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
	15C000	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVYSTONE SENIOR LIVING	7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110

(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 COMPLAINT #: NJ00186587; NJ00186323 CENSUS:109 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 389	8:36-4.1(a)(16) 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: 16. The right to be free from physical and mental abuse and/or neglect;	A 389		

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

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A 389	Continued From page 1 This REQUIREMENT is not met as evidenced by: z Complaint #: NJ00186587 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident's right to be free from [NJ Exec Order] was enforced for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On [NJ Exec Order 26.4b1] the Department of Health received a Reportable Event Record (RER) completed by the facility's Executive Director (ED) on [NJ Exec Order 26.4b], for an [NJ Ex Order 26.4] incident of NJ Exec Order 26.4b1 that occurred on [NJ Exec Order 26.4b]. The RER indicated that Resident #2 was [NJ Exe] by Caregiver #1 and that the resident NJ Exec Order 26.4b1 to his/her [NJ Exec Order 26.4b1]. In addition, the RER indicated that during an investigation, other residents stated that Caregiver #1 would [NJ Exec O]. On 6/4/25 at 10:16 a.m., the surveyor interviewed Resident #2 to inquire if staff at the facility treated the resident [NJ Exec Or]. Resident #2 stated that one staff member [NJ Exe] him/her in the [NJ Exec Order 26.4b] and [NJ Exec Order 26.4b1]. The surveyor inquired what the name of the staff member was, however, Resident #2 could not recall the staff member's name. The surveyor inquired the reason the staff member [NJ Exe] the resident, and Resident #2 stated that the staff member [NJ Exe] him/her because the resident was told to [NJ Exec Order 26.4b1] his/her [NJ Exec Order 26.4b1]. The surveyor then inquired if Resident #2 had seen the staff member who [NJ Exe] him/her in the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b] since the incident took place, and the resident stated that he/she had not. The surveyor reviewed the Medical Record (MR)	A 389		

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of Resident #2, which revealed that the resident was admitted to the facility in NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1

The surveyor also reviewed an investigative summary dated NJ Exec Order 26.4b which indicated that Resident #2 told the ED that Caregiver #1, NJ Exec [redacted] in the NJ Exec Order 26.4b1 because I NJ Exec Order 26.4b1 [redacted]." The surveyor also reviewed signed statements dated NJ Exec Order 26.4b that were attached to the investigative summary and written by a Certified Medication Aide (CMA) and a third-party NJ Exec Order 26.4 aide.

The CMA's statement indicated, "Today at 9:30 AM [Resident #2's] NJ Exec Order 26.4 aide stated she was told by [Resident #2] that [Caregiver #1] NJ Exec Order [redacted] in the NJ Exec Or NJ Exec Order 26.4b1 I then went to ask [Resident #2] what happened. [Resident #2] stated, "she NJ Exec Order [redacted] in the NJ Exec O and NJ Exec Order 26.4b because NJ Exec Order 26.4b1 [redacted]." I asked [Resident #2] who is she? [Resident #2] said, [Caregiver #1]."

The NJ Exec Order 26.4 aide's statement indicated, "[Resident #2] has a NJ Exec Order [redacted] on [his/her] NJ Exec Order 26.4b1 [Resident #2 acquired] it sometime after 12:30 pm yesterday when I left. After looking at [Resident #2] at 9:30 am today I asked if [he/she] had NJ Exec Order [redacted] [he/she] preceded to tell me no. 'She NJ Ex [redacted] me.' I then ask[ed] [Resident #2] who NJ Ex [redacted] you. [Resident #2] said [Caregiver #1]."

At 10:23 a.m., the surveyor interviewed previously mentioned NJ Exec Order 26.4 aide, who worked with Resident #2 NJ Exec Order 26.4b1 [redacted] to inquire if she witnessed any NJ Exec Order [redacted] while at the facility. The NJ Exec Order 26.4 aide stated that one day she observed a NJ Exec Order [redacted] to the NJ Exec Order 26.4b1 of Resident #2's NJ Exec Order 26.4b1 that she did

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not see the day before, and that she reported the [redacted] to the CMA on duty. The [redacted] aide stated that she asked Resident #2 how he/she got the [redacted] and the resident stated that a [redacted]

At 10:33 a.m., the surveyor interviewed the CMA who was informed of the [redacted] incident of NJ Exec Order 26.4b1 by the [redacted] aide, to inquire about the incident. The CMA stated that around 9:30 a.m., a [redacted] aide informed her that she observed a [redacted] on Resident #2's [redacted] and that the resident told the [redacted] aide that a staff member [redacted] him/her on the [redacted] and [redacted] because the resident was NJ Exec Order 26.4b1 [redacted]. The CMA stated, "when I questioned [Resident #2], [the resident] made the same complaint verbatim". The CMA stated that she then reported the incident to the Director of Nursing (DON).

At 12:13 p.m. and 12:29 p.m., the surveyor interviewed the Administrator (ADM), who was the acting ED, and the DON to inquire about the previously mentioned incident. The ADM stated that he did not know everything about the incident but knew that Resident #2 stated that a staff member [redacted] him/her. The ADM then stated that, "with the investigation it seemed credible." The ADM explained that other residents stated that the [redacted] staff member would no[redacted] at them but would [redacted] at them.

The DON stated that she was not present at the facility on [redacted] when the incident took place. The DON stated that she received a phone call from the previously mentioned CMA, who told her that the [redacted] nurse informed her that Resident #2 had a [redacted] on his/her [redacted] that was not

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A 389	Continued From page 4 there on [NJ Exec Order 26.4b] The DON stated that she told the CMA to go check and that Resident #2 told the CMA that he/she was [NJ Ex] by Caregiver #1 in his/her [NJ Exec Orc] and [NJ Exec Order 26.4b] because the caregiver told the resident to do something, and the resident [NJ Exec Order 26.4b1] The DON stated that Caregiver #1 was sent to the ED's office and then home. In addition, the DON stated that the ED conducted an investigation and that two additional residents stated that Caregiver #1 would [NJ Exec] all the time. At 1:51 p.m., the surveyor interviewed Caregiver #1 by telephone, to inquire about the previously mentioned incident, and the caregiver stated that she did not know what happened and that she did not [NJ Ex] anyone. Caregiver #1 stated that she put Resident #2 to bed between 5:30 p.m. and 6:00 p.m., and that she did not see any [NJ Exec Order] on the resident. Caregiver #1 also denied [NJ Exec Order] at residents. The surveyor reviewed the facility's policy titled, "Abuse and Neglect Policy," which indicated, "... [This facility] maintains zero tolerance for any form of abuse, neglect, or exploitation ...."	A 389		
A 745	8:36-7.2(f) Resident Assessments and Care Plans (f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice. This REQUIREMENT is not met as evidenced	A 745		

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A 745	Continued From page 5 by: Complaint #: NJ00186587 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a health care assessment was documented by a Registered Nurse (RN) as required in accordance with professional standards of practice after a resident NJ Exec Order 26.4b1 from a NJ Exec Order 26.4b1 allegation for 1 of 3 residents reviewed. Resident #2. This deficient practice was evidenced by the following: On NJ Exec Order 26.4b1, the Department of Health (DOH) received a Reportable Event Report (RER) completed by the Executive Director (ED) on NJ Exec Order 26.4b1 for an NJ Ex Order 26.4b1 incident of NJ Exec Order 26.4b1 that occurred on NJ Exec Order 26.4b1 The RER indicated that Resident #2 was NJ Exec by a staff member and that the resident NJ Exec Order 26.4b1 a NJ Exec Order 26.4b1 to his/her NJ Exec Order 26.4b1 The RER also indicated that nursing did a NJ Exec Order 26.4b1 and found NJ Exec Order 26.4b1. During the survey on 06/04/25, the surveyor reviewed the Medical Record (MR) of Resident #2, who was admitted to the facility in NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1 The surveyor reviewed a Progress Note (PN) dated NJ Exec Order 26.4b1 written by the Director of Nursing (DON), which indicated that the DON assessed Resident #2 and observed a NJ Exec Order on the resident's NJ Exec Order 26.4b1 that measured NJ Exec Order 26.4b1 At 12:30 p.m., the surveyor interviewed the DON, who stated that she was not present at the facility on NJ Exec Order 26.4b and that she was not scheduled to work that weekend. The DON stated that she did not assess Resident #2 until she returned to work	A 745		

