New Jersey Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUR\	
AND PLAN C	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETE	טי
		15C000	B. WING		08/02/2	2024
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
IVYSTONE	SENIOR LIVING		E 130 NORTH			
			KEN, NJ 08110			
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A 000	Initial Comments		A 000			
	Initial Comments: TYPE OF SURVEY:	Complaint				
	COMPLAINT #: NJ00	175151				
	CENSUS: 116					
	SAMPLE SIZE: 2					
	all of the standards in Administrative Code & Licensure of Assisted Comprehensive Pers Assisted Living Progr submit a Plan of Corr completion date for e that the plan is impler	3:36, Standards for Living Residences, onal Care Homes and ams. The facility must ection, including a ach deficiency and ensure mented. Failure to correct alt in enforcement action in isions of New Jersey Fitle 8, Chapter 43E,				
A 310	8:36-3.4(a)(1) Admini	stration	A 310			
	1. Ensuring the c	ot limited to, the following:				

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

TITLE

(X6) DATE

09/03/24

PRINTED: 01/22/2025 FORM APPROVED New Jersey Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ С B. WING 15C000 08/02/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7999 ROUTE 130 NORTH IVYSTONE SENIOR LIVING** PENNSAUKEN, NJ 08110 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 310 A 310 Continued From page 1 This REQUIREMENT is not met as evidenced Complaint#: NJ00175151 Based on interview, review of medical records, and pertinent facility documents, it was determined that the facility failed to implement or develop a comprehensive policy for resident General Service Plans (GSPs) and Health Service Plans (HSPs). Additionally, the facility failed to ensure that an assessment was conducted by a Registered Nurse upon the resident's NJ ex order 26.4b1 for 1 of 2 residents reviewed, Resident #2, for which an Imminent Danger was identified. The deficient practice was evidenced by the following:

On 7/2/24, the surveyor reviewed Resident #2's medical record (MR) which revealed a move in date of Newsons 2019, and diagnoses that included

NJ ex order 26.4b1

Resident #2's MR revealed a facility document with specific areas of "focus" that included: New York and Included:

On 7/2/24 at 12:30 p.m., the surveyor interviewed the facility Director of Nursing (DON), who stated that she was aware Resident #2 Nursing (Boundary 26.4b1), and that he/she

DON identified a document as the resident's GSP

AND PLAN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
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A 310	Continued From page	e 2	A 310			
	HSP. The surveyor responsible to the facility that Reside welcomed back to the indicated that Reside indication that the GS reflect that Resident for interventions were resulted.	e program as the physician nt #2 NJ ex order 26.4b1  The surveyor observed no BP/HSP was updated to #2 NJ ex order 26.4b1 or that the goals and/or viewed and/or revised.  The surveyor observed no BP/HSP was updated to with the goals and/or viewed and/or revised.				
	DON, she further stat was attempted, howe #2 returned to the fact an assessment was and she standard she she standard she standard she standard she	ed an undated policy titled, es" which revealed the Plans 1. Individual care ped by the staff for each of Care Plans. Each care ssessment, developed upon				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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			KEN, NJ 08110			
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A 310	Continued From page	3	A 310			
	changing needs of the	e frequently if indicated by e resident."  r (ID) was reported to the				
		ring Administrator on Nex order 26				
	•	uded information about				
	failure to develop or implement facility policy on General and Health Service Plans.					
	and verified that the F implemented that incl "Care plans/ HSP/GS	or completed a revisit survey Removal Plan was uded new policies titled, P", "Assessments", and an , "Change in a Resident's				
	Condition or Status."	, Change in a Nesident's				
A 735	8:36-7.2(e)(1-5) Resident	dent Assessments and Care	A 735			
	written health service	Ith care assessment, a plan shall be developed. an shall include, but not be g:				
	Orders for trea medications, and diet	atment or services, , if needed;				
	2. The resident's himself or herself;	needs and preferences for				
	3. The specific go if appropriate;	pals of treatment or services,				
	4. The time interverseponse to treatment will be	vals at which the resident's				
		to be used to assess the				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
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				·		
A 735	Continued From page	e 4	A 735			
	This REQUIREMENT	is not met as evidenced				
	by:					
	Complaint#: NJ00175	5151				
	Based on interview a	nd review of medical				
	records, it was determined the facility failed to					
	ensure that a residen	t health service plan was				
	developed for a reside	ent's individual health care				
	needs that included a	SNJ ex order 26.4b1 and				
		of 2 residents reviewed,				
		an Imminent Danger was				
		nt practice was evidenced				
	by the following:	·				
	, ,					
	On 7/2/24 the survey	or reviewed Resident #2's				
	1	evealed a move in date of				
		which NJ ex order 26.4b1				
	,	Further				
	review of the MR reve	ealed a progress note (PN)				
	titled 'NJ ex order	,				
		8:22 p.m., written by a facility				
		urse (LPN), which indicated				
	Resident #1 NJ ex o					
		review of the PN revealed				
	that NJ ex order 20					
	Resident #2 NJ ex o					
	1 CONCORD #2	The				
	PN further indicated t					
		#2 NJ ex order 26.4b1				
	anived and Resident	#2 NO EX OIGET 20.40 I				
	On 7/0/04 -+ 40:00					
		m., the surveyor interviewed				
	the facility Director of	Nursing (DON), who stated				
	that she NJ ex order 26.4b1 th	nat Resident #2 NJ ex order 26.4b1				

