2:55 p.m., the surveyor notified the Executive Director (ED) that the CMA administered NJ ex order 26.4b1 to Resident #1. The ED stated that he was new to the facility and was not aware of the medication administration procedures nor knowledge of any facility waivers. On 10/10/24 at 12:30 p.m., the surveyor interviewed CMA #3 regarding administering NJ Ex Order 26.4(b)(1) to Resident #1. CMA #3 stated that she NJ ex order 26.4b1 to the resident on NJ ex order 26.4b1	A 941		

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A 941	Continued From page 31 At 12:34 p.m., the surveyor requested the RN/CMA medication pass observation, review, and training records from the RHWD. The RHWD stated that she was unable to locate the CMA medication pass observation, review, and training records by a RN. The surveyor reviewed the facility policy and procedure titled, "Medication Management" which revealed that the "...All staff who perform ...Medication Administration receive specific orientation and must successfully pass a medication skills checklist prior to performing these functions. ...Delegation of Medication ...Medication to other qualified personnel is done in accordance with specific state laws and regulations. ..." At 3:06 p.m., the surveyor requested a removal plan from the ED for NJ ex order 26.4b1 to Resident #1 by CMAs without a waiver. In addition, there was no documented evidence of CMA medication pass observation, medication review, and training by a RN. On 11/1/24, the facility submitted a revised removal plan that included CMA removal from administering NJ ex order 26.4b1 and only LPNs and RNs to administer this NJ ex order 26.4b1. In addition, the removal plan included staff training and RN oversight for medication administration, including CMA competency check and evaluation.	A 941		
A 945	8:36-11.5(b)(5) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C.	A 945		

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A 945	Continued From page 32 13:37-6.2 to certified medication aides, as defined in this chapter. 5. The delegating nurse shall review with the certified medication aide medication actions and untoward effects for each drug to be administered. Pertinent information about medications' adverse effects, side effects, contraindications, and potential interactions shall be incorporated into the plan of care for each resident, with interventions to be implemented by the personal care assistant and other caregiving staff, and documented on the medication administration record (MAR). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents it was determined that the facility failed to provide documented evidence of a Registered Nurse (RN) medication review and training with Certified Medication Aides (CMA) for 1 of 14 residents, Resident #1 as evidenced by the following: On 10/8/24 at 11:40 a.m., the surveyor during inspection of the medication cart with CMA #1 observed that there was a medication labeled NJ ex order 26.4b1 to Resident #1. At 11:57 a.m., the surveyor interviewed CMA #1 regarding RN review of the NJ ex order 26.4b1 and medication training. CMA #1 stated that there was no RN at the facility to conduct medication oversight or medication review. In addition, CMA #1 stated that if she had an issue with medication	A 945		

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A 945	Continued From page 33	A 945		

administration she would notify the Licensed Practical Nurse (LPN) who was also the Assistant Health and Wellness Director (AHWD).

At 12:35 p.m., the surveyor interviewed the AHWD/LPN regarding RN medication review and CMA training. The AHWD/LPN stated that she was not aware of any CMA competency binder or where to locate the CMA competencies. In addition, the AHWD stated that the Director of Nursing (DON) NJ ex order 26.4b1 and the Regional RN covered the facility.

At 1:34 a.m., the surveyor interviewed the Regional Director of Health and Wellness (RHWD)regarding CMA medication review and training. The RHWD stated that she was not aware of where to find the CMA review of medication and training records. In addition, the RHWD stated that the traveling RN that covered the facility was not available and she was unable to notify the RN to find out where the CMA medication review and training were located.

On 10/9/24 at 10:44 a.m., the surveyor interviewed CMA #2 regarding CMA training and medication review with an RN. CMA #2 stated that the RN was supposed to do medication pass observations every three months but she could not remember when the last medication observation was last conducted by the RN.

At 2:30 p.m., the surveyor requested the CMA delegation/RN oversight and training policy and procedure from the RHWD.

At 2:55 p.m., the surveyor also requested the CMA delegation/RN oversight and training policy from the Executive Director (ED). The ED was new to the facility and was not aware of all policy

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A 945	Continued From page 34 and procedures. On 10/10/24 at 12:34 p.m., the RHWD stated that she was unable to locate a policy and procedure for CMA delegation/RN oversight and training. The surveyor reviewed the facility policy and procedure titled, "Medication Management" which revealed, "...All staff who perform ...Medication Administration receive specific orientation and must successfully pass a medication skills checklist prior to performing these functions. ...Delegation of Medication ...Medication to other qualified personnel is done in accordance with specific state laws and regulations. ..." During review of the "Medication Management" policy and procedure, the surveyor did not identify a procedure specific to CMA training and RN oversight. Reference: A0941, 8:36-11.5(b)(3)(i-v)	A 945		
A 963	8:36-11.5(f) Pharmaceutical Services (f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that medication was accurately documented as	A 963		

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A 963	Continued From page 35 administered in accordance with prescriber's orders for 3 of 14 residents, Resident #8, Resident #9, and Resident #11 as evidenced by the following: On 10/9/24 at 1:04 p.m., the surveyor conducted a medication pass with a Certified Medication Aide (CMA). The surveyor reviewed the Medication Administration Record (MAR) where staff were required to document that a medication was administered in accordance with prescriber's orders. The surveyor observed blanks where staff failed to document the administration of medications with no explanation as to why the medication was not given. On 10/9/24 at 1:15 p.m., during resident medical record (MR) and MAR review, the surveyor identified that the MARs for the month of NJ ex order 26.4b [redacted] were missing staff initials to validate medication administration. 1. At 1:20 p.m., the surveyor reviewed Resident #8's MAR dated NJ ex order 26.4b1 which revealed that on NJ ex order 26.4b1 the resident's NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] to the resident and there was no documented rationale on the MAR as to why the medication was not administered. 2. At 1:45 p.m., the surveyor reviewed Resident #9's MAR dated NJ ex order 26.4b [redacted] which revealed on NJ ex order 26.4b1 the resident's NJ ex order 26.4b1 [redacted] with no documented rationale on the MAR as to why the NJ ex order 26.4b1 [redacted]. In addition, the surveyor reviewed Resident #9's MAR dated	A 963		

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A 963	Continued From page 36	A 963		

NJ ex order 26.4b1 which revealed that twenty one (21) medications were not documented as administered to Resident #9 with no documented rationale as follows:

a) On NJ ex order 26.4b1, and NJ ex order 26.4b1 NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 9:00 p.m., NJ ex order 26.4b1 tablet 9:00 p.m., NJ ex order 26.4b1 tablet 9:00 a.m., NJ ex order 26.4b1 tablet 9:00 a.m., NJ ex order 26.4b1 tablet 9:00 a.m., 1:00 p.m., 5:00 p.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 tablet 9:00 a.m., and 5:00 p.m., doses were not documented as administered to Resident #9 with no documented rationales.

