

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2025
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NAME OF PROVIDER OR SUPPLIER IVYSTONE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110
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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 000	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Complaint</p> <p>Complaint #: NJ 00185441, NJ 00180828</p> <p>Census: 107</p> <p>Sample Size: 4</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00185441, NJ 00180828</p> <p>Based on interview and record review it was determined that the Administrator failed to ensure the implementation of facility policys and procedures titled, "Incident and Accident Reporting Policy, Resident Rights, Smoking Policy, and Resident and Staff Safety" with regard to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b in undesignated areas for 3 of 4 residents reviewed, Resident #'s 1, 2, and 3. This deficient practice is evidenced by the following:</p> <p>1. On 4/24/25 and 4/25/25, the Department of Health (DOH) investigated a facility reportable Event (FRE), (a document facilities use to report events to the DOH) dated NJ Exec Order 26.4b1, regarding a NJ Exec Order 26.4b1 that occurred on NJ Exec Order 26.4b1. According to the FRE, "A NJ Exec Order 26.4b1 in the dining room turned into a NJ Exec Order 26.4b1 later in the television (TV) room.</p> <p>On 4/24/25 at 10:00 a.m., the surveyor reviewed the medical record (MR) of Resident #1 which revealed a move in date in NJ Exec Order 26.4b1, and a diagnosis of NJ Exec Order 26.4b1.</p> <p>At 11:00 a.m., the surveyor reviewed the MR of Resident #2 which revealed a move in date in NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1.</p> <p>At 2:11 p.m., the surveyor interviewed the Certified Home Health Aide (CHHA), who worked</p>	A 310		
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A 310	<p>Continued From page 2</p> <p>on the unit on [redacted], regarding Resident #2 being [redacted] with [redacted] by Resident #1. The CHHA stated that she witnessed Resident #2 in a [redacted] with Resident #1 in the dining room, after Resident #2's wheelchair [redacted] into Resident #1's wheelchair. In addition, the CHHA stated that at that time, she sent Resident #2 out of the dining room area to [redacted] the two residents. As Resident #2 was leaving the dinning room area, Resident #1 began making [redacted], and stating that he/she [redacted] Resident #2. The CHHA stated that she thought that she [redacted] the situation so she never reported the dining room [redacted] to supervising staff.</p> <p>At 3:13 p.m., the surveyor interviewed the Executive Director (ED) regarding the [redacted] NJ Exec Order 26.4b1 [redacted] which involved Resident #2 being [redacted] with a [redacted] of [redacted] by Resident #1. The ED stated that he was not made aware that Resident #2 had a [redacted] with Resident #1 earlier in the day until after he started the investigation.</p> <p>2. On 4/24/25 and 4/25/25 the DOH investigated an FRE dated [redacted], regarding Resident #3 [redacted] a [redacted] in his/her [redacted] on [redacted], at 5:00 p.m., which led to a [redacted].</p> <p>On 4/25/25 at 9:15 a.m., the surveyor interviewed the ED regarding the above FRE, and inquired if Resident #3 had any prior incidents of [redacted] in un-designated areas. The ED stated that the Resident #3 was caught [redacted] near a door inside the building, prior to the [redacted] incident.</p> <p>At 12:25 p.m., the surveyor reviewed the closed MR of Resident #3, which indicated a move in date in [redacted], with a diagnosis of</p>	A 310		
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A 310	<p>Continued From page 3</p> <p>NJ Exec Order 26.4b1), and a move out date in NJ Exec Order 26.4b1. In addition, the surveyor observed documentation in the MR that revealed on NJ Exec Order 26.4b1 Resident #3 was NJ Exec Order 26.4b1 in his/her apartment by a Licensed Practical Nurse.</p> <p>Upon further review of the MR, the surveyor observed that there were no updates made to Resident #3's "Service Plan" to include interventions for NJ Exec Order 26.4b1 in un-designated areas following the NJ Exec Order 26.4b1 incident, or prior to the resident starting a NJ Exec Order 26.4b1 in his/her NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1, which placed other residents at risk for NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed the facility policy and procedure titled, "Resident Rights" which documented residents rights, which include, "...The right to live in safe... conditions..."</p> <p>The surveyor also reviewed the facility policy and procedure titled, "Resident and Staff Safety Policy," which documented its purpose was, "To ensure a safe, secure, and healthy environment for all residents, ...in accordance with state and federal regulations ..."</p> <p>In addition, the surveyor reviewed the facility policy and procedure titled, "Incident and Accident Reporting Policy," which documented "...This policy ensures that all incidents and accidents, whether involving residents, ...are addressed promptly and thoroughly to maintain a safe and healthy environment for all ...Immediate Reporting: All incidents and accidents must be reported immediately to a supervisor, nurse, or administrator. ...If the incident involves a resident, the care plan should be reviewed and updated as needed to prevent future occurrences. ..."</p>	A 310		
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A 310	Continued From page 4 The surveyor reviewed the facility policy and procedure titled, "Smoking Policy" which indicated, "The residence is a smoke-free environment..." Reference: A401, 8:36-4.1(a)(22), A749, 8:36-7.3(a)	A 310		
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 #: NJ 00185441, NJ 00180828 Based on interview and record review it was determined that the facility failed to maintain a safe environment, free from harm when a care staff failed/neglected to report a NJ Exec Order 26.4b1 which then led to a NJ Exec Order 26.4b1 and a resident being NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and the facility failed to immediately address resident NJ Exec Order 26.4b1 in	A 401		