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A 745	Continued From page 6 on [NJ Exec Order 26.4b] At this time, the surveyor interviewed the DON to inquire where Resident #2 's ccompleted Comprehensive Medical Assessment (CMA) and [NJ Exec Order 26.4b1] assessment were documented. The DON stated that the assessment that was completed following the incident was documented in the PNs and that she would locate Resident #2's completed CMA. At 2:46 a.m., the DON stated that she was not able to locate Resident #2's completed CMA. The surveyor reviewed the facility's policy titled, "Health Service Plan," which indicated, "... 4. The initial health care assessment shall be documented by the registered nurse and shall be updated as required in accordance with the rules of this chapter and professional standards of practice ...." In addition, the surveyor reviewed the facility's policy titled, "Significant Change," which indicated, "... 3. The RN must do a comprehensive reassessment on all significant changes that have occurred as soon as possible ...." Resident #2 [NJ Exec Order 26.4b1] and was not assessed by a Registered Nurse until three days later. In addition, the DON was not able to provide the surveyor with Resident #2's completed CMA. There was no documented evidence to confirm that Resident #2 was assessed by the RN as required.	A 745		
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	A 891		

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A 891	Continued From page 7 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, interview, and review of pertinent facility documents, it was determined that the facility failed to comply with the provisions of Chapter 24, N.J.A.C. 8:24 "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines," which put the highly susceptible population of residents at risk for foodborne illnesses. This deficient practice was evidenced by the following: On 6/4/25 at 11:06 a.m., the surveyor toured the kitchen and observed a server prepare food for residents without a hair restraint applied. In addition, the aforementioned server and Dietary Aide #3 wore cross-body purses during food preparation. At this time, the surveyor also observed a cook, who identified herself as the Kitchen Manager, apply a hairnet to the aforementioned server, as the server mixed a full-size 6-inch-deep sheet pan of tuna salad. The surveyor observed the server use her gloved hand to mix the salad. The surveyor also observed Dietary Aide #1 and #2 inside the food preparation area without hair restraints.	A 891		

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A 891	Continued From page 8 At 11:07 a.m., 11:10 a.m., and 11:15 a.m., the surveyor interviewed Dietary Aide #1, the server, and Dietary Aide #2 to inquire the reason they did not wear hair restraint while in the food preparation area. Dietary Aide #1 stated that she had just come in for her shift and that there were no hairnets available at the entrance she came in. The server stated that she had a hairnet on, but it fell off. Dietary Aide #2 stated he never had to wear one before. At 11:11 a.m., the surveyor interviewed the previously mentioned Cook/Kitchen Manager to inquire the reason she applied a hair restraint to a server while the server prepared food. The Cook stated that the server had just arrived and that she did not know why the server did not have a hair restraint applied, so she helped the server apply one. The Cook explained that when she worked, she would come out of the office at approximately 11:10 a.m. to ensure that all staff had hair restraints applied. In addition, the surveyor inquired the reason the server and Dietary Aide #3 wore cross body purses while they prepared food for residents, and the Cook stated that kitchen staff did not have lockers to store their belongings. At 2:20 p.m., the surveyor interviewed the Culinary Supervisor (CS) and inquired the reason dietary staff members did not wear hair restraints while in the kitchen. The CS stated that the former CS was not present at the facility much so kitchen staff did not wear hair restraints. The CS explained that he had been employed at the	A 891		

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A 891	Continued From page 9 facility for two weeks and that he discussed hair restraint usage in morning huddles. In addition, the surveyor inquired if kitchen staff were allowed to mix food with gloved hands, and the CS stated that small pans could be mixed with gloved hands, but larger pans should be mixed with a spoon. The surveyor then inquired the reason kitchen staff wore cross body purses during food preparation. The CS stated that kitchen staff informed him that in the past theft was an issue. The CS stated that the facility's owner ordered lockers for the kitchen. At 2:49 p.m., the surveyor interviewed the facility's owner to inquire if he ordered lockers so that staff could have a place store their personal belongings, and the owner stated that there was an employee lounge on the second floor that was already equipped with lockers for staff to store their belongings. At this time, the owner showed the surveyor the facility's employee lounge, which was equipped with 28 lockers. The surveyor reviewed a facility document titled, "Kitchen Sanitation Checklist," which indicated that a hair covering should be worn. The Administrator was not able to provide the surveyor with a policy that addressed hair restraints and proper dress code in the kitchen.	A 891		

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

Complaint Survey dated 06/04/2025

St- A 389 8:36-4.1(a)(16) 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: 16. The right to be free from physical and mental abuse and/or neglect;

1 **Immediate Correction of Deficiency**
The ED was notified on [redacted] at 11:30am and the DON was notified on [redacted] at 11:33am of the alleged [redacted] by Caregiver #1. As a result, Caregiver #1 was immediately removed from her assignment and taken off the schedule as of [redacted] pending investigation. Resident #2 was evaluated by CMA on [redacted] and found [redacted] on [redacted] and no [redacted]. On 5/19/25 RN did a follow-up assessment on Resident #2 and found [redacted] on [redacted] no [redacted] noted. RN notified NP and family on Resident #2. ED notified DOH & Ombudsman via email on [redacted] at 4:51pm.

2. **Residents with the potential to be affected**
All residents at the facility have the potential to be affected by this deficient practice.

3. **Measures put in place to ensure the deficient practice will not re-occur**
ED in serviced all nursing staff regarding the facility's policy pertaining to resident abuse and neglect, as well as proper notification to administrator or designee in the event of an [redacted] resident [redacted] incident on [redacted]. Caregiver #1 did her annual in-service on abuse and neglect on [redacted]. Caregiver #1 was put on suspension pending investigation on [redacted] At the conclusion of the investigation Caregiver #1 was terminated on [redacted].

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**
During quarterly quality assurance meeting we will review previous allegations and/or investigations of staff to resident abuse. Identifying and reporting abuse education is discussed at all resident council meetings. Director will ensure all staff to resident abuse allegations/investigations steps are completed as per policy at the next daily directors meeting. All staff is in-serviced on abuse and neglect annually and at time of hire.

Completion date: 7/31/2025

St- A745 8:36-7.2(f) Resident Assessments and Care Plans (f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice.

1 Immediate Correction of Deficiency
DON was in-serviced by the ED on 5/22/25 regarding our policy and procedure regarding health service plans and significant change.

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

3. **Measures put in place to ensure the deficient practice will not re-occur**
On 5/22/25 ED educated DON and nursing staff on post incident protocols such as the need for change in condition assessment for events such as resident-to-resident altercation, resident to staff altercation, an injury, or any change of condition an RN assessment must be completed. In addition to completing service plan updates, if applicable. If an RN is not in the facility to complete an RN assessment, the resident will be sent to the hospital for evaluation. Upon the DON or RN's return to the facility, the DON or RN will complete an in-house RN assessment. Upon move in the DON or RN will complete the comprehensive medical assessment in compliance with state regulation.

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 will review all move-ins to ensure the initial comprehensive medical assessment is done. DON will ensure that a re-assessment is completed when there is a change of condition or a significant event. ED will conduct monthly audits to review a few move ins and change of condition/incidents assessments during the month to verify timely completion for six months.

Completion date: 7/31/2025

St- A891 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.

1. **Immediate Correction of Deficiency**
Hair restraints signs were posted on 6/5/25 by the FSD. FSD/ Designee will ensure that hair restraints are worn. FSD ordered hair restraints on 6/6/25. Hair restraints were received on approximately 6/9/25. On 6/5/25 signage reminding staff of hair restraint requirement was posted on the inside and outside of all kitchen doors by FSD.

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

3. **Measures put in place to ensure the deficient practice will not re-occur**
On 6/7/25 FSD or designee in-serviced all staff on the requirement to wear hair restraints, not having personal handbags while in the kitchen, and the proper procedure in preparing ready to eat foods. Each day during kitchen staff huddle FSD or Designee will verify all staff has proper hair restraints. As of 6/7/25 all staff were instructed that personal handbags must be left in their car or placed in the employee breakroom or office during their shift by FSD or Designee.

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 or designee will monitor each meal for three months to ensuring all staff are wearing a hair restraint, staff is not wearing cross-body handbags while working in the kitchen, and that staff does not mix food in large pans with gloved hands.

Completion date: 7/31/2025

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
15C000 Y1	A. Building B. Wing Y2	9/17/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
IVYSTONE SENIOR LIVING	7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110

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 A0389 Reg. # 8:36-4.1(a)(16) LSC	Correction Completed 09/17/2025	ID Prefix A0745 Reg. # 8:36-7.2(f) LSC	Correction Completed 09/17/2025	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 09/17/2025
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	
6/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: MZE812