PRINTED: 01/22/2025 FORM APPROVED New Jersey Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ С B. WING 15C000 08/02/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7999 ROUTE 130 NORTH IVYSTONE SENIOR LIVING** PENNSAUKEN, NJ 08110 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 735 A 735 Continued From page 5 NJ ex order 26.4b1 . The facility DON further stated that NJ ex order 26.4b1 however, Resident #2's insurance would not cover NJ Ex Order 26.4b1 and Resident #2 returned to the facility. During continued surveyor interview, the DON clarified that there was a General Service Plan that was also used as the Health Service Plan (HSP); however, there was not a specific HSP that included Resident #2's NJ ex order 26.4b1 An Imminent Danger (ID), was reported to the Licensed Assisted Living Administrator on at 3:00 p.m., that included information about failure to develop or implement facility policy on General and Health Service Plans. On 8/2/24 the surveyor completed a revisit survey and verified that the Removal Plan was implemented which included documentation that the DON was educated on Health Service Plans and General Service Plans. Additionally pertinent health information was added to the GSP/HSP including information about the NJ ex order 26.4b1, and that Resident #2 NJ ex order 26.4b1

STATE FORM 6899 QWBP11 If continuation sheet 6 of 17

A 751

A 751 8:36-7.3(b) Resident Assessments and Care

(b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.

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A 751	Continued From page	<b>e</b> 6	A 751			
	by: Complaint#: NJ00175  Based on staff intervier records, it was detern to ensure that a Healt revised based on the care provided and any status, for 1 of 2 facilit Resident #2, NJ ex order to ensure that a Healt revised based on the care provided and any status, for 1 of 2 facilit Resident #2, NJ ex order the survey Medical Record (MR) move-in-date of the NJ ex order 26.4th with a tire Licensed Practical Nu Resident #2 NJ ex order #2 N	ew and review of medical mined that the facility failed th Service Plan (HSP) was resident's response to the y changes in the resident's ity residents reviewed, order 26.4b1  The sevidenced by the following:  For reviewed Resident #2's and diagnoses that of the manner				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
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A 751	Continued From page	e 7	A 751		
	stated that there was Resident #2; however				
	with the ID template v	ring Administrator on Woxoneral ninistrator was presented which included information view and revise the Health			
	and verified that the F implemented which in the facility DON was of Plans and General Sof pertinent health inform	ecluded documentation that educated on Health Service ervice Plans. Additionally mation was added to the ided information about the der 26.4b1, and that order 26.4b1 and			
A 763	8:36-7.4(b) Resident	Assessments and Care	A 763		
	responsible for developolicies and procedur	ssional nurse shall be oping nursing practice res and the coordination of resident's			
	This REQUIREMENT	is not met as evidenced			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
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A 763	Continued From page	e 8	A 763			
	by: NJ00175151					
	and pertinent facility of determined that the facoordination of service	acility failed to provide				
		for which an Imminent  The deficient practice was				
	On 7/2/24 the surveyor reviewed Resident #2's medical record (MR) which revealed a move in date of and diagnoses that included NJ ex order 26.4b1  . Further review of the MR revealed a					
	, dated by a facility Licensed	tled, "NJ ex order 26.4b1" with a time of 8:22 p.m., Practical Nurse (LPN), that 2NJ ex order 26.4b1 The PN				
	was administered to F	the NJ ex order 26.4b1 , a NJ Ex Order 26.4(b)(1)				
		and Resident #2 was				
	the facility Director of that she was aware the	m., the surveyor interviewed Nursing (DON) who stated nat Resident #2 had NUEX OTHER /she was NJ Ex Order 26.4(b)(1)				
	facility. The DON stat	ten he/she came to the red that Resident #2 was was NJ Ex Order 26.4b1 was				

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1,10		,	1,7,6	DEFICIENCY)		
A 763	Continued From none	- 0	A 763			
A 703	Continued From page		A 703			
	NJ ex order 26.4b	; however, Resident				
	#2's NJ ex order 2					
	and Reside	ent #2 NJ ex order 26.4b1.				
	<b>-</b> .					
	•	ed the General Service Plan (GSP/HSP) and noted				
	an entry dated	that indicated the Nex orders				
	an entry dated	informed the				
	facility that Resident	#2NJ ex order 26.4b1				
		as the physician indicated				
	that Resident #2 NJ	ex order 26.4b1				
		The surveyor review of the				
		gress notes (PNs) showed				
	NJ ex order 26.4k	01				
	NJ ex order 26.4b1 to Reside	ent #2.				
	The curveyer addition	pally asked the DON if an				
	-	nally asked the DON if an ducted by a Registered				
	Nurse (RN) upon the	e resident's NJ ex order 26.4b1				
	rtaree (rat), apert are	, and she stated that				
	Resident #2 NJ ex 0					
		ew of the MR revealed a PN				
		lated NJ ex order 26.4°, that indicated				
	Resident #2 NJ ex C	order 26.4b1 ent #2 NJ ex order 26.4b1				
	about Reside	NJ ex order 26.4b1				
	The PN further indica	ted that the DON educated				
	the resident on the N					
		or interviewed one of the				
		ated that the facility had				
	psychiatric support av	_				
		d a Licensed Clinical Social				
	Worker (LCSW) that					
		n the hours of 5:00 p.m. to				
		er that visits on Fridays and er stated that additionally				
	Saturdays. The owne	or otatou triat additionally	1			1

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 763	Further review of the that Resident #2 was for NJ Ex Order 26 documentation of confacility and NJ Ex Order 26 documentation was environmentation.  At the time of the survey documentation was environmentation was environmentation was environmentation.	Advanced Practioner Nurse ell.  MR revealed no indication seen by the facility LCSW 6.4(b)(1) or munication between the 26.4(b)(1).  was reported to the ing Administrator on inistrator was presented which included information ex order 26.4b1 for order 26.4b1  vey, there was no exprovided of the for Resident for Resident for Completed a revisit survey Removal Plan was accluded documentation that educated on coordination of a Additionally, pertinent is added to the GSP/HSP ion about the survey recompleted a revisit survey Removal Plan was accluded documentation that reducated on coordination of a Additionally, pertinent is added to the GSP/HSP ion about the survey removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the GSP/HSP ion about the survey Removal Plan was added to the survey Re	A 763			
A 765	Plans	nt Assessments and Care	A 765			
		d procedures shall be mented to ensure, but not be				

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A 765	Continued From page	= 11	A 765			
	limited to, the followir					
	residents who has shall be reassessed a often on an as ne	of all residents with a general semi-annually, and those ave a health service plan at least quarterly and more eded basis, including and eturn to the facility from the				
	by: Based on staff intervirecords and pertinent determined the facility assessment was con Nurse (RN) upon the hospital following a					
	medical record (MR) of NJ ex orders, and diagnost titled, 'NJ ex order with a time of Licensed Practical Nu Resident #2 NJ ex Order 26.4(b)(1), and	8:22 p.m., written by a facility urse (LPN), that indicated brder 26.4b1  further indicated that a to Resident #2 with then a NJ ex order 26.4b1  The PN further ex order 26.4b1 and				

PRINTED: 01/22/2025

FORM APPROVED New Jersey Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_

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A 765	stretcher.  Further review of the that Resident #2 was Nurse (RN) NJ ex o Addition no documentation of I which is facility. The facility Director of (DON/RN), who state Resident #2 NJ ex o which s #2's The facility Director of (DON/RN), who state Resident #2's NJ ex o a facility. The surveyor assessment was cond NJ ex order 26.4b1 Resident #2's NJ ex order 26.4b Resident #2 NJ ex order 26.4b R	MR showed no indication assessed by a Registered rder 26.4b1 mally, the surveyor observed Resident #2's Mexorder 26.4b1 m., the surveyor interviewed Nursing/Registered Nurse d that she was aware that order 26.4b1 the stated Mexorder Resident PON further stated that as attempted, however order 26.4b1 and he/she returned to the asked the DON if an ducted upon Resident #2's 1, and she stated that order 26.4b1  (ID) was reported to the ing Administrator on inistrator was presented that included information anduct an assessment upon order 26.4b1  or completed a revisit survey Removal Plan was included an assessment by ent #2, and documentation are educated on providing an a resident's return from the	A 765		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	services facilities and home-based services facilities, hospice facil residences, comprehe homes, and assisted only those serious pre that are within the cor	, that is, home health care lities, assisted living			
	adverse events relate provided directly to re residence, compreher assisted living prograf	act to serious preventable d to health care services sidents of an assisted living ensive personal care home or m by another health care eactly providing the service to the Department.			
	This REQUIREMENT by: Complaint#: NJ0017	is not met as evidenced			
	Based on staff intervie	ew, review of medical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1.5 . 2.1.0 . 00.1.1.20			A. BUILDING: _		C		
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NAME OF P	ROVIDER OR SUPPLIER	TE, ZIP CODE					
IVYSTONE	SENIOR LIVING		'E 130 NORTH KEN, NJ 0811				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)					(X5) COMPLETE DATE	
H2640	determined that the faresidents reviewed, R  NJ ex order 26.4th practice was evidence  On 7/2/24 the surveyor medical record (MR), date of NJ ex order 26.4th Further review progress note (PN) tit Summary", dated written by a facility Lie (LPN), that indicated  PN further indicated the was administered to R  The PN  NJ ex order 26.4b1  On 7/2/24 at 12:30 p. the facility Director of she was aware that R She addition  #2 NJ ex order 26  stated that Resident #4 after NJ ex order 2	facility documents, it was acility NJ ex order 26.4b1 for 1 of 2 facility Resident #2, for which an old and the control of the MR revealed a move in agnoses that included old and the control of the MR revealed a move in agnoses that included old and the control of the MR revealed a move in agnoses that included old and the control of the MR revealed a the contr	H2640				
	During continued sur	veyor interview, the DON					

PRINTED: 01/22/2025 FORM APPROVED New Jersey Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ С B. WING 15C000 08/02/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7999 ROUTE 130 NORTH IVYSTONE SENIOR LIVING** PENNSAUKEN, NJ 08110 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H2640 H2640 Continued From page 15 clarified that there was a General Service Plan (GSP), that was also utilized as the facility Health Service Plan (HSP); however, there was no specific HSP observed that included Resident #2's NJ ex order 26.4b1 The surveyor reviewed the GSP/HSP and noted an entry dated NJ Ex Order 26.4(b)(1) informed the facility that Resident #2 NJ ex order 26.4b1 that Resident #2 NJ ex order 26.4b1 The surveyor observed no indication that the GSP/HSP was updated to reflect that Resident #2 NJ ex order 26.4b1 NJ ex order 26.4b1, or that the goals and/or interventions were reviewed and/or revised.

to Resident #2.

During the same interview, the surveyor asked the DON if an assessment was conducted by a RN upon the resident's NJ ex order 26.4b1

Surveyor review of the PN's showed no indication that NJ Ex Order 26.4(b)(1) was offered

NJ ex order 26.4b1 and she stated that Resident

#2 NJ ex order 26.4b1

Further surveyor review of the MR revealed a PN written by the DON dated worder 26. 454

Resident #2 NJ ex order 26.4b1

Resident #2 NJ ex order 26.4b1

The PN further indicated that the DON educated the resident on the NJ ex order 26.4b1

On 7/2/24, the surveyor interviewed one of the

PRINTED: 01/22/2025 FORM APPROVED New Jersey Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ С B. WING 15C000 08/02/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7999 ROUTE 130 NORTH IVYSTONE SENIOR LIVING** PENNSAUKEN, NJ 08110 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H2640 H2640 Continued From page 16 facility owners who stated that the facility had psychiatric support available for the facility residents that included a Licensed Clinical Social Worker (LCSW), that visited the facility four evenings a week from the hours of 5:00 p.m. to 9:00 p.m., and another that visited on Fridays and Saturdays. The owner stated that additionally there was a psychiatric Advanced Practioner Nurse (APN) that came the facility to see residents. Further review of the MR showed no indication that Resident #2 NJ ex order 26.4b1 for NJ ex order 26.4b1 documentation of communication between the facility and NJ Ex Order 26.4(b)(1) for coordination of treatment. Additionally the facility NJ ex order 26.4b1 Resident #2's NJ ex order 26.48 At the time of the survey, PNs for Resident #2.

			ST	ATE FORM: RE	EVISIT REPORT						
PROVIDER / SUPPLIER / CLIA / MULTIPLE IDENTIFICATION NUMBER A. Building			LTIPLE CONSTRUCTION						DATE OF REVISIT		
15C000		B. Wing	P Wing			Y2					
NAME OF FACILITY					STREET ADDRESS, CIT	TY, STATE, ZIF	CODE				
IVYSTONE SENIOR LIVING					7999 ROUTE 130 NORTH						
					PENNSAUKEN, NJ 081	10				_	
corrective	e action was accompl tion prefix code previo	ished. Each deficien	cy should be	e fully identified us	ly reported that have bee sing either the regulation des shown to the left of e	or LSC prov	ision number an	d the			
ITEM		DATE	ITEM		DATE	ITEM			DATE		
Y4		Y5	Y4		Y5	Y4			Y5	_	
ID Prefix	A0310	Correction	ID Prefix	A0735	Correction	ID Prefix	A0751		Correct	ion	
Reg.#	8:36-3.4(a)(1)	Completed	Reg. #	8:36-7.2(e)(1-5)	Completed	Reg. #	8:36-7.3(b)		Comple	tec	
LSC		10/02/2024	LSC		10/02/2024	LSC			10/02/20	24	
ID Prefix	A0763	Correction	ID Prefix	A0765	Correction	ID Prefix			Correct	on	
Reg.#	8:36-7.4(b)	Completed	Reg. #	8:36-7.4(c)(1)	Completed	Reg. #			Comple	ted	
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**REVIEWED BY** 

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DATE

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FOLLOWUP TO SURVEY COMPLETED ON

LSC

**ID Prefix** 

Reg.#

**ID Prefix** 

Reg. #

**REVIEWED BY** 

REVIEWED BY

CMS RO

8/2/2024

STATE AGENCY

LSC

LSC

				STATE	FORM: RE	VISIT REPORT				
PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTITUTE IDENTIFICATION NUMBER A. Building			STRUCTION					DATE OF	REVISIT	
15C000 <sub>Y1</sub> B. Wing							Y2	10/3/202	24 <sub>Y3</sub>	
NAME OF FACILITY IVYSTONE SENIOR LIVING					STREET ADDRESS, CITY, STATE, ZIP CODE 7999 ROUTE 130 NORTH PENNSAUKEN, NJ 08110					
corrective	e action was acco	omplished	d. Each deficien	cy should be fully	/ identified us	y reported that have bee ing either the regulation es shown to the left of e	or LSC provision	number and t	he	
ITEM DATE			ITEM		DATE	ITEM			DATE	
Y4		Y5	Y4		Y5	Y4			Y5	
ID Prefix	H2640		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	8:43E-10.6(a)(2)(	i)	Completed	Reg. #		Completed	Reg. #			Completed
LSC			10/02/2024	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
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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	SIGNATU	RE OF SURVEYOR			DATE			
REVIEWE CMS RO	D BY	REVIEW (INITIAL		DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 8/2/2024						RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN			YES	□ NO

Page 1 of 1 EVENT ID: QWBP12