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A 401	<p>Continued From page 5</p> <p>undesignated areas for 3 of 4 residents reviewed, Resident #'s 1, 2, and 3. This deficient practice was evidenced by the following:</p> <p>1. On 4/24/25 and 4/25/25, the Department of Health (DOH) investigated a facility reportable Event (FRE), (a document facilities use to report events to the DOH) dated ^{NJ Exec Order 26.4b} regarding a NJ Exec Order 26.4b1 that occurred on ^{NJ Exec Order 26.4b}. According to the FRE, "A ^{NJ Exec Order 26.4b} in the dining room turned into a NJ Exec Order 26.4b1 later in the television (TV) room.</p> <p>On 4/24/25 at 10:00 a.m., the surveyor reviewed the medical record (MR) of Resident #1 which revealed a move in date in ^{NJ Exec Order 26.4b1}, and a diagnosis of ^{NJ Exec Order 26.4b1}. According to Resident #1's "Service Plan" (SP) dated ^{NJ Exec Order 26.4b1}, the resident was ^{NJ Exec Order 26.4b1} with ^{NJ Exec Order 26.4b1}, and used a wheelchair for ^{NJ Exec Order 26.4b1}.</p> <p>During continued review of Resident #1's MR, the surveyor observed that a Certified Medication Aide (CMA) documented on ^{NJ Exec Order 26.4b1} at 6:32 p.m., that Resident #1 was ^{NJ Exec Order 26.4b1} the premises by the ^{NJ Exec Order 26.4b1}.</p> <p>At 11:00 a.m., the surveyor reviewed the MR of Resident #2 which revealed a move in date in ^{NJ Exec Order 26.4b1}, and a diagnosis of ^{NJ Exec Order 26.4b1}. According to Resident #2's "Service Plan (SP)" dated ^{NJ Exec Order 26.4b1} the resident was ^{NJ Exec Order 26.4b1} and ^{NJ Exec Order 26.4b1} and used a wheelchair for ^{NJ Exec Order 26.4b1}.</p> <p>Continued surveyor review of Resident #2's MR, revealed that a CMA documented on ^{NJ Exec Order 26.4b1} at 6:07 p.m., in the "Progress Notes" (PN) that Resident #2 had a ^{NJ Exec Order 26.4b1} with another resident, ^{NJ Exec Order 26.4b1}) was</p>	A 401		

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A 401	<p>Continued From page 6</p> <p>called, and Resident #2 was sent to the [redacted] for evaluation.</p> <p>At 12:30 p.m., the surveyor interviewed the CMA regarding her documentation in the PN and the [redacted] that occurred on [redacted]. The CMA stated that on [redacted], Resident #2 [redacted] in his/her wheelchair to the Nurse's Station and showed the Nurse an [redacted]. Further, the CMA stated that Resident #2 was [redacted] by Resident #1 with a [redacted] of [redacted] while [redacted] in the back TV area of the facility, and that [redacted], notified the Director of Nursing (DON), and Resident #2 was taken to the [redacted] for [redacted].</p> <p>Upon continued review of the MR, the surveyor observed an [redacted] "After Visit Summary" dated [redacted] which documented that Resident #2 was diagnosed with a [redacted]" and was [redacted] or [redacted] at 12:25 a.m.</p> <p>At 12:45 p.m., the surveyor interviewed the DON regarding the [redacted] incident when Resident #2 was [redacted] by Resident #1. The DON stated that she was not aware of any prior [redacted] between the two residents, including the [redacted] that occurred earlier that day, until the CMA notified her of the [redacted].</p> <p>At 1:25 p.m., the surveyor interviewed Resident #2 regarding the [redacted] incident with Resident #1. Resident #2 stated that on [redacted] he/she was seated in the dining room area, at the table, when he/she got into a [redacted] with Resident #1 [redacted]. Resident #2 further stated that Resident #1, [redacted], and staff [redacted]. Resident #2 explained that later, on [redacted] in the TV room, he/she and</p>	A 401		
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A 401	<p>Continued From page 7</p> <p>Resident #1 got into another [redacted] NJ Exec Order 26.4b1 and that Resident #1 [redacted] NJ Exec Order 26.4b1, at which time, Resident #2 [redacted] NJ Exec Order 26.4b1 and Resident #1 [redacted] NJ Exec Order 26.4b1 Resident #2 with the [redacted] NJ Exec Order 26.4b1</p> <p>At 1:37 p.m., the surveyor interviewed Resident #1 regarding the [redacted] NJ Exec Order 26.4b1 incident with Resident #2. Resident #1 stated that Resident #2 [redacted] NJ Exec Order 26.4b1 him/her [redacted] NJ Exec Order 26.4b1 and he/she pulled [redacted] NJ Exec Order 26.4b1 his/her [redacted] NJ Exec Order 26.4b1 to [redacted] NJ Exec Order 26.4b1 Resident #2 [redacted] NJ Exec Order 26.4b1 and not to [redacted] NJ Exec Order 26.4b1 Resident #2.</p> <p>At 2:11 p.m., the surveyor interviewed the Certified Home Health Aide (CHHA), who worked on the unit on [redacted] NJ Exec Order 26.4b1 regarding Resident #2 being [redacted] NJ Exec Order 26.4b1 with [redacted] NJ Exec Order 26.4b1 by Resident #1. The CHHA stated that she witnessed Resident #2 in a [redacted] NJ Exec Order 26.4b1 with Resident #1 in the dining room, after Resident #2's wheelchair [redacted] NJ Exec Order 26.4b1 into Resident #1's wheelchair. In addition, the CHHA stated that at that time, she sent Resident #2 out of the dining room area to [redacted] NJ Exec Order 26.4b1 the two residents. As Resident #2 was leaving the dining room area, Resident #1 [redacted] NJ Exec Order 26.4b1, and stating that he/she [redacted] NJ Exec Order 26.4b1 Resident #2. The CHHA stated that she thought that she [redacted] NJ Exec Order 26.4b1 the situation so she never reported the dining room [redacted] NJ Exec Order 26.4b1 to supervising staff.</p> <p>At 2:25 p.m., the surveyor reviewed the facility "Investigation Summary" which revealed on [redacted] NJ Exec Order 26.4b1, "At approximately 5:30 p.m., [the Executive Director (ED)] was notified that Resident #1 [redacted] NJ Exec Order 26.4b1 Resident #2 with a [redacted] NJ Exec Order 26.4b1." In addition, the surveyor reviewed the written statement of the CHHA which revealed that on [redacted] NJ Exec Order 26.4b1, during dining</p>	A 401		

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A 401	<p>Continued From page 8</p> <p>services, she heard Resident #1 [redacted] that he/she was [redacted] Resident #2. The CHHA also documented that while doing after dining care, she heard a [redacted] in the TV area, she entered the area and Resident #2 told her that he/she [redacted]. The CHHA then called the DON for guidance.</p> <p>At 3:13 p.m., the surveyor interviewed the ED regarding the [redacted] where Resident #2 was [redacted] with a [redacted] by Resident #1. The ED stated that he was not made aware that the resident had an [redacted] with Resident #1, who [redacted] until his investigation was completed.</p> <p>2. On 4/24/25 and 4/25/25 the DOH investigated a FRE dated [redacted], regarding Resident #3 [redacted] a [redacted] in his/her [redacted] which led to a [redacted] at the facility approximately 5:00 p.m.</p> <p>On 4/25/25 at 9:15 a.m., the surveyor interviewed the ED regarding the FRE dated [redacted]. The ED stated that on [redacted] at approximately 5 p.m., care staff were making rounds and when they got to the door of Resident #3's [redacted] and observed [redacted] coming from Resident #3's bedside table drawer. The ED also stated that the Home Health Aide (HHA) observed a [redacted], which had [redacted]. According to the ED, the HHA [redacted] the [redacted]. In addition, the ED explained that the [redacted] and [redacted] arrived, and the resident's room was inspected and cleared for [redacted].</p> <p>At 10:56 a.m., the surveyor interviewed the HHA regarding the [redacted] in Resident #3's room</p>	A 401		

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A 401	<p>Continued From page 9</p> <p>and confirmed the above statement by the ED.</p> <p>At 12:25 p.m., the surveyor reviewed the closed MR of Resident #3, which revealed a move in date in NJ Exec Order 26.4b1, and a diagnosis of NJ Exec Order 26.4b1, and a move out date in NJ Exec Order 26.4b1.</p> <p>During continued review of the MR the surveyor observed that a Licensed Practical Nurse (LPN) on NJ Exec Order 26.4b1 at 1:56 p.m., documented in the "Progress Notes" that Resident #3 "was also NJ Exec Order 26.4b1".</p> <p>The LPN documented that she advised the resident of NJ Exec Order 26.4b1 and notified administration. The LPN documented that the resident stated, "NJ Exec Order 26.4b1" when the resident was educated on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. However, the surveyor did not observe any interventions documented in the resident's SP that addressed the resident's NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1.</p> <p>During interview with the ED, the surveyor inquired if the resident had prior incidents of NJ Exec Order 26.4b1. The ED stated that the resident was NJ Exec Order 26.4b1 near a door in the building prior to the NJ Exec Order 26.4b1. In addition, the ED stated that on NJ Exec Order 26.4b1 the resident signed a managed risk agreement and agreed NJ Exec Order 26.4b1 or inside the facility. The ED also stated that if the agreement was violated the resident would be issued a 30-day discharge notice.</p> <p>The surveyor reviewed the facility policy and procedure titled, "Resident Rights" which the resident has "...The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while</p>	A 401		
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A 401	<p>Continued From page 10</p> <p>providing services and care; ..."</p> <p>The surveyor also reviewed the facility policy and procedure titled, "Resident and Staff Safety Policy" which indicated its purpose was, "To ensure a safe, secure, and healthy environment for all residents, ...in accordance with state and federal regulations ..."</p> <p>In addition, the surveyor reviewed the facility policy and procedure titled, "Incident and Accident Reporting Policy" which documented, "...This policy ensures that all incidents and accidents, whether involving residents, ...are addressed promptly and thoroughly to maintain a safe and healthy environment for all ...Immediate Reporting: All incidents and accidents must be reported immediately to a supervisor, nurse, or administrator..."</p> <p>The surveyor reviewed the facility policy and procedure titled, "Smoking Policy" which documented, "The residence is a smoke-free environment..."</p>	A 401		
A 749	<p>8:36-7.3(a) Resident Assessments and Care Plans</p> <p>(a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.</p>	A 749		

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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
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A 749	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00180828</p> <p>Based on interview and record review it was determined that the facility failed to review and update resident Service Plan (SP) with intervention(s) implemented for resident [redacted] in [redacted] areas for 1 of 4 residents reviewed, Resident #3. This deficient practice was evidenced by the following:</p> <p>On 4/24/25 and 4/25/25 the Department of Health (DOH) investigated a facility reportable event (FRE) (a document facilities use to report events to the DOH) dated [redacted], regarding Resident #3 [redacted] in his/her [redacted] which led to a [redacted] on [redacted] at approximately 5:00 p.m.</p> <p>On 4/25/25 at 9:15 a.m., the surveyor interviewed the ED regarding the FRE dated [redacted]. The ED stated that on [redacted], at approximately 5 p.m., care staff were making rounds and when they got to the door of Resident #3's [redacted] and [redacted] coming from Resident #3's bedside table drawer. The ED also stated that the Home Health Aide (HHA) [redacted], which [redacted]. According to the ED, the HHA [redacted] the [redacted]. In addition, the ED explained that the [redacted] and [redacted] arrived, and the resident's room was inspected and cleared for [redacted].</p> <p>At 10:56 a.m., the surveyor interviewed the Home Health Aide (HHA) regarding the [redacted] in the resident's room. The HHA stated that on [redacted] she was entering the resident's room and [redacted] coming from the bedside</p>	A 749		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2025
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NAME OF PROVIDER OR SUPPLIER IVYSTONE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110
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A 749	<p>Continued From page 12</p> <p>table drawer. The HHA also stated that she opened the drawer and NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1. The HHA also stated that she used the NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1, and the NJ Exec Order 26.4b1 arrived, assessed the resident's room and they also NJ Exec Order 26.4b1 Resident #3 to NJ Exec Order 26.4b1 in the facility, who then responded that he/she NJ Exec Order 26.4b1.</p> <p>At 12:25 p.m., the surveyor reviewed the closed medical record (MR) of Resident #3, which revealed a move in date in NJ Exec Order 26.4b1, and a diagnosis of NJ Exec Order 26.4b1, and a move out date in NJ Exec Order 26.4b1.</p> <p>During the MR review, the surveyor observed that a Licensed Practical Nurse (LPN) on NJ Exec Order 26.4b1 at 1:56 p.m., documented in the "Progress Notes" that Resident #3 NJ Exec Order 26.4b1. The LPN documented that she advised the resident of NJ Exec Order 26.4b1 and notified administration. The LPN documented that the resident stated, NJ Exec Order 26.4b1 when the resident was educated on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. According to surveyor review of Resident #3's SP dated NJ Exec Order 26.4b1 the resident was care planned for behaviors including the NJ Exec Order 26.4b1.</p> <p>Continued review of the resident's SP revealed that the SP was initiated for "NJ Exec Order 26.4b1" on NJ Exec Order 26.4b1 with accompanied goals and interventions that listed Resident #3, "Will maintain NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1" as the goal, and "NJ Exec Order 26.4b1" as the intervention. However, the surveyor did not observe any updates to Resident #3's SP that reflected interventions in place for the documented incident of resident NJ Exec Order 26.4b1 a</p>	A 749		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2025
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NAME OF PROVIDER OR SUPPLIER IVYSTONE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110
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A 749	<p>Continued From page 13</p> <p>NJ Exec Order 26.4b1 in his/her room on NJ Exec Order 26.4b1</p> <p>At 12:35 p.m., the surveyor interviewed the Director of Nursing (DON) regarding the resident's SP and care. The DON stated that Resident #3 was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 against facility policy and procedures. In addition, the DON stated that she did not put interventions in place until after the NJ Exec Order 26.4b.</p> <p>The surveyor reviewed the facility policy and procedure titled, "General Service Plan" which revealed "...A General Service Plan is completed ...as changes in condition warrant ..."</p> <p>In addition, the surveyor reviewed the facility policy and procedure titled, "Incident and Accident Reporting ..." which revealed "If the incident involves a resident, the care plan should be reviewed and updated as needed to prevent future occurrences. ..."</p> <p>Reference: A401, 8:36-4.1(a)(22)</p>	A 749		



Poc #2
accepted
8/29/25

Ivystone Senior living
NJ#15C000
7999 Route 130 North
Pennsauken, New Jersey 08110

Complaint Survey dated 04/25/2025

St- 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;

1 Immediate Correction of Deficiency

Director of Nursing (DON) or designee was re-educated on 4/28/25 by our Contracted RN & Licensed Administrator on updating Service plans when an incident occurs or a change in condition or behavior happens. Executive Director (ED) and DON were re-educated on 4/28/25 on our policies (Incident Accident Reporting, Resident rights, Smoking policy, and Resident and Staff Safety). Specifically, when the police are called. Resident #1 in currently NJ Exec Order 26.4b1 [redacted]. Resident #2 is NJ Exec Order 26.4b1 and living in the community NJ Exec Order 26.4b1. Resident # 3 no longer resides here in the community. D/C

2. Residents with the potential to be affected

All residents at the facility have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not re-occur

DON or designee in-serviced staff (done, 4/28/2025) on policies pertaining to proper notification to administrator or designee in the event of a resident incident, as well as the policies on resident rights to a safe place to live and in a healthy environment. This will be done upon hire and annually ongoing. Nursing staff was also be re-educated on entering notes in resident file when incident happen. RN or designee shall audit after event to ensure appropriate management was notified of incident.

4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date

DON/ Designee will ensure all appropriate management is made aware of incidents. Any changes needed to resident care will be notated in Service plan. ED and DON will monitor as incidents are occurring and reviewed weekly if we are being notified in proper timing for accurate reporting to DOH.

Completion date: 7/15/2025

accepted 8/29/25

St- A401 8:36-4.1 (a)(22) Resident Rights (a) Each assisted living provider will post and distribute a statement of residence rights for all residents of assisted living residences,



comprehensive personal care homes, and assist the living programs. Each resident is entitled to the following rights: 22. Right to live in safe and clean conditions and a facility that does not admit or residence that can safely accommodate while providing services and care;

1 Immediate Correction of Deficiency

All Management were in-serviced 4/28/25 on the importance to notify Administrator or Director of Nursing in the event of a resident incident. All staff will also be re-educated 4/28/2025 by their department heads on the importance of notifying their manager if an incident occurs on their shift. The policy on importance of notifying the ED & DON in the event of an incident will be reviewed upon hire and reviewed again annually. Residents #1 & 2 NJ Exec Order 26.4b1. Resident #1 NJ Exec Order 26.4b1. Due to ensuring safe discharge, resident moved out as of NJ Exec Order 26.4b1. Resident #2 received NJ Exec Order 26.4b1 with nursing to ensure safety. Resident #2 also asked to NJ Exec in NJ Exec Order 26.4b1 until further notice to limit future incidents. Resident #3 no longer lives in the community. D/C NJ Exec Order 26.4b1

2. Residents with the potential to be affected

All residents have the potential to be affected

3. Measures put in place to ensure the deficient practice will not re-occur

DON in-serviced 4/28/25 all nursing personnel to report to the Charge nurse or the DON in the event there is an incident. On an ongoing basis upon hire, nursing staff will be educated on immediate notification to DON or designee of resident events for proper reporting purposes. In the event a resident is found smoking in their room, it will be reported to the Executive Director or designee and the resident will receive a Managed Risk agreement. If they are found again smoking in the room, they will be issued an Involuntary Discharge and we will work with them to find a safe discharge placement.

4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date

ED will review each morning along with the DON events that happened the day before through viewing the 24-hour report or in Morning meeting to make sure He/She is aware of all incidents and appropriate actions have been taken and if it pertains to a reportable. Review will do done by ED on a monthly basis.

Completion date: 7/15/2025

accepted
8/29/25
NJ Exec Order 26

St- A 749 8:36-7.3(a) resident Assessments and Care Plans (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the residence response to the care provided in any changes in the residence physical or cognitive status.

1 Immediate Correction of Deficiency

DON was re-educated 4/26/2025 by the Administrator regarding the facilities policy and procedure for General Service Plans. Resident #3 moved out and no longer lives in the Community. NJ Exec Order 26.4b1

2. Residents with the potential to be affected

All residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not re-occur

DON will ensure this in-service is given to all nursing personnel engaged in care planning for resident needs. Initially on on-boarding and again annually. This will be completed by 7/15/25 DON. DON/designee will monitor the use of the State binder and promptly inputting her notes in residents plan to make sure each incident is documented correctly.

4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date

DON/designee will ensure that General Service plans are complete and updated by the 14th day of admission and to stay in compliance with all policy and procedures as well as state regulations. DON/Designee will also audit all amended GSP/ Health service plans on a quarterly basis to make sure both resident and community representative gave signed off on updates. The administrator will monitor by auditing 5 residents per week using midnight census report to review GSP/ HSP plans are completed as well as updated are made with any incidents that happen. This will ensure compliance.

Completion date: 7/15/2025

Accepted
8/29/25
NJ Exec Order 26

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/25/2025
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NAME OF PROVIDER OR SUPPLIER IVYSTONE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110
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{A 000}	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Complaint</p> <p>Complaint #: NJ 00185441, NJ 00180828</p> <p>Census: 107</p> <p>Sample Size: 4</p> <p>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.</p>	{A 000}		

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

TITLE

(X6) DATE

08/22/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 15C000	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/25/2025
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NAME OF FACILITY IVYSTONE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110
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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 A0749	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-7.3(a)	Completed
LSC	07/15/2025	LSC	07/15/2025	LSC	07/15/2025
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/25/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 15C000	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/25/2025
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NAME OF FACILITY IVYSTONE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110
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LSC	07/15/2025	LSC	07/15/2025	LSC	07/15/2025
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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FOLLOWUP TO SURVEY COMPLETED ON 4/25/2025	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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