On 8/5/24, NJ ex order 26.4b1 capsule 9:00 a.m., dose was not initialed as administered with no documented rationale. In addition, on NJ ex order 26.4b1 tablet 9:00 a.m., NJ ex order 26.4b1

Further, NJ ex order 26.4b1 9:00 p.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 5:00 p.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 5:00 p.m., and NJ ex order 26.4b1 9:00 a.m., and 5:00 p.m., doses were not documented as administered to Resident #9 NJ ex order 26.4b1, and NJ ex order 26.4b1

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A 963	Continued From page 37 b) On NJ ex order 26.4b1, NJ ex order 26.4b1 9:00 p.m., NJ ex order 26.4b1 dose, NJ ex order 26.4b1 9:00 p.m., NJ ex order 26.4b1 Patch 9:00 a.m., NJ ex order 26.4b1 and NJ ex order 26.4b1 doses, NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 dose, NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 and NJ ex order 26.4b1 NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 and NJ ex order 26.4b1 doses, NJ ex order 26.4b1 9:00 a.m., NJ ex order 26.4b1 and NJ ex order 26.4b1, NJ ex order 26.4b1 5:00 p.m., NJ ex order 26.4b1 tablet 9:00 a.m., NJ ex order 26.4b1 and NJ ex order 26.4b1 doses, and 5:00 p.m., NJ ex order 26.4b1 doses were not documented as administered to Resident #9 with no documented rationale. 3. At 2:15 p.m., the surveyor reviewed Resident #11's MAR dated NJ ex order 26.4b which revealed on NJ ex order 26.4b1 9:00 p.m., dose was not documented as administered to the resident with no documented rationale. The surveyor also observed that on NJ ex order 26.4b1 and NJ ex order 26.4b1 9:00 a.m., doses were not documented as administered to the resident with no documented rationale. During the medication observation, the surveyor interviewed the CMA regarding medication documentation in the MAR. The CMA stated that sometimes staff forget to sign out the medication as administered or omitted in the MAR. In addition, the CMA stated that the staff should document in the MAR the reason a medication was omitted or not administered to the resident. At 2:30 p.m. the surveyor interviewed a Licensed Practical Nurse (LPN) regarding the unsigned	A 963		

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A 963	Continued From page 38 medications in the residents MAR. The LPN stated that the MAR was initialed and signed after medication administration. In addition, the LPN stated that if a medication was omitted or not administered to a resident the reason was supposed to be documented on the back of the MAR. On 10/10/24 at 3:06 p.m., the surveyor notified the Executive Director (ED) of the missing signatures and missing documentation on the residents MAR during exit conference. The ED stated he was new to the facility and was not aware of the missing documentation. The surveyor reviewed the facility policy and procedure titled, "Medication Management" that revealed, "...Medication Administration is documented on the MAR ...at the time the medication is provided or taken ...Medication omissions and/or refusals are documented on the MAR...."	A 963		
A 983	8:36-11.7(a)(5) Pharmaceutical Services (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications that are not self-administered by the residents. The storage area requirement may be satisfied through the use of a locked medication cart. 5. Medications shall be stored in accordance with manufacturer's instructions, and/or extemporaneously applied pharmacy labels and/or directions, and/or United States Pharmacopoeia Drug Information (USP DI) Volume I, Drug Information for the Health Care	A 983		

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A 983	Continued From page 39 Professional, 2005, incorporated herein by reference, as amended and supplemented and USP DI Volume II: Advice for the Patient, incorporated herein by reference, as amended and supplemented. USP DI Volume I: Drug Information for the Health Care Professional and USP DI Volume II: Advice for the Patient can be obtained by contacting Thomson-Micromedex, 6200 S. Syracuse Way, Suite 300, Greenwood Village, CO 80111, (303) 486-6400. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that the resident medications were stored in accordance with the pharmacy labeling for 1 of 14 residents, Resident #12 as evidenced by the following: On 10/8/24 at 11:42 a.m., the surveyor inspected the medication cart with Certified Medication Aide (CMA #1). The surveyor observed that there was a zip locked bag which contained a total of [redacted] stored in a locked room temperature narcotic drawer. In additon, the surveyor observed that the [redacted] was prescribed for [redacted] administration as needed for [redacted] for Resident #12. According to the label, the [redacted] and the bag contained a cautionary label to [redacted] the medication.	A 983		

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(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 983	Continued From page 40 At 11:45 a.m., the surveyor interviewed the Certified Medication Aide (CMA) regarding the storage of the [redacted]. The CMA stated that she did not know the medication needed to [redacted] as it was always kept in the locked medication cart. At 12:30 p.m., the surveyor reviewed Resident #12's Medication Administration Record (MAR) dated [redacted] which revealed that the resident did not receive any doses of the [redacted] that was not stored per the manufactures instructions to [redacted] At 1:00 p.m., the surveyor interviewed the Assistant Health and Wellness Director who was a Licensed Practical Nurse (AHWD/LPN) and the Regional Health and Wellness Director (RHWD) regarding refrigeration of the [redacted]. The AHWD/LPN stated that she was not aware that the [redacted] was labeled to refrigerate since it was usually stored in the locked [redacted] drawer. The RHWD stated that the storage of the medication should have been clarified with the pharmacy.	A 983		
A1057	8:36-15.4 Resident Records All records shall be maintained for a period of 10 years after the discharge of a resident from the assisted living residence, comprehensive personal care home or assisted living program. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00157990	A1057		

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	922TYU	A. BUILDING: _____ B. WING _____	C 10/10/2024

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A1057	Continued From page 41 Based on interview, record review, and review of pertinent facility documents it was determined that the facility failed to ensure that a resident's closed Medical Record (MR) was available to the Department of Health (DOH) for review for 1 of 14 residents, Resident #7, as evidenced by the following: On 10/8/24 at 2:58 p.m., the surveyor requested the closed MR of Resident #7 from the Executive Director (ED). On 10/10/24 at 11:06 a.m., the surveyor interviewed the Regional Director of Health and Wellness (RDHW) to inquire about Resident #7's closed MR, and the RDHW stated that all medical records prior to NJ Ex Order 26.4(b)(1) were held in storage. In addition, the RDHW stated that she requested the MR on 10/8/24, and that it would take 48 hours to receive the MR. Resident #7's closed MR was not available at the facility for review by the DOH.	A1057		
A1097	8:36-16.6 Physical Plant All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23.	A1097		

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A1097	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation on 10/08/2024, it was determined the facility failed: 1) Conduct Quarterly Inspections (every 3 months) of the buildings fire sprinkler system, 2) To provide proper fire sprinkler coverage to all areas of the facility, as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems. This deficient practice was evidence by the following: Reference #1: Uniform Construction Code, Special detailed requirements based on use and occupancy section 407 group I-2, [F] 407.5 Automatic sprinkler system. Smoke compartments containing patient sleeping units shall be equipped throughout with an automatic fire sprinkler system in accordance with Section 903.3.1.1. The smoke compartment shall be equipped with approved quick-response or residential sprinklers in accordance with section 903.3.2. Reference #2: National Fire Protection Association (NFPA) 13 Standard for the Installation of Sprinkler Systems. During the entrance conference on 10/08/2024 at 9:35 a.m., the surveyor made a request to the Administrator and Facilities' Director (FD) to provide, 1) The quarterly fire sprinkler inspections from 06/01/2023 through 10/07/2024 for review later. 2) A copy of the facility lay out which identifies	A1097		

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A1097	Continued From page 43	A1097		

the various rooms in the facility.
The surveyor also requested, how many Residential Units are in the facility.
The FD told the surveyor there are 81 Resident apartments.

A review of the facility provided lay-out identified the following:
The 3rd. floor has 31 Residential Units (apartments) and common areas.
The 2nd. floor has 32 Residential Units (apartments) and common areas.
The 1st. floor has 18 Residential Units (apartments) and common areas.

Starting at approximately 10:00 AM, in the presence of the FD a tour of the building was conducted.

Along the tour of the facility the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations:

1) At approximately 11:43 AM, the surveyor observed no evidence of fire sprinkler coverage inside the 2nd. floor Dining/ Activities room approximately 2' by 2' Heating, Ventilation and Air Conditioning (HVAC) closet.

Later at approximately 12:30 PM, the surveyor reviewed the following quarterly sprinkler inspections, 05/16/2023, 08/21/2023 and 11/06/2023.

Later the surveyor made a request was made to the FD if he could provide any additional quarterly inspections of the fire sprinkler system for 2024.

At approximately:10 PM, the FD provided one additional quarterly inspection of the fire sprinkler

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A1097	Continued From page 44 system dated 02/05/2024. The facility failed to provide the 2nd. and 3rd. 2024, quarterly inspections of the fire sprinkler system. The FD confirmed the finding at the times of observation and review of facility provided documentation. The Administrator and FD were informed of the deficiency during the survey exit on 10/08/2024 at approximately 3:31 PM. Fire Safety hazard. Refer to tag: NJAC 8:36 -16.6	A1097		
A1169	8:36-16.15(a) Physical Plant (a) Fire extinguishers shall comply with National Fire Protection Association (NFPA) 10, Standards For Portable Fire Extinguishers, 2002 edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 10/08/2024 in the presence of facility management, it was determined that the facility failed to: 1) Inspect 2 of 23 portable fire extinguishers annually, as required by National Fire Protection Association NFPA 101, 2012 Edition, Section	A1169		

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A1169	Continued From page 45 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. and N.J.A.C. 5:70. References: NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, "... 4-3 Inspection Maintenance. 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require... 4- 3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers... 4- 4.3 Six Year Maintenance, Every 6 years, stored-pressure fire extinguishers shall require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon recovery systems. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall be from that date ... 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification...." The findings include the following: On 10/08/2024 during the survey entrance at approximately 9:35 AM, a request was made to the facility Administrator and Facilities' Director	A1169		

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A1169	Continued From page 46 (FD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a three-story (3) building. Starting at approximately 10:30 AM, in the presence of the facility's FD, an inspection tour of the building was conducted. During the tour the surveyor observed and inspected twenty-three (23) fire extinguishers in various locations. Twenty-One (21) fire extinguishers were last annually inspected November 2023 and two (2) fire extinguishers with the following identified: 1) At approximately 10:03 AM, the surveyor observed inside the 3rd. floor Residents laundry room, one (1) ABC type fire extinguisher last annually inspected November 2021. 2) At approximately 11:20 AM, the surveyor observed inside the 3rd. floor storage room (located next to elevator #1) had no annual inspection tag attached to the extinguisher. The surveyor observed the fire extinguisher was manufactured in 2016. The FD confirmed the findings at the time of observation. The Administrator and FD were informed of the deficiency during the survey exit on 10/08/2024 at approximately 3:31 PM. Refer to tag: NJAC 8:36 -16.15 (a).	A1169		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance	A1249		

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A1249	Continued From page 47 The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observations on 10/08/2024 in the presence of facility management, it was determined that the facility failed to maintain the two (2) hour fire rated stairwell construction. The evidence includes the following, During the entrance conference on 10/08/2024 at 9:35 a.m., the surveyor made a request to the Administrator and Facilities' Director (FD) to provide a copy of the facility lay out which identifies the various rooms in the facility. A review of the facility provided lay-out identified the facility is a three-story building with 3 exit stairwells for Residents, Visitors and Staff to use to exit the building in the event of an emergency. Starting at approximately 10:00 AM, in the presence of the FD a tour of the building was conducted. During the tour of the facility, the surveyor observed and conducted closure tests of nine (9) fire rated stairwell access doors with the	A1249		

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A1249	Continued From page 48 following results: 1) At approximately 1:11 PM, during a closure test of the first floor exit access door leading into stairwell #2 when tested and allowed to self-close, the door did not positive latch into its frame as required to maintain the 2 hour fire rated construction. This test was repeated two additional times with the same results. The stairwell doors need to positive latch into its frame to maintain the 2 hour fire rated construction. The FD confirmed the finding at the time of observation. The Administrator and FD were informed of the deficiency during the survey exit on 10/08/2024 at approximately 3:31 PM. Fire safety hazard.	A1249		
A1275	8:36-18.2(a)(1) Infection Prevention and Control Services (a) The facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications and OSHA standards, incorporated herein by reference, as amended and supplemented: 1. Guidelines for Hand Hygiene in Health Care Settings, MMWR/51 (RR-16), October 25, 2002;	A1275		

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A1275	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility's staff failed to perform proper hand hygiene technique in accordance with the Centers for Disease Control (CDC) recommendations and the facility's policy titled, "Hand Washing " for 2 of 2 staff members observed for handwashing: Food Service Director (FSD) and Server. This deficient practice was evidenced by the following: On 10/8/2024 at 11:45 a.m., while conducting a standard and complaint survey, the surveyor observed the facility's FSD washing his hands at a handwashing sink located in the facility's kitchen. The FSD turned on the water faucet, wet his hands, lathered the soap in his hands for 5 seconds before placing his hands under the running water while continuing to scrub his hand. The FSD then rinsed his hands, dried his hands utilizing a paper towel, and then turned the faucet off. At that time, the surveyor interviewed the FSD who stated that he was educated on proper handwashing and stated that he should've sang happy birthday twice while lathering his hands. On 10/9/2024 at 9:59 a.m., the surveyor observed the facility's Server, Server #1 washing her hands at a handwashing sink located int the facility's kitchen. Server #1 turned on the water faucet, wet her hands, later the soap in her hands for 25 seconds, and then turned off the faucet with her bare hands before retrieving a paper towel and drying her hands. At that time, the surveyor interviewed the server who stated she was trained on hand washing and pointed to a signage titled, "Proper Hand-Washing" near the	A1275		

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A1275	Continued From page 50 handwashing station that listed the steps of handwashing. The sixth step listed on the signage instructed the facility employees to, "Turn off the faucet using paper towel." The signage also included graphics of the steps. Surveyor review of the facility's policy titled, "Hand Washing" revealed, " ... III. PROCEDURES ... 3. Method/Steps for Hand washing:... 3. Rub hands together using friction for 20 (CDC guidelines) seconds. Front and backs of hands, fingers, in between the fingers, around the nail, cuticle and under the nails should all be thoroughly cleaned. 4. Rinse hands under warm running water. 5. Dry hands with a paper towel or blower type dryer activated with the elbow. 6. Turn water off using a dry paper towel (prevents hands from becoming re-contaminated) ..." As per CDC guidelines, handwashing should consist of scrubbing one's hand for 20 seconds. Reference: https://www.cdc.gov/clean-hands/about/index.html	A1275		

Rcd 2/3/25
Picked
2/5/25
accepted
2/7/25

MT. ARLINGTON
SENIOR LIVING

FIVE STAR
SENIOR LIVING

State of New Jersey
Department of Health
RE: -Provider 922TYU- Mt. Arlington Senior Living Plan of Correction

A-310 8:36-3.4(a)(1)

1.There were no residents negatively affected by this deficient practice. The Regional Director of Health and Wellness (RDHW) provided training to all nurses and certified medication aides (CMAs) on 10/9/2024 and 10/10/2024 on the Registered Nurse (RN)/Certified Medication Aide (CMA) process, the waivered medication administration process, which includes [NJ Ex Order 26.4(b)] and Medication Management Guidelines, including Appendix E: New Jersey. All Certified Medication Aides (CMAs) signed an updated job description titled Certified Caregiver (which was updated on 11/1/24) as of 12/20/24.

2. All residents have the potential to be negatively affected by this deficient practice.

3. All newly hired Certified Medication Aides (CMAs) will complete training with the Director of Health & Wellness (DHW) or Registered Nurse (RN) designee on the Registered Nurse (RN)/Certified Medication Aide (CMA) process, the waivered medication administration process, which includes Ozempic and Medication Management Guidelines, including Appendix E: New Jersey prior to passing any medication. The training will be documented and signed off by the RN and CMA. A copy will be kept in the Certified Medication Aide's (CMA) file as well as the survey results binder that is kept in the administrator's office. Omnicare will begin providing medication administration training to Certified Medication Aides (CMAs) by 2/7/25. Ongoing training by the Director of Health and Wellness (DHW) or RN designee will be completed bi-annually.

4. The Director of Health or Wellness (DHW) or Registered Nurse designee will review physician's orders and electronic medication administration record (EMAR) for 5 residents to ensure only licensed nurses are administering any medication which is considered a waivered medication weekly for 6 weeks then biweekly for 6 weeks then monthly for 3 months to ensure compliance with this regulation.

5. Completion Date: 12/20/24

A-355 8:36-4(a)(1) Resident Rights

1. Resident 2[NJ Ex Order 26.4(b)(1)], however [NJ Ex Or] last physical date in the community was [NJ ex order 26.4b1] Prior to resident #2 [NJ ex order 26.4b1], the resident [NJ ex order 26.4b1] and [NJ ex order 26.4b1]. Regional Director of Health and Wellness (RDHW) reviewed [NJ Ex Order 26.4(b)(1)] Risk evaluations and General Service Plans (GSP), including interventions, for residents 3, 4 and 5 on 10/10/24 to ensure personalized services in accordance with their General Service Plans (GSPs). Resident 3 was moved to our [NJ Ex Order 26.4(b)(1)] on 11/16/24.

2. All residents have the potential to be negatively impacted by this deficient practice.

3. Regional Director of Health and Wellness (RDHW) reviewed Elopement Risk evaluations for current residents, including residents 3, 4 and 5, on 10/11/24. For residents who were identified as at risk for

elopement, their General Service Plans, including interventions, were reviewed to ensure personalized services were appropriate to maintain their safety. For residents 3, 4 and 5, the following has been added to their General Service Plan, "My caregivers will observe my location in the community, when I want to sit or walk outside the community, a team member will accompany me while I am outside the community but on the premises. My caregivers must report any wandering behavior and attempted interventions to nursing immediately." Regional Director of Health and Wellness (RDHW) provided training on 10/14/24 to Registered Nurse (RN) Clinical Specialist and Assistant Director of Health and Wellness (ADHW) on reviewing and updating General Services Plans and the requirements of this regulation.

4. Audit of 3 residents identified as "At Risk for Elopement", their corresponding General Service Plans will be reviewed by the Director of Health and Wellness (DHW) or Registered Nurse (RN) designee biweekly for 4 weeks then monthly for 2 months then quarterly for 3 months to ensure compliance with this regulation.

5. Completion Date: 10/20/24

A-401 8:36-4.1(a)(22) Resident Rights

1. Resident 2 NJ ex order 26.4b1 , however, NJ Ex last physical date in the community was NJ ex order 26.4b1 NJ ex order 26.4b1 and NJ ex order 26.4b1 While residents 3, 4, 5 and 6 have been identified as at risk for NJ Ex Order 26.4(b)(1), none of those residents NJ ex order 26.4b1 . NJ ex order 26.4b1 to residents 4, 5, and 6. Their General Service Plans (GSP) were reviewed and updated on 10/10/24 to ensure personalized services were appropriate to maintain their safety. This includes being added to the newly created hospitality program. Resident 3 NJ ex order 26.4b1 on 11/16/24.

2. All residents have the potential to be negatively impacted by this deficient practice.

3. When a resident who has been identified as at risk for elopement wants to go outside, the front desk team member will call on the walkie talkie to say, "hospitality duty". This is our internal code for residents who have been identified as at risk for elopement and want to go outside so they need someone to accompany them. A team member will respond to this page and escort that resident outside and remain with him/her until they are ready to come back into the community. If the resident who wants to go outside is wearing a wanderguard, the team member who is accompanying the resident outside will momentarily deactivate the door alarm so the resident can go outside. The front desk maintains a daily sheet which contains the resident's name, date and time out/in the community and is initialed by the team member who accompanied the resident outside. The binder at the front desk which contains these daily sheets also has face sheets for all residents identified as at risk for elopement with their picture and their room number. This information is reviewed and updated monthly or as needed by the Director of Health and Wellness (DHW) or Registered Nurse (RN) designee. This binder is reviewed daily by the Executive Director (ED) or designee and is signed off by them after it is reviewed. Once the daily sheet has been completed and reviewed, it is moved to a binder in the Executive Director's office. The current staff was trained on the new process titled Hospitality Duty for residents, identified as at risk for elopement. The training was initiated by the Regional Director of Health and Wellness (RDHW) on 10/10/24 and completed by Executive Director (ED) on 10/20/24. This training will be conducted by the Executive Director or designee for any new employees as part of their initial onboarding process. Elopement drills are also scheduled each quarter per company policy.

4. Audit of 3 residents identified as "At Risk for Elopement", their corresponding General Service Plans will be reviewed by the Director of Health and Wellness (DHW) or Registered Nurse (RN) designee biweekly for 4 weeks then monthly for 2 months then quarterly for 3 months to ensure compliance with this regulation.

5. Completion Date: 10/20/24

A-511 8:36-5.5(a) General Requirements

1. On 12/12/24, the Business Office Manager reviewed all employee files including employee # 4's file to make sure all job descriptions were signed off and dated.

2. The Business Office Manager, who does the paperwork for all new hires, will ensure that the job descriptions are signed and placed into their file. The Business Office Manager was re-educated on the expectation of the job on 12/5/24.

3.- The Executive Director (ED) will review all new employee files upon hiring to ensure compliance. A review of all new current employees (Jan 1, 2024- December 31, 2024) will be completed by the Executive Director on or before 1/15/2025. The Business Office Manager was reeducated on 12/5/24 to ensure all employee files have the necessary documentation completed.

4. The community will monitor employee files by doing semi-annual employee file reviews. The Business Office Manager and Executive Director will complete the review by the following dates each year. One review will be completed by June 30 and the other by December 31 of each year.

5.The review for 2024 will be completed by 1/15/25.

A-517 8:36-5.6(b)-General Requirements

1. As a result of the surveyor's findings, we started an audit of all employee files on 12/06/24. All personnel will go through an ongoing training and education program at time of hire as well as during the year there will be at the least annual in-service education. This will cover the following, -the provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment, Emergency plans and procedures, infection prevention and control program, resident rights, abuse and neglect, pain management, and the care of residents with Alzheimer and related dementia conditions. Training was started on 12/9/24 for employee #'s 2,3,4,5,6,7,9, and 10 and they will have all required online training completed by 01/31/25

2. All residents have the potential to be negatively affected by this deficient practice.

3. The Business Office Manager was educated on the policies of online training on 12/12/24. Revised monitoring of online training occurs weekly in our daily standup. This practice ensures that the department heads meet with their staff weekly to ensure they are being compliant. All required training must be done within 60 days after the due date.

4. The Business Office Manager (BOM) is responsible for weekly monitoring of all online employee training. These reports are brought in weekly to our directors' daily standup and reviewed. A weekly audit tool is kept with the Business Office Manager and in the Executive Director's office.

5. Completion data of this audit was 12/12/24.

A-539 8:36-5.7(a)General Requirement

1. The community ("corporate") has an online policy and procedure manual which is updated during the year. A printed version of said manual will be kept in the health and wellness office. We started to print out the policy and procedures on 12/30/24. This policy will describe as follows:

   a. 2 -a description of the services which the assisted living residence is capable of providing for residents.

2.-No residents were affected by this deficient practice

3.- There will always be a printed copy available for a department surveyor at all times. It will be kept in the health and wellness office.

5. This will be completed by 01/31/25.

A-547 8:36-5.7(a)-General Requirements:

1.If the following employees (1,2,4,5,6,7) are still currently employed by the community they will have a completed NJ Ex Order 26.4(b)(1) by 1/31/25. We will also be auditing all employee files to ensure a history & physical (H&P) is in the file. Any current team member without a history and physical will be scheduled to have one completed no later than 1/31/25. An audit of all employee files was completed on 12/26/24 and only one current employee was found to need a NJ Ex Order 26.4(b)(1) and that will be complete by 01/31/25.

2. All residents have the potential to be negatively affected by this deficient practice.

3.The community will be doing semi-annual audits of all employee files. The Business Office Manager and Executive Director will be doing these together and sign off on an audit sheet (audit # 1 by June 30th and 2nd audit by Dec 31 of each year going forward. The Business Office Manager was reeducated on correct hiring procedures on 12/5/24 to ensure that all employees have current health & physical (H&P) on file upon hire, and they are in their employee file.

4.The community as stated above will be doing semi-annual audits of all employee files. The Business Office Manager and the Executive Director will be doing this together and sign off on an audit sheet each time the audits are completed.

5. The completion date is 1/31/25.

A-553 8:36-5.7(b) General Requirements

1.A printed copy of the policy and procedure manual will be available for review for residents, guardians, designated responsible individual, prospective applicants and referring agencies as well as the department of health surveyor. The manual will be available in the health and wellness office. This will be completed by 01/17/25.

2.All residents have the potential to be impacted by this deficient practice.

3.The community will update the printed manual at the beginning of each year, and it will be completed by Jan 31st of that year. Staff will be educated on the location of said policy & procedure manual and its

contents. All staff were made aware of the manual, its contents and where it is located at our community town hall meetings on 01/15/25. A notice will also be posted in all employees' breakroom, by the time clock and in the health & wellness office as well as the front desk.

4. The administrative staff (The Business Office Manager, Executive Director, Health & Wellness Director) or their designee will have shared responsibility in assuring the updates occur yearly and will be notated with a yearly sign off sheet to be completed by the end of January each calendar year.

5. The completion date will be 01/17/25.

A-581 8:36-5.11(a) General Requirements
1.Right after the DOH survey was completed on 10/10/24, the community has a posted notice of the business hours of the facility.
2. All residents have the potential to be negatively impacted by this deficient practice.
3. The Business Office Manager and Executive Director will review and update the posted notice if there are any changes in the business hours of the community.
4. The Business Office Manager and Executive Director will review monthly to ensure any changes are made in the posted business hours and update the notices accordingly.
5. This will be completed by 01/31/25.

A-585 8:36-5.11(a)-General Requirements
1. After the Department of Health completed their survey on 10/10/24, the community posted a framed by the front entrance door with the telephone numbers of the local county agencies as well as the State of NJ Office of the Ombudsman.
2. All residents have the potential to be negatively impacted by this deficient practice.
3. The Executive Director or a designee will review a list of phone numbers quarterly to ensure that all the local county agencies as well as the State of NJ Office of the Ombudsman are correct, and any changes will be posted within 24 hours.
4. The Executive Director or designee will review the listed phone number each quarter and update the notices accordingly. If a change happens beforehand the notices will be updated by the next business day.
5. Completion date was 10/11/24.

A-587 8:36-5.11(a) General Requirements
1. Upon completion of the DOH site survey on 10/10/24, the community posted a framed notice by the front entrance door with the Five Star Corporate offices phone number. The notice also states a list of the directors' names and departments.
2. All residents have the potential to be negatively impacted by this deficient practice.
3. The Business Office Manager or designee will review the notices monthly and make any changes if necessary.
4. The Business Office Manager or designee will make any changes to the board as it pertains to any directors or department heads changing positions. This notice will be updated by the next business day and reviewed by the Executive Director.
5.Completetion date was 10/11/24.

A-891 8:36-10.5 (a) Dining Services 8:24-4.6(a)
1. The ice machine is set up on a semi-annual cleaning schedule with our service provider. We were waiting for parts to come in order to complete the repair of the ice machine. This repair was completed

on 1/8/25. Prior to the repair from 12/1/24 until 01/07/25, we were purchasing bags or ice for the residents' drinks. Now since repairs have been made to the ice machine, the Food Service Director will also be setting up a monthly cleaning schedule with his staff and keeping a logbook to record the monthly cleaning. The waffle maker was cleaned immediately after the surveyor noticed it on 10/10/24 and staff were educated that once the machine is cooled down, it must be immediately cleaned. About the surveyors' inspections of the saucepans and rectangular pans on 10/8/24, the pans in question were immediately discarded and new ones were ordered that afternoon. Upon inspection by the surveyor on 10/8/24 as it pertains to a paper and metal cup located inside the rice storage container, they were immediately removed by the Food Service Director and a review of kitchen protocols was done with his staff as supervised by the Executive Director. The cutting boards in question that were observed by the surveyor on 10/8/24 were also immediately discarded and new ones were ordered the very next day. This review was completed over several days in order to make sure all shifts were covered. This was completed as of 12/13/24.
2. All residents have the potential to be negatively impacted by this deficient practice.
3. The Food Service Director (FSD) will be implementing a cleaning schedule of the ice machine for his staff. A log will be kept by the ice machine and reviewed monthly as part of a kitchen audit process that is documented in the online TELS (maintenance) system. The Executive Director does a monthly audit to ensure all kitchen appliances are functioning correctly,
4.The monthly audit by the Executive Director shall make sure that all kitchen maintenance and proper procedures are followed. This audit is put into our online system that is maintained by the company and available for the surveyors at their request. The Food Service Director may or may not be present during the Executive Directors monthly audit.
5. Completion date of 01/31/25.

A-937 8:36-11.5(a) Pharmaceutical Services

1. There were no residents negatively impacted by the deficient practice but resident #1 received [redacted] from Certified Medication Aides assigned to administer medications on that assignment when the [redacted] was scheduled to be administered without an approved waiver. Regional Director of Health and Wellness (RDHW) provided training to the Registered Nurse (RN) Clinical Specialist on the Registered Nurse (RN)/Certified Medication Aide (CMA) process and the waivered medication administration process, which includes [redacted] on 10/14/24. On 10/9/24, Regional Director of Health & Wellness (RDHW) redelegated [redacted] to licensed nurses to administer.

2. All residents have the potential to be negatively impacted by the deficient practice.

3. All newly hired CMAs will complete training with the Director of Health & Wellness (DHW) or Registered Nurse (RN) designee on the Registered Nurse (RN)/Certified Medication Aide (CMA) process, the waivered medication administration process, which includes Ozempic and Medication Management Guidelines, including Appendix E: New Jersey prior to passing any medication. The training will be documented and signed off by the Registered Nurse and Certified Medication Aides. A copy will be kept in the employee's file as well as the survey results binder that is kept in the administrator's office. Omnicare will begin providing medication administration training to Certified Medication Aides by 2/7/25. Director of Health and Wellness (DHW) or RN designee will provide Certified Medication Aides (CMAs) with medication administration training bi-annually, including the requirements of this regulation.

4. The Director of Health or Wellness (DHW) or RN designee will review physician's orders and electronic medication administration record (EMAR) for 5 residents to ensure only licensed nurses are administering any medication which is considered a waivered medication weekly for 6 weeks then biweekly for 6 weeks then monthly for 3 months to ensure compliance with this regulation.

5. Completion Date: 12/20/24

A-941 8:36-11.5(b)(3)(i-v) Pharmaceutical Services

1. There were no residents negatively impacted by the deficient practice but resident #1 received [redacted] from Certified Medication Aides assigned to administer medications on that assignment when the [redacted] was scheduled to be administered without an approved waiver. Regional Director of Health & Wellness provided training to all nurses and certified medication aides (CMAs) on 10/9/2024 and 10/10/2024 on the Registered Nurse (RN)/Certified Medication Aide (CMA) process, the waivered medication administration process, which includes [redacted] and Medication Management Guidelines, including Appendix E: New Jersey. On 10/9/24, Regional Director of Health & Wellness (RDHW) redelegated [redacted] to licensed nurses to administer. Regional Director of Health and Wellness (RDHW) provided training to the Registered Nurse (RN) Clinical Specialist on the Registered Nurse (RN)/Certified Medication Aide (CMA) process and the waivered medication administration process, which includes [redacted] on 10/14/24. All Certified Medication Aides signed an updated job description titled Certified Caregiver, which was updated on 11/1/24, as of 12/20/24.

2. All residents have the potential to be negatively impacted by the deficient practice.

3. All newly hired CMAs will complete training with the Director of Health & Wellness (DHW) or Registered Nurse (RN) designee on the Registered Nurse (RN)/Certified Medication Aide (CMA) process, the waivered medication administration process, which includes Ozempic and Medication Management Guidelines, including Appendix E: New Jersey prior to passing any medication. The training will be documented and signed off by the Registered Nurse and Certified Medication Aides. A copy will be kept in the employee's file as well as the survey results binder that is kept in the administrator's office. Omnicare will begin providing medication administration training to Certified Medication Aides by 2/7/25. Director of Health and Wellness (DHW) or RN designee will provide Certified Medication Aides (CMAs) with medication administration training bi-annually, including the requirements of this regulation.

4. The Director of Health or Wellness (DHW) or RN designee will review physician's orders and electronic medication administration record (EMAR) for 5 residents to ensure only licensed nurses are administering any medication which is considered a waivered medication weekly for 6 weeks then biweekly for 6 weeks then monthly for 3 months to ensure compliance with this regulation.

5. Completion Date: 12/20/24

A-945 8:36-11.5(b)(5) Pharmaceutical Services

1. There were no residents negatively impacted by the deficient practice but resident #1 received [redacted] from Certified Medication Aides assigned to administer medications on that assignment when the [redacted] was scheduled to be administered without an approved waiver. The Regional Director of Health & Wellness provided training to the RN Clinical Specialist on the Registered Nurse (RN)/Certified Medication Aide (CMA) process and the waivered medication administration process, which includes [redacted] on 10/14/24. RDHW provided training to all nurses and certified medication aides (CMAs) on 10/9/2024 and 10/10/2024 on the Registered Nurse (RN)/Certified Medication Aide (CMA) process, the waivered medication administration process, which includes Ozempic and Medication Management Guidelines, including Appendix E: New Jersey. All Certified Medication Aides signed an updated job description titled Certified Caregiver, which was updated on 11/1/24, as of 12/20/24.

2. All residents have the potential to be negatively impacted by the deficient practice.

3. All newly hired CMAs will complete training with the Director of Health & Wellness (DHW) or Registered Nurse (RN) designee on the Registered Nurse (RN)/Certified Medication Aide (CMA) process, the waivered medication administration process, which includes Ozempic and Medication Management Guidelines, including Appendix E: New Jersey prior to passing any medication. The training will be documented and signed off by the Registered Nurse (RN) and Certified Medication Aide (CMA). A copy will be kept in the employee's file as well as the survey results binder that is kept in the administrator's office. Omnicare will begin providing medication administration training to Certified Medication Aides (CMAs) by 2/7/25. Director of Health and Wellness (DHW) or RN designee will provide Certified Medication Aides (CMAs) with medication administration training bi-annually, including the requirements of this regulation.

4. The Director of Health or Wellness (DHW) or RN designee will review physician's orders and electronic medication administration record (EMAR) for 5 residents to ensure only licensed nurses are administering any medication which is considered a waivered medication weekly for 6 weeks then biweekly for 6 weeks then monthly for 3 months to ensure compliance with this regulation.

5. Completion Date: 12/20/24

A-963 8:36-11.5(f) Pharmaceutical Services

1. There were no residents negatively impacted by this deficient practice but due to residents 8, 9 and 11 having documentation errors which led to this deficient practice and are unable to be addressed this far after the occurrence, the Regional Director of Health and Wellness (RDHW) provided training to all nurses and certified medication aides (CMAs) on 10/9/2024 and 10/10/2024 on the Registered Nurse (RN)/Certified Medication Aide (CMA) process and Medication Management Guidelines, including Appendix E: New Jersey. This training included proper documentation of medication administration, including reasons being listed for medications which are not administered. All Certified Medication Aides signed an updated job description titled Certified Caregiver, which was updated on 11/1/24, as of 12/20/24.

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

3. This community transitioned to PointClickCare (PCC) electronic medication administration records (EMAR) on 12/3/24. All newly hired Certified Medication Aides (CMAs) will complete training with the

Director of Health & Wellness (DHW) or Registered Nurse (RN) designee on the Registered Nurse (RN)/Certified Medication Aide (CMA) process and Medication Management Guidelines, including Appendix E: New Jersey prior to passing any medication. This training will include proper documentation of medication administration, including reasons being listed for medications which are not administered. The training will be documented and signed off by the Registered Nurse (RN) and Certified Medication Aides (CMAs). A copy will be kept in the employee's file as well as the survey results binder that is kept in the administrator's office. Omnicare will begin providing medication administration training to CMAs by 2/7/25. Director of Health and Wellness (DHW) or RN designee will provide Certified Medication Aides (CMAs) with medication administration training bi-annually, including the requirements of this regulation.

4. The Director of Health and Wellness (DHW) or Registered Nurse (RN) designee will audit electronic medication administration records (EMARs) weekly for 4 weeks then biweekly for 4 weeks then monthly for 1 mont to ensure compliance with this regulation.

5. Completion Date: 12/20/24

A-983 8:36-11.7(a)(5) Pharmaceutical Services

1.There were no residents negatively impacted by this deficient practice. On 10/9/24, NJ ex order 26.4b1 for resident #12 was moved to the medication refrigerator and continued to be stored there until it was discontinued and destroyed on 11/20/24. No doses of this medication were administered between 10/9/24 - 11/20/24. NJ Ex Order 26 tablets were ordered on 11/20/24, which can be stored in the NJ Ex Order 26.4(b storage area of the medication cart. RDHW provided training to all nurses and CMAs on 10/9/2024 and 10/10/2024 on Medication Management Guidelines, including Appendix E: New Jersey.

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

3. Regional Director of Health and Wellness provided training to all nurses and certified medication aides (CMAs) on 10/9/2024 and 10/10/2024 on the Registered Nurse (RN)/Certified Medication Aide (CMA) process and Medication Management Guidelines, including Appendix E: New Jersey. This training included proper medication storage. All Certified Medication Aides signed an updated job description titled Certified Caregiver, which was updated on 11/1/24, as of 12/20/24. All newly hired CMAs will complete training with the Director of Health & Wellness (DHW) or Registered Nurse (RN) designee on the Registered Nurse (RN)/Certified Medication Aide (CMA) process prior to passing any medication. The training will be documented and signed off by the RN and CMA. A copy will be kept in the employee's file as well as the survey results binder that is kept in the administrator's office. Omnicare will begin providing medication administration training to CMAs by 2/7/15. Director of Health and Wellness (DHW) or RN designee will provide Certified Medication Aides (CMAs) with medication administration training bi-annually, including the requirements of this regulation.

4. The Director of Health and Wellness (DHW) or Registered Nurse (RN) designee will audit 1 medication cart weekly for 6 weeks then biweekly for 6 weeks then monthly for 3 months to ensure proper medication storage and compliance with this regulation.

5. Completion Date: 12/20/24

A-1057 8:36-15.4 Resident Records Complaint

1. Pursuant to state regulations, records will be readily made available (onsite or offsite) when requested by state surveyors for a minimum of 10 years. After a 10-year period, the records will be transferred and secured at our contracted vendors facility to be maintained. Resident #7 was a closed record and did not arrive from the offsite company in time during the time the surveyor was at the facility.
2. All residents have the potential to be affected by this deficient practice.

3.-The Business Office Manager (BOM) will do a quarterly review of discharged residents files in order to identify which one can be transferred to our secured vendor for storage.

- An audit review log will be reviewed each quarter by the Business Office Manager (BOM) and the Executive Director (ED) and / or designee and then signed off quarterly by both administrators in order to ensure that any records being moved to the secured vendor are 10 plus years old.

4.The Business Office Manager and/ or the Executive Director will on a quarterly basis review and sign off on any files that are 10 years or older before the secured vendor is contacted to come and secure the files. This will be done by 01/31/25.

5-Resident records are being requested to be returned to the community from 2014-present and will be on site by 02/15/25. Including resident #7.

A-1097 8:36-16.6 Physical Plant

1.The Facility Director (FD) has contracted with a local fire inspection company to do quarterly inspections of the fire sprinkler system.

2. All residents have the potential to be impacted by this deficient practice.

3. The fire inspection company has the community on their quarterly schedule to come and do inspections and an email reminder is sent to the FD with the date they will be coming to do the inspections.

With regard to the observation at 11:43am by the surveyor as it pertains to the fire sprinkler coverage in the 2nd floor dining/ activity room approximately 2' by 2' HVAC closet. The Mt. Arlington building department, after weeks of review, cannot locate the blueprints we need. At this time, we are getting quotes from our HVAC company to remove the unit and take away the enclosed closet space. We are waiting for quotes and will have the unit removed and the closet taken down by 02/05/25. pics received 2/5/25 Invoice

1. The Facility Director has an online (maintenance check) system (TELS) that has a checklist of tasks that need to be completed by him and is reviewed by the ED and his regional facility director in order to ensure compliance.
2. The completion date of the log will be 02/05/25.

A-1169 8:36-16.15(a) Physical Plant

1.The Facility Director (FD) immediately notified the fire inspection company of the missed yearly inspection / test of the extinguisher located inside the 3rd floor laundry. When said company came out on 11/08/24 to do the yearly inspection, they made note and completed said task. Regarding the dead extinguisher that was placed in the 3rd floor storage room, it was immediately removed and placed with a dead tag in the Facility Directors office to be picked up by the inspection company when they came and did their yearly 2024 audit on 11/8/24.

2. All residents have the potential to be impacted by this deficient practice.

3. The FD has a list of all extinguishers and the FD, or the designee, will go with the company when they do their inspections to ensure that all equipment is inspected as required.

4.The FD and his designee will review the inspection reports with the Executive Director upon completion of all fire suppression system tests as scheduled.

5.The completion date was 11/08/24.

A-1249 8:36-17.7Housekeeping-Sanitation-Safety-Maintenance

1.The stairwell door (#2) that is referenced by the surveyor at 1:11pm was immediately fixed that afternoon by the Facility Director.
2.All residents have the potential to be impacted by this deficient practice.
3.An audit sheet was put in place as of 12/19/24 so that stairwell # 2 will be inspected by the FD or designee daily (x2 weeks), weekly (x4), biweekly (x2) and then monthly (x1) per month until 100% compliance is achieved by 02/15/25.
4. The FD or his designee inspect the door while performing their morning walk through of the building and report back to the ED during the morning standup meetings M-F. The manager on duty on the weekends will also check said door to ensure it is working properly.

A-1275 8:36-18.2(a)-Infection Prevention and Control Services

With regard to 10/8/24 at 11:45am handwashing:
The Food Service Director went through an on service on 12/04/24 to ensure proper handwashing techniques were observed by the Executive Director and a Registered Nurse.
Regarding the above :A handwashing in-service was completed by the Food Service Director (FSD) under the supervision of the ED. The in-service took place starting on 12/6/24 and all shifts were educated. Server # 1 was included in the in-service training.
1.All employees will be trained upon hire and ongoing throughout the year in proper hand hygiene. The Director of Health and Wellness or their designee (Assistant Director of Health and Wellness and or ED or FSD for kitchen staff) will routinely do in-services on proper hand hygiene.
2 All residents have the potential to be impacted by this deficient practice.
3.-As part of our ongoing inspection of proper handwashing, the Health & Wellness Director, Executive Director or their designee will routinely and randomly spot check employees. A handwashing audit tool has been created and is to be signed off by the employee and the observer. A copy of such is kept in the Plan of Correction binder in the Executive Director's office. We will do annual hand washing training each year and it will bel completed by June 30th of each calendar year.
4.-As part of the Executive Director / or the Health and Wellness Director's monthly schedule, they will randomly do spot checks for employees in any and all departments.
5-Completion date of the in-service training for all kitchen personnel was completed by 12/13/24.

Thank you in advance and we welcome any feedback.

Respectfully

NJ Ex Order 26.4(b)(1)

(NJ Ex Order 26.4(b)(1)—Executive Director.

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
	922TYU	A. BUILDING: _____ B. WING _____	R-C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT ARLINGTON SENIOR LIVING	2 HILLSIDE DRIVE MOUNT ARLINGTON, NJ 07856

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments Initial Comments: Type of Survey: Standard with Complaint Complaint #: NJ 00166243, NJ 00177380, NJ 00157990 Census: 79 Sample Size: 14 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}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/09/24

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
922TYU Y1	A. Building B. Wing Y2	10/10/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MT ARLINGTON SENIOR LIVING	2 HILLSIDE DRIVE MOUNT ARLINGTON, NJ 07856

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	Correction	ID Prefix A0355	Correction	ID Prefix A0401	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed
LSC	12/10/2024	LSC	10/20/2024	LSC	10/20/2024
ID Prefix A0539	Correction	ID Prefix A0581	Correction	ID Prefix A0585	Correction
Reg. # 8:36-5.7(a)(2)	Completed	Reg. # 8:36-5.11(a)(4)	Completed	Reg. # 8:36-5.11(a)(6)	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	10/11/2024
ID Prefix A0587	Correction	ID Prefix A0891	Correction	ID Prefix A0937	Correction
Reg. # 8:36-5.11(a)(7)	Completed	Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-11.5(a)	Completed
LSC	10/11/2024	LSC	01/31/2025	LSC	12/20/2024
ID Prefix A0941	Correction	ID Prefix A0945	Correction	ID Prefix A0963	Correction
Reg. # 8:36-11.5(b)(3)(i-v)	Completed	Reg. # 8:36-11.5(b)(5)	Completed	Reg. # 8:36-11.5(f)	Completed
LSC	12/20/2024	LSC	12/20/2024	LSC	12/20/2024
ID Prefix A0983	Correction	ID Prefix A1057	Correction	ID Prefix	Correction
Reg. # 8:36-11.7(a)(5)	Completed	Reg. # 8:36-15.4	Completed	Reg. #	Completed
LSC	12/20/2024	LSC	01/31/2025	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/10/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
922TYU Y1	A. Building B. Wing Y2	10/10/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MT ARLINGTON SENIOR LIVING	2 HILLSIDE DRIVE MOUNT ARLINGTON, NJ 07856

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	Correction	ID Prefix A0401	Correction	ID Prefix A0511	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-5.5(a)	Completed
LSC	12/10/2024	LSC	10/20/2024	LSC	01/15/2025
ID Prefix A0517	Correction	ID Prefix A0539	Correction	ID Prefix A0547	Correction
Reg. # 8:36-5.6(b)(1-7)	Completed	Reg. # 8:36-5.7(a)(2)	Completed	Reg. # 8:36-5.7(a)(6)	Completed
LSC	12/12/2024	LSC	01/31/2025	LSC	01/31/2025
ID Prefix A0553	Correction	ID Prefix A0581	Correction	ID Prefix A0585	Correction
Reg. # 8:36-5.7(b)	Completed	Reg. # 8:36-5.11(a)(4)	Completed	Reg. # 8:36-5.11(a)(6)	Completed
LSC	01/17/2025	LSC	01/31/2025	LSC	10/11/2024
ID Prefix A0587	Correction	ID Prefix A0891	Correction	ID Prefix A0937	Correction
Reg. # 8:36-5.11(a)(7)	Completed	Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-11.5(a)	Completed
LSC	10/11/2024	LSC	01/31/2025	LSC	12/20/2024
ID Prefix A0941	Correction	ID Prefix A0945	Correction	ID Prefix A0963	Correction
Reg. # 8:36-11.5(b)(3)(i-v)	Completed	Reg. # 8:36-11.5(b)(5)	Completed	Reg. # 8:36-11.5(f)	Completed
LSC	12/20/2024	LSC	12/20/2024	LSC	12/20/2024

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
922TYU Y1	A. Building B. Wing Y2	10/10/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MT ARLINGTON SENIOR LIVING	2 HILLSIDE DRIVE MOUNT ARLINGTON, NJ 07856

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	A0983	Correction	ID Prefix	A1057	Correction	ID Prefix	A1097	Correction
Reg. #	8:36-11.7(a)(5)	Completed	Reg. #	8:36-15.4	Completed	Reg. #	8:36-16.6	Completed
LSC		12/20/2024	LSC		01/31/2025	LSC		02/05/2025
ID Prefix	A1169	Correction	ID Prefix	A1249	Correction	ID Prefix	A1275	Correction
Reg. #	8:36-16.15(a)	Completed	Reg. #	8:36-17.7	Completed	Reg. #	8:36-18.2(a)(1)	Completed
LSC		11/08/2024	LSC		12/19/2024	LSC		12/13/2024

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	
10/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO