STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A115	A. BUILDING: _____ B. WING _____	C 10/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE JACKSON	11 HISTORY LANE JACKSON, NJ 08527

(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: Complaint and COVID-19 Focused Infection Control COMPLAINT #: NJ00112768 CENSUS: 59 SAMPLE SIZE: 1 SURVEY DATE: 10/28/20 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, based on this Complaint Survey. The facility was found to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19, based on this COVID-19 Focused Infection Control Survey. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following:	A 310		

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
	15A115	A. BUILDING: _____ B. WING _____	C 10/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE JACKSON	11 HISTORY LANE JACKSON, NJ 08527

(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 1 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00112768 Based on record review, interviews and facility policy review, the facility failed to implement their policy for determining a resident's [redacted] for one (Resident #1) of one sampled resident reviewed for [redacted]; and failed to implement the facility policy to maintain a completed copy of the Universal Transfer Form (UTF) for one (Resident #1) of one sampled resident reviewed for the UTF. This had the potential to affect all residents. The facility census was 59. Findings included: 1. A facility form entitled, "Advanced Directives (Assisted Living Manual)," revised on 04/22/14, was reviewed and it indicated: "1. Prior to Move-in, the Admission Coordinator	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A115	A. BUILDING: _____ B. WING _____	C 10/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE JACKSON	11 HISTORY LANE JACKSON, NJ 08527

(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 2 (or designee) will determine whether the individual has completed the state-designated, Orders for Life Sustaining Treatment form. 2. If the individual does not have a completed state-designated, Orders for Life Sustaining Treatment form, the admitting Registered Nurse (or designee) will offer the patient the opportunity to discuss the Orders for Life Sustaining Treatment form with the physician, or other practitioners as permitted by state law, when Orders for Life Sustaining Treatment are recognized in the state .... 6. Advanced Directives ...should be reviewed and updated if appropriate to reflect the individual's or authorized decision maker's wishes. Reviews should occur, minimally, at the following times: 6.1 Upon move-in ... 7. The initial review and ongoing discussions about continuing, revising, or revoking Orders for Life Sustaining Treatment shall be documented in the record." Resident #1 was admitted on NJ Ex Order 26.4(b)(1). The resident was no longer residing in the facility. On 10/28/2020 at 3:00 PM, a review of the closed record of Resident #1 was conducted. The closed record contained no indication the resident had signed an Orders for Life Sustaining Treatment form and/or if the resident had been offered the opportunity to discuss the form. On 10/28/2020 at 4:00 PM, the Administrator and Director of Wellness were asked to review the resident's closed record. They were asked if the resident's medical record contained any information about the resident's advanced directives and/or resuscitation status. They confirmed it did not contain the resident's code status or requested life sustaining treatment	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A115	A. BUILDING: _____ B. WING _____	C 10/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE JACKSON	11 HISTORY LANE JACKSON, NJ 08527

(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	A 310		

information. They were asked if the record indicated if the Life Sustaining Treatment form had been signed and placed in the medical record. If not, did the record indicate if the resident had been offered the opportunity to discuss the form. They both confirmed it did not indicate if a form had been signed or if it had been discussed with the resident.

2. A facility policy entitled, "Policy Statement" dated March 2017, was reviewed and it indicated: "This facility provides a completed and accurate Transfer Form to a resident transferred or discharged from our facility.
1. Should it become necessary to transfer a resident from the facility, a Transfer Form will be executed and forwarded with the resident ....
3. A copy of the Transfer Form will be filed in the resident's medical record."

Resident #1 was admitted on [redacted]. The resident no longer resided in the facility.

On 10/28/2020 at 3:00 PM, a review of the closed record of Resident #1 was conducted. The closed record did not indicate if the facility had maintained a completed copy of the UTF when the resident was transferred to a [redacted] in [redacted] of [redacted], which would have contained pertinent information, such as a resident's code status.

On 10/28/2020 at 4:00 PM, the Administrator and Director of Wellness were asked to review the resident's closed record. They were asked if a completed copy of the resident's UTF was in the resident's medical record. They both stated the medical record did not contain a completed copy of the Resident #1's UTF from the hospital transfer in [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A115	A. BUILDING: _____ B. WING _____	C 10/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE JACKSON	11 HISTORY LANE JACKSON, NJ 08527

(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 10/28/2020 at 6:30 PM, the Administrator stated they had not been saving copies of the UTF in residents' medical records.	A 310		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
15A115 Y1	Y2	12/17/2020 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE JACKSON	11 HISTORY LANE JACKSON, NJ 08527

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 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 10/29/2020	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
10/28/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO