

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FNP72Z	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/05/2023
NAME OF PROVIDER OR SUPPLIER ROYAL SENIOR CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1041 (500) HIGHWAY 36 ATLANTIC HIGHLANDS, NJ 07716		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments Type of Survey: Complaint Complaint #: NJ00162535 Census: 40 Sample Size: 6 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 263	8:43F-3.4(a)(5) Administration (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed by written confirmation within 72 hours of the following: 5. All fires, all disasters, and all deaths resulting from accidents or incidents in the facility or related to facility services. The written confirmation shall contain information about injuries to participants and/or personnel, disruption of services, and extent of damages.	M 263		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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M 263	Continued From page 1 This REQUIREMENT is not met as evidenced by: NJ00162535 Based on interview and record review, it was determined that the facility failed to notify the Department of Health (DOH) of a facility motor vehicle accident which resulted in participants being taken to the Emergency Room for evaluation of injuries for 6 of 6 participants, Participant #1, Participant #2, Participant #3, Participant #4, Participant #5, and Participant #6. This deficient practice was evidenced by the following: On 4/5/23 at 9:58 a.m., during the entrance to the facility the surveyor asked for the Administrator (ADM) and the Assistant Administrator (AA) explained the ADM was not at the facility and would not be available due to religious beliefs. 1. On 4/5/23 at 10:35 a.m., the surveyor reviewed the medical record (MR) of Participant #1 which showed Participant #1 was admitted to the facility on [REDACTED] with diagnoses of [REDACTED] During review of Participant #1's MR, the surveyor identified "Notes" dated [REDACTED] by the AA which showed on [REDACTED] Participant #1 was involved in a [REDACTED] along with other participants and "had [REDACTED] [with]	M 263		

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M 263	Continued From page 2 ██████ [the] ██████." The Emergency Room (ER) "After Visit Summary," dated ██████ revealed the reason for visit was a "██████ [with] Diagnoses [of a] ██████ [and] ██████" 2. On 4/5/23 at 11:00 a.m., the surveyor reviewed the medical record (MR) of Participant #2 which showed Participant #2 was admitted to the facility on ██████ with diagnoses of ██████. During review of Participant #2's MR, the surveyor identified "Notes" dated ██████ by the AA which showed on ██████ Participant #2 was involved in a ██████ along with other participants and was "taken to the hospital" for evaluation and "was released with no [injuries]." 3. On 4/5/23 at 11:20 a.m., the surveyor reviewed the medical record (MR) of Participant #3 which showed Participant #3 was admitted to the facility on ██████ with diagnoses of ██████. During review of Participant #3's MR, the surveyor identified "Notes" dated ██████ by the AA which showed on ██████ Participant #3 was "involved in an accident [along] with [other] clients... [and] had a ██████." In addition, Participant #3 was "released from hospital that evening." 4. On 4/5/23 at 11:50 a.m., the surveyor reviewed the medical record (MR) of Participant #4 which showed Participant #4 was admitted to the facility on ██████ with diagnoses of ██████. During review of	M 263		

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M 263	Continued From page 3 Participant #4's MR, the surveyor reviewed "Notes" written on [REDACTED] by the AA which showed on [REDACTED] Participant #4 was involved in a [REDACTED] along with other participants and was taken to the hospital for evaluation. According to the "Notes," Participant #4 on [REDACTED], "was taking [taken] to Hospital [and] had [REDACTED] on [REDACTED]." 5. On 4/5/23 at 12:20 p.m., the surveyor reviewed the medical record (MR) of Participant #5 which showed Participant #5 was admitted to the facility on [REDACTED] with diagnoses of [REDACTED]. During review of Participant #5's MR, the surveyor reviewed "Notes" dated [REDACTED] written by the Director of Nursing (DON) which showed on [REDACTED] [Participant #5] was involved in an accident [and] was transported to the hospital to be evaluated. [Participant #5] had no visible injury and was released with instructions to follow up with PCP [Primary Care Physician]." In addition, according to "Notes" documented by the DON on [REDACTED] Participant #3's Home Manager reported "some [REDACTED] to [Participant #3's] [REDACTED] but [was] otherwise fine [and] will be ready to return to program on [REDACTED]. On [REDACTED] the DON wrote "[Participant #5] returned to program following the [REDACTED] t...[with] No apparent injuries noted, denied [REDACTED] [and] [REDACTED]" 6. On 4/5/23 at 12:50 p.m., the surveyor reviewed the medical record (MR) of Participant #6 which showed Participant #6 was admitted to the facility on [REDACTED] with diagnoses of [REDACTED]. During review of Participant #6's MR, the surveyor reviewed "Notes" dated [REDACTED] written by the AA which showed on [REDACTED] Participant #6 was involved in a bus accident	M 263		

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M 579	Continued From page 5	M 579		
M 579	8:43F-12.2(a) Social Work Services The facility shall arrange for the provision of social work services to participants who require them, in accordance with N.J.S.A. 45:15BB-1 et seq. and N.J.A.C. 13:44G. This REQUIREMENT is not met as evidenced by: NJ00162535 Based on observation, interview, and record review it was determined the facility failed to ensure that a Licensed or Certified Social Worker (SW) was available to participants to provide services as needed. This deficient practice was evidenced by the following: On 04/05/2023 at 10:15 a.m., during interview with the Director of Nursing (DON), the surveyor asked about staffing. The DON gave a verbal list of all staff but did not mention a SW. The surveyor asked if there was a SW, and the DON informed the surveyor the facility did not have one. On 04/05/2023 at 10:45 a.m., the Assistant Administrator (AA) submitted the staffing list. Upon review of the staffing list, it was noted that a social worker was not listed. On 04/05/2023 at 2:00 p.m., The surveyor interviewed the AA regarding the facility's SW. The AA explained the facility did not currently have a SW but created job postings on job posting sites. The AA explained the facility had a	M 579		

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M 579	Continued From page 6 few interviews but have not found anyone willing to work the required hours. The facility did not have a Licensed or Certified Social Worker available to provide services to participants from January 1, 2023, until day of survey on 04/05/2023.	M 579			



*Your care,
dignity
and respect
is our "royal"
commitment*

Provider: Royal Senior Care

ST- M- Social Work Services- Plan Of Correction

1. Royal Senior Care has been advertising online sites for Social Workers for all positions full-time, part-time or someone to consult for Licensed or Certified Social Worker. As of 05/23/2023
2. No participants have been affected 05/23/2023
Participants have the potential to be affected
3. We will continue our contracts with hiring agencies to ensure our facility has access to a licensed Social Worker
4. As of 07/07/2023 The Administrator has hired a Licensed Social Worker to consult for Royal Senior Care so that our facility is in compliance with al State regulations regarding Social Work Services



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Provider: Royal Senior Care

St – M-0263

1. Royal Senior Care administrator, assistant administrator, and staff were informed of procedure notification as of 05/23/2023 information has been posted throughout the building in case of an incident, accident, steps to be followed call 911 / immediate call to supervisor / call to N.J. D.O.H.

In-Services as of 05/23/2023 are put into place quarterly

2. No participants have been affected

Participants have the potential to be affected

3. Policy and Procedure In-Services were done 05/23/2023 and will continue quarterly

4. Royal Senior Care will be monitoring our corrective plan of action as of 05/23/2023 and ongoing.

Assistant Administrator / Register Nurse will insure all In-Services are done by all employees

Dated and signed quarterly.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER FNP72Z	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/5/2023
NAME OF FACILITY ROYAL SENIOR CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1041 (500) HIGHWAY 36 ATLANTIC HIGHLANDS, NJ 07716	

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 M0263	Correction	ID Prefix M0579	Correction	ID Prefix	Correction
Reg. # 8:43F-3.4(a)(5)	Completed	Reg. # 8:43F-12.2(a)	Completed	Reg. #	Completed
LSC	06/30/2023	LSC	07/10/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON 4/5/2023

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