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 03/22/2023

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: Focused Infection Control (FIC), Standard, & Complaint COMPLAINT #: NJ00162963, NJ00161763 CENSUS: 72 SAMPLE SIZE: 12 A Covid-19 Focused Infection Control Survey was conducted by the State Agency. The facility was found not 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. The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following:	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/02/23

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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: Based on interview and record review it was determined that the facility's Administrator failed to implement and enforce the facility's policy and procedure titled, "Sanitation Requirements." This deficient practice was evidenced by the following: On 3/16/2023 at 11:33 a.m., while conducting a handwashing observation at the facility's Assisted Living (AL) common area sink with the facility Home Health Aide (HHA), HHA #1. HHA #1 stated the facility did fill the hand soap dispensers and were responsible for supplying their own hand soap and paper towels. At 11:39 a.m., the surveyor interviewed the facility's Memory Care (MC) Ceritified Nursing Assistant (CNA), CNA #1, who stated she had to go home to use the restroom due the facility not providing hand soap or paper towel for employee use. At 11:40 a.m., the surveyor toured the facility's	A 310		

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A 310	Continued From page 2 MC bathroom that revealed an empty paper towel dispenser and an empty hand soap dispenser. The surveyor toured the MC nursing station which revealed an empty paper towel dispenser and an empty soap dispenser. At 12:55 p.m., the surveyor interviewed the facility's Maintenance Director (MD) who stated that nursing staff was to inform the housekeeping staff that items were needed. The surveyor then toured the facility with the MD checking all common area sinks and bathrooms which revealed the following: At 12:58 p.m., the MD confirmed that there was an empty paper towel dispenser and an empty soap dispenser in the MC bathroom. At 1:00 p.m., the MD confirmed that there was an empty paper towel dispenser and an empty soap dispenser in the MC nursing station. At 1:02 p.m., the MD confirmed that there was an empty paper towel dispenser and an empty soap dispenser in the Wellness Area, Exam Room #1. The MD also confirmed that there was an empty paper towel dispenser in the Wellness Area, Exam Room #2. At 1:05 p.m., the MD led the surveyor to the facility's storage room which revealed multiple boxes of hand soap and paper towels. Surveyor review of the facility's policy and procedure titled, "Sanitation Requirements" revealed, "Policy and Procedure ... 10. Toilet tissue, soap, paper towels or air dryers, and waste receptacles shall be provided in each common area toilet residence at all times."	A 310		

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A 473	Continued From page 3	A 473		
A 473	8:36-5.1(g) General Requirements (g) The assisted living residence, comprehensive personal care home, or assisted living program shall adhere to applicable Federal, State, and local laws, rules, regulations, and requirements. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility documents, it was determined that the facility's Administrator failed to employee or enter a contract with an Infection Control Preventionist. This deficient practice was identified during a [redacted] Focused Infection Control survey conducted on 3/22/23. This deficient practice was evidence by the following: Reference: N.J.S.A. 26:2H-12.87.2(e)(1) "...The department shall require each [assisted living] facility to establish an infection prevention and control committee and assign to the facility's infection prevention and control committee an individual designated as the infection preventionist who is a licensed health care provider and who possesses five years of experience in infection control, or an individual who has successfully completed an online infection prevention course through the federal Centers for Disease Control and Prevention or the American Health Care Association course with a valid certificate therefrom...	A 473		

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A 473	Continued From page 4 Reference: N.J.S.A. 26:2H-12.87.2(f)(1) "...An infection preventionist assigned to [an assisted living] a facility's infection prevention and control committee pursuant to subsection e. of this section shall be a managerial employee and:.. (4) [An assisted living residence] A facility that is unable to hire an infection preventionist on a full-time or part-time basis may contract with an infection preventionist on a consultative basis..." Reference: EXECUTIVE DIRECTIVE NO. 20-026 "...II. Required Core Practices for Infection Prevention and Control. 1. Regardless of a facility's current reopening phase, core infection prevention and control practices must be in place at all times... ii. Facilities are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; or b. A physician who has completed an infectious disease fellowship; or c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of infection control experience.	A 473		

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A 473	Continued From page 5 iii. The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPC program by conducting internal quality improvement audits. Additional information is available at the NJDOH Healthcare Associated Infections page at https://www.nj.gov/health/cd/topics/hai.shtml, the NJDOH COVID-19 page at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml, and CDC's Infection Control Assessment Tools page at: https://www.cdc.gov/hai/prevent/infectioncontrol-assessment-tools.html..." At the time of the survey the facility's Director of Nursing provided the survey team with a line listing that indicated that five residents tested NJ Exec Order 26.4b1. In addition, during the survey it was revealed that the line listing did not include an additional resident that tested NJ Exec Order 26.4b1 [redacted]. On 3/15/2023 at 10:00 a.m., during the survey entrance conference, the facility's Administrator identified the facility's Director of Nursing (DON) as the facility's Infection Preventionist (IP). At 1:40 p.m., the surveyor interviewed the facility's DON who stated he was the acting IP due to the facility not having an IP. The DON denied having IP credentials such as a certification in infection control. The DON also stated since the time of his employment the facility had not employed an IP. At 1:41 p.m., the Administrator stated the facility's DON became the acting IP during a NJ Exec Order 26.4b1 outbreak in November of 2022. The Administrator stated although the DON did not have IP certification or training, the DON signed the	A 473		

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A 473	Continued From page 6 facility's IP job description. The administrator also stated since she began her employment, she had not hired an IP other than the DON. Facility records indicate the Administrator was hired on [redacted] At 1:46 p.m., the facility's Administrator titled, "Infection Control Preventionist Job description" revealed: "Position Summary The infection preventionist is responsible for the facility infection prevention and control program (IPCP), which is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. CMS definition: "Infection preventionist: term used for the person(s) designated by the facility to be responsible for the infection prevention and control program. Qualifications Any combination of education and experience that would provide the required knowledge, skills, and abilities; as well as any required licenses or certifications. Education: Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; and have completed specialized training in infection prevention and control as specified in NJ infection control regulations. Experience: Be qualified by education, training, experience, or certification in infection control. Must work at least part-time ..."	A 473		

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A 473	Continued From page 7 The document also included the DON name as the IP employee and had a hire date of [redacted] The document also contained the signature of the DON and Administrator, which was dated [redacted] On 3/20/2023 at 1:10 p.m., the surveyor interviewed the facility's Certified Medication Technician (CMT), CMT #1 and CMT #2 stated the facility did not employee an IP. CMT #1 and CMT #2 were unable to identify the DON as the facility IP. CMT #1 and CMT #2 stated they did not receive COVID 19 training.	A 473		
A 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures; 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect;	A 517		

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A 517	Continued From page 8 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to provide documented evidence of orientation and annual training for 9 (nine) of 9 (nine) employees, Culinary Supervisor (CS) #1, Director of Maintenance (DM) #2, Licensed Practical Nurse (LPN) #3, Housekeeper (HK) #4, LPN #5, Clinical Nurse Supervisor (CNS) #6, Activity Aide (AA) #7, Home Health Aide (HHA/Unit Clerk) #8, and Certified Medication Technician (CMT) #9. This deficient practice was evidenced by the following: On 3/16/23 at 11:15 a.m., the surveyor reviewed the employee personnel files and observed the following employees' files did not have documentation of orientation and annual training as listed below:	A 517		

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A 517	Continued From page 9 1. CS #1 was hired on [NJ ex order 2] with no documentation of Orientation, Emergency Drill, Assisted Living Concepts, Resident Rights, Infection Control, Emergency Training, Alzheimer Dementia, and Pain Management. 2. DM #2 was hired on [NJ ex order 26.] with no documentation of Orientation, Emergency Training, Alzheimer Dementia, and Pain Management. 3. LPN #3 was hired on [NJ ex order 26] with no documentation of Orientation, Assisted Living, Alzheimer Dementia, and Pain Management. 4. HK #4 was hired on [NJ ex order 26] with no documentation or record of Orientation, Emergency Drill, Infection Control, Emergency Training, Alzheimer Dementia, and Pain Management. 5. LPN #5 was hired on [NJ ex order 26.4b] and re-hired [NJ Exec Orde] with no documentation of Assisted Living, Resident Rights, Emergency training, Alzheimer Dementia, and Pain Management. 6. CNS #6 was hired on [NJ ex order 26] with no documentation of Orientation, Emergency Drill, Assisted Living Concepts, Resident Rights, Infection Control, Emergency Training, Alzheimer Dementia, and Pain Management. 7. AA #7 was hired on [NJ ex order 26.4b1] with no documentation of Orientation, Emergency Drill, Assisted Living Concepts, Resident Rights, Infection Control, Emergency Training, Alzheimer Dementia, and Pain Management. 8. HHA/Unit Clerk was hired on [NJ ex order 26] with no	A 517		

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A 517	Continued From page 10 documentation of Orientation, Emergency Drill, Assisted Living Concepts, Resident Rights, Infection Control, Emergency Training, Alzheimer Dementia, and Pain Management. 9. CMT was hired on [NJ ex order 26] with no documentation of Orientation, Assisted Living Concepts, Resident Rights, Emergency Training, Alzheimer Dementia, and Pain Management. On 3/16/23 at 12:00 p.m., after employee file review, the surveyor requested employee training from the Administrator (ADM). The ADM provided the surveyor with copies of incomplete employee trainings for the aforementioned employees. Also, the ADM explained that the Marketing Director oversaw new hire training and compliance. On 3/16/23 at 1:40 p.m., the surveyor interviewed the Marketing Director regarding additional employee orientation and training who explained that on hire an employee was set up with computer training and what was provided by the ADM was what the employee had completed. The facility was unable to provide the surveyor with documented evidence of completed employee orientation training and annual training.	A 517		
A 547	8:36-5.7(a)(6) General Requirements (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the	A 547		

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A 547	Continued From page 11 following: 6. Policies and procedures for the maintenance of personnel records for each employee, including at least his or her name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description, records of orientation and inservice education, and evaluation of job performance; This REQUIREMENT is not met as evidenced by: Based on interview and employee file review it was determined that the facility failed to maintain employee files to include records of physical examinations for 7 (seven) of 9 (nine) employees reviewed, Culinary Supervisor (CS) #1, Director of Maintenance (DM) #2, Licensed Practical Nurse (LPN) #3, Housekeeper (HK) #4, LPN #5, Clinical Nurse Supervisor (CNS) #6, and Activity Aide (AA) #7. This deficient practice was evidenced by the following: On 3/16/23 at 11:15 a.m., the surveyor during a standard inspection reviewed the facility employee records and identified documentation History and Physical (H&P) was not included in the employee files. The surveyor then requested the employee health records from the administrator for review. On 3/20/23 at 10:30 a.m., the surveyor reviewed the employee health records which showed the following:	A 547		

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A 547	Continued From page 12 1. CS #1 was hired on [NJ ex order 26.4b1] with no documentation or record of a H&P in employee file. 2. DM #2 was hired on [NJ ex order 26.4b1] with no documentation or record of a H&P in employee file. 3. LPN #3 was hired on [NJ ex order 26.4b1] with no documentation or record of a H&P in employee file. 4. HK #4 was hired on [NJ ex order 26.4b1] with no documentation or record of a H&P in employee file. 5. LPN #5 was hired on [NJ ex order 26.4b1] and re-hired [NJ ex order 26.4b1] with no documentation or record of a H&P in employee file. 6. CNS #6 was hired on [NJ ex order 26.4b1] with no documentation or record of H&P in employee file. 7. AA #7 was hired on [NJ ex order 26.4b1] with no documentation or record of H&P in employee file. On 3/20/23 at 1:40 p.m., the surveyor interviewed the Director of Marketing (DOM) who explained she, the DOM, assisted with the maintenance of employee files and there were no other employee health records available for the employees reviewed. On 3/21/23 at 12:45 p.m., the surveyor interviewed the Executive Director (ED) who explained the facility was under new ownership and at this time the employee files were being reviewed and updated.	A 547		

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A 547	Continued From page 13 The facility was unable to provide the surveyor with H&P's for the aforementioned employees.	A 547		
A 783	8:36-7.5(e) Resident Assessments and Care Plans (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure residents received an annual physical examination (PE) and certification to confirm that the resident needs could continue to be met at the Comprehensive Personal Care Home (CPCH) facility for 2 (two) of 2 (two) residents reviewed, Resident #6 and Resident #11. This deficient practice was evidenced by the following: On 3/16/23 at 10:00 a.m., the surveyor reviewed the medical record (MR) of Resident #6 which showed Resident #6 moved into the facility on [redacted] with diagnoses [redacted]	A 783		

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A 783	Continued From page 14 During Resident #6's MR review, the surveyor observed documentation for "MEDICAL EVALUATION (RESIDENT)" dated [NJ ex order 26.4b] which showed the physicians signature and certification that needs could be met at the facility. On 3/16/23 at 10:40 a.m., the surveyor reviewed Resident #11's MR which showed Resident #11 moved into the facility on [NJ ex order 26.4b] with diagnoses [NJ ex order 26.4b1] The surveyor observed in Resident #11's [NJ ex order 26.4b1] On 3/16/23 at 11:15 a.m., the above findings were shared with the Clinical Nurse Specialist (CNS) who confirmed that Resident #6 and Resident #11 [NJ ex order 26.4b1], but due to Medical Staff changing the PE and certifications were not done. The CNS was unable to provide any documented evidence to show that an annual [NJ ex order 26.4b1] on Resident #6 and Resident #11.	A 783		
A 907	8:36-10.5(c)(7) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 7. Between-meal snacks and beverages shall be available at all times for each resident, unless medically contraindicated as documented by a physician in the resident's health care plan;	A 907		

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A 907	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documents, it was determined that the facility failed to ensure that snacks and beverages were always available for each resident. This deficient practice was evidenced by the following: On 3/15/2023 at 9:00 a.m. the surveyor entered the facility and observed that some residents were eating breakfast in the main dining room. At 10:00 a.m., the surveyor observed that there were no snacks or beverages available for the residents to enjoy between meals. Later that day at 1:00 p.m., the surveyor interviewed a Certified Medication Technician (CMT) in regard to the lack of snacks available for residents to enjoy between meals. The CMT stated that the dietary department will send a tray of sandwiches for the residents every day at 5:00 p.m. The CMT further stated that the residents need to ask the Nurse or CMT for a sandwich. The surveyor also asked the CMT about available beverages; the CMT stated that the residents need to ask the staff for a beverage. On 3/16/2023 at 11:00 a.m., the surveyor observed an activity assistant (AA) in the memory care unit and residents gathered at a large table. The AA lead an exercise activity with the residents. The surveyor observed a large pitcher of juice on the activity cart. The surveyor interviewed the AA who stated that she provided snacks and drinks for the residents every other day after an activity. The AA further stated that the snacks were stored upstairs on the second floor in a closet.	A 907		

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A 907	Continued From page 16 On 3/22/2023 at 11:40 a.m., the surveyor interviewed a Home Health Aide (HHA) who stated that the facility does not provide snacks. The HHA pointed to the vending machines and stated that is where the snacks and drinks are located for the residents to purchase. During surveyor interview the Executive Director (ED) stated that the facility provided snacks in the evening and if any resident wanted a snack or beverage, they would need to ask a staff member. On 3/22/2023 at 2:00 p.m., the surveyor reviewed the facility's resident council minutes dated 12/30/2022 and 1/27/2023, which revealed that snacks were available at the nurse's station upon request on a "first come first serve basis." The facility failed to ensure that beverages and snacks were readily available for all residents.	A 907		
A 945	8:36-11.5(b)(5) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C. 13:37-6.2 to certified medication aides, as defined in this chapter. 5. The delegating nurse shall review with the certified medication aide medication actions and untoward effects for each drug to be administered. Pertinent information about medications' adverse effects, side effects, contraindications, and potential interactions shall be incorporated into the plan of care for each resident, with interventions to be implemented by	A 945		

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A 945	Continued From page 17 the personal care assistant and other caregiving staff, and documented on the medication administration record (MAR). This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the facility's Registered Nurse (RN) made appropriate delegation of medications administered by an agency Certified Medication Technician (CMT) for one of one residents, Resident #7, reviewed for medication administration. Appropriate delegation of medication administration under N.J.A.C. 13:37-6.2 requires the facility RN to properly supervise ancillary nursing personnel to whom such delegation is made. This deficient practice was evidenced by the following: On 3/20/2023 at 10:30 a.m., the surveyor met with the Director of Nursing (DON) and requested the medication administration observation documents. The DON returned with a binder that was titled, "Medication Pass Observation." The surveyor observed that there were six CMT's that had a "MEDICATION ADMINISTRATