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
	11A013	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF PRINCETON JUNCT	861 ALEXANDER ROAD PRINCETON, NJ 08540

(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
H 000	Initials Comments This was a complaint survey conducted on / / . [Facility name] is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedure and Standards Applicable to All Licensed Facilities for this complaint only (C#).	H 000		
H3440	8:43E-10.11(a)(1) Other Rprtng Rqrmnts Unrltd to Pt Sfty Act A health care facility shall immediately report to the appropriate police authorities all criminal acts or potentially criminal acts that occur within a facility and pose a danger to the life or safety of patients or residents, employees, medical staff or members of the public present in the facility. "Acts occurring within a facility" means, in the case of a home-based service, that is, services provided by home health care facilities, hospice facilities, assisted living residences, comprehensive personal care homes, and assisted living programs, acts related to events within the control of the facility or directly caused by or related to services of the facility. This REQUIREMENT is not met as evidenced by: Complaint : NJ00166155 Based on interview and record review it was determined that the facility failed to immediately notify the the appropriate NJ Ex Order 26.4(b)(1) of a *NJ Ex Order 26. 4B1* [redacted] for 1 of 3 residents reviewed, Resident #2.	H3440		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A013	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF PRINCETON JUNCT	861 ALEXANDER ROAD PRINCETON, NJ 08540

(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
H3440	Continued From page 1	H3440		

NJ Ex Order 26. 4B1 under the NJ Ex Order 26.4(b)(1) Act used to treat NJ Ex Order 26. 4B. This deficient practice was evidenced by the following:

Review of a Facility Reportable Event (FRE) record dated and faxed to the Department of Health (DOH) on NJ Ex Order 26.4(b)(1) indicated that the facility lost a NJ Ex Order 26. 4B1 remaining which was identified during a NJ Ex Order 26.4(b) medication count at the change of shift on NJ Ex Order 26.4(b)(1) at 11:45 p.m.

At 08/04/2023 at 11:15 a.m., the surveyor reviewed Resident #2's medical records who had a move in date of NJ Ex Order 26.4(b)(1) and diagnoses which included NJ Ex Order 26. 4B1 . The surveyor reviewed the "Charting Notes" for Resident #2 which revealed, on NJ Ex Order 26.4(b)(1) at 11:43 p.m., LPN #1 was unable to locate Resident #2's NJ Ex Order 26. 4B1 in the locked NJ Ex Order 26.4(b)(1) refrigerator or in the locked medication cart. A further search of the facility was conducted by LPN #1; however, the NJ Ex Order 26. 4B1 was not found.

At 12:15 p.m., The surveyor interviewed the ED who stated she did not report the missing NJ Ex Order 26. 4B1 . The ED further stated LPN #3 continued working during the investigation process until NJ Ex Order 26.4(b)(1), when she was NJ Ex Order 26. 4B1 . The ED further stated she did not notify the DOH NJ Ex Order 26.4(b)(1), because she thought they would find the NJ Ex Order 26. 4B1, the Director of Health and Wellness was NJ Exec Order 26.4 and there was a NJ Ex Order 26.4(b)(1) all occurring around the same time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A013	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF PRINCETON JUNCT	861 ALEXANDER ROAD PRINCETON, NJ 08540

(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
H3440	Continued From page 2 A review of the "Controlled Medication Loss Investigation Guidelines" policy revealed the ED and/or [Director of Health and Wellness] DHW will immediately notify: Appropriate State Agency (per state-specific requirements).	H3440		
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00166155 CENSUS: 53 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A013	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF PRINCETON JUNCT	861 ALEXANDER ROAD PRINCETON, NJ 08540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 310	Continued From page 3 and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Complaint: NJ00166155 Based on interview and record review it was determined that the facility's Administrator failed to implement and enforce the facility's policy and procedure titled, "Controlled Medication Loss Investigation Guidelines" by not immediately contacting the [NJ Exec Order] regarding the missing [NJ Ex Order 26. 4B1] [redacted], by not notifying the pharmacy of the loss within 24 hours, and by waiting 14 days to [NJ Exec Order 26.4b] a suspected staff member in association with missing [NJ Ex Order 26. 4B1]. This deficient practice was evidenced by the following: Review of a Facility Reportable Event (FRE) record dated and faxed to the Department of Health (DOH) on [NJ Ex Order 26.4(b)(1)] indicated that the facility lost a [NJ Ex Order 26. 4B1] [redacted] remaining which was identified during a [NJ Ex Order 26.4(b)] medication count at the change of shift on [NJ Ex Order 26.4(b)(1)] at 11:45 p.m.	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A013	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF PRINCETON JUNCT	861 ALEXANDER ROAD PRINCETON, NJ 08540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 310	Continued From page 4 On 08/04/2023 at 11:15 a.m., the surveyor reviewed Resident #2's medical records who moved in on NJ Exec Order 26.4b1 and diagnoses which included *NJ Ex Order 26. 4B1* [redacted]. The surveyor reviewed the "Charting Notes (CN)" for Resident #2 which revealed, on NJ Ex Order 26.4(b)(1) at 11:43 p.m., the Licensed Practical Nurse (LPN) #1 was unable to locate Resident #2's *NJ Ex Order 26. 4B1* in either the locked NJ Ex Order 26.4(b)(1) refrigerator located in the Wellness Office or in the locked medication cart in the NJ Ex Order 26.4(b)(1) unit of the facility. A further search was of the facility was conducted by LPN #1; however, the *NJ Ex Order 26. 4B1* was not found. LPN #1 informed the Director of Nursing (DON) and the Executive Director (ED) via text message and later spoke with the ED via telephone to inform her of the missing *NJ Ex Order 26. 4B1*. A review of the LPN #3's investigation statement revealed, at approximately 8:30 a.m. on NJ Ex Order 26.4(b)(1), LPN #3 and LPN #4 retrieved the *NJ Ex Order 26. 4B1* from the Wellness Office. LPN #4 drew up the medication on top of the medication cart counter and went with LPN #3 to administer the medication. The last time the LPN #3 remembered seeing the *NJ Ex Order 26. 4B1* was when it was on the counter above the medication cart. At 12:15 p.m., The surveyor interviewed the ED who stated she did not report the missing *NJ Ex Order 26. 4B1* to the NJ Ex Order 2 unti NJ Ex Order 26.4(b)(1) at 3:15 p.m. The ED further stated LPN #3 continued working during the investigation process NJ Ex Order 26.4(b)(1), when she was *NJ Ex Order 26. 4B1* [redacted]. The ED further stated she did not notify the DOH unti NJ Ex Order 26.4(b)(1) because she thought they would find the *NJ Ex Order 26. 4B1*, the Director of	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A013	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF PRINCETON JUNCT	861 ALEXANDER ROAD PRINCETON, NJ 08540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 310	Continued From page 5 Health and Wellness was out sick and there was a [redacted] NJ Ex Order 26.4(b)(1) all occurring around the same time. At 1:30 p.m., the surveyor interviewed LPN #2 who stated she did not inform the pharmacy of the missing [redacted] NJ Ex Order 26. 4B1 . Surveyor review of the facility's policy and procedure titled, "Controlled Medication Loss Investigation Guidelines" revealed, Procedures: The ED and/or [Director of Health and Wellness] DHW will immediately contact local police. 2. The pharmacy will be notified of the drug loss/suspected tampering. A new dose of medication will be requested for delivery with a 24-hour period. 3. If the investigation identifies that an associate was responsible for controlled medication diversion, the associate will be terminated in accordance with facility policy.	A 310		
A1011	8:36-11.7(k) Pharmaceutical Services (k) Controlled dangerous substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts, N.J.S.A. 24:21-1 et seq. and all other Federal and State laws and regulations concerning the procurement, storage, dispensation, administration, and disposition of same. This REQUIREMENT is not met as evidenced by:	A1011		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A013	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF PRINCETON JUNCT	861 ALEXANDER ROAD PRINCETON, NJ 08540

(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
A1011	Continued From page 6 Complaint : NJ00166155 Based on interview and record review, it was determined that the facility failed to ensure that the Licensed Practical Nurse LPN(s) were performing a shift-to-shift count of a [NJ Exec Order 26.4b1] [redacted] in order to maintain accountability in accordance with facility policy for 1 of 3 residents reviewed, Resident #2. In addition, the facility failed to ensure that the LPN(s) were securing the outside lock on the [NJ Exec Order 26.4b1] refrigerator located in the Wellness Office. These deficient practices were evidenced by the following: At 08/04/2023 at 11:15 a.m., while conducting a complaint survey the surveyor reviewed Resident #2's medical records who had a move in date of [NJ Ex Order 26. 4B1] and diagnoses which included [NJ Ex Order 2] [redacted]. Review of a Facility Reportable Event (FRE) record dated and faxed to the Department of Health (DOH) on [NJ Ex Order 26.4(b)(1)] identified that the facility lost a [NJ Ex Order 26. 4B1] [redacted] remaining which was identified during a [NJ Ex Order 26.4(b)] medication count at the change of shift on [NJ Ex Order 26.4(b)(1)] at 11:00 p.m. The document further revealed "A [NJ Exec Order 26.4b1] count audit was conducted on all [NJ Exec Order 26.4b1] in the community; all [NJ Exec Order 26.4b1] are accounted for - all [NJ Exec Order 26.4b1] sheets were completed and accurate." At 11:55 a.m., the surveyor entered the Wellness Office and noticed the outside lock was not secured on the refrigerator designated for NJ Ex Order 26.4(b)(1) medications. At 1:30 p.m., the surveyor re-entered the	A1011		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A013	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF PRINCETON JUNCT	861 ALEXANDER ROAD PRINCETON, NJ 08540

(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
A1011	Continued From page 7 Wellness Office and noted the outside lock was still not secured on the refrigerator designated for NJ Exec Order 26.4b1 medications. The surveyor reviewed the NJ Ex Order 26.4(b)(1) -Count Record" for the Wellness Refrigerator which revealed multiple omissions. In addition, the form contained the initials of LPN #1 on NJ Ex Order 26. 4B1 ; however, LPN #1 was not scheduled and did not work during those three days. At 3:00 p.m., the surveyor interviewed the Director of Health and Wellness who reported the initials of LPN #1 on NJ Ex Order 26. 4B1 was investigated, but they were unable to determine who was responsible. Post survey a telephone interview was conducted on 08/09/2023 at 12:30 p.m., with LPN #1 who denied working on NJ Ex Order 26. 4B1 . A review of the "Controlled Medications" policy revealed, The counting of narcotic/controlled drugs will be done with two (2) persons who have been trained to administer medication (licensed nurse or Care Partner). One of two persons counting should be a licensed nurse, whenever possible. If not, then a licensed nurse should review the narcotic/controlled drug count sheets daily. 1. "If the count is correct, then both persons sign the narcotics/controlled drug count sheet." 2. "If the count is incorrect, both persons will sign the sheet and note the discrepancy. The Director of Health and Wellness (DHW) is made aware immediately and an investigation will be initiated."	A1011		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A013	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF PRINCETON JUNCT	861 ALEXANDER ROAD PRINCETON, NJ 08540

(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
A1011	Continued From page 8 3. "The Director of Health and Wellness should be auditing the narcotics/controlled drug medications and count sheets on a routine basis (weekly, biweekly or monthly)." 4. "Storage: All controlled drugs will be kept under a Double Lock system." 5. "Narcotics/controlled medications that need to be refrigerated will also be kept under a Double Lock system."	A1011		

NJ Exec Order 26.4b1 [redacted]

ARTIS SENIOR LIVING
Princeton Junction
Your Partner in Memory Care

POC Survey 8/04/2023

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

1. Resident #2 was NJ Exec Order 26.4b1 this deficient practice and is currently a resident in the facility. The primary care physician was notified; the medication is administered at night; the resident was NJ Exec Order 26.4 so it was not administered. The pharmacy was contacted; an additional dose was delivered. The Executive Director will notify the DOH immediately when a missing medication is identified and follow up within 72 hours regarding the results of the internal investigation.
2. All residents have the potential to be affected.
3. The Executive Director will in-service the director team regarding the requirement to immediately notify the Executive Director and the Director of Health and Wellness when missing medication has been identified. The policies III.2 Medication Management and III.9 Controlled Medication loss Investigation Guidelines, will be reviewed monthly at the nursing department meeting for the next three months and quarterly thereafter. The Director of Health and Wellness will conduct weekly narcotic count audits for 3 months and monthly thereafter
4. The Executive Director will review narcotic audits monthly for three months and then quarterly thereafter.

Completed 9/6/2023

H 3440 General Requirements

1. Resident #2 was NJ Exec Order 26.4b1 this deficient practice. The Executive Director will notify the DOH immediately when a missing medication is identified and follow up within 72 hours regarding the results of the internal investigation. The Executive Director will also report any missing medication immediately to West Windsor Police Department, the Primary Care Physician and the Pharmacy.
2. All residents have the potential to be affected.
3. The Director Team will be in-serviced quarterly by the Executive Director to immediately notify the Executive Director and the Director of Health and Wellness when missing medication has been identified.

ARTIS
SENIOR LIVING
Princeton Junction
Your Partner in Memory Care

4. The Director of Health and Wellness will verify that the procedures have been followed and report all incidents at the daily stand-up meeting.

Completed 9/6/2023

A 1011 8:36-11.7(k) Pharmaceutical Service

1. Resident #1 was NJ Exec Order 26.4b1 this deficient practice. The affected resident was NJ Exec Order 26.4b1 and was not given the dose on NJ Exec Order 26.4b.
2. All residents have the potential to be affected.
3. All nurses will be in-serviced quarterly by the Director of Health and Wellness regarding the double lock system for narcotic medications stored in the medication refrigerator and on the med cart.
4. The Director of Health and Wellness and the Assistant Director of Health and Wellness will verify, on a weekly basis, that all narcotic medications are stored using the double lock system. The lock was repaired by the Maintenance Director on 8/4/23.

Completed 8/4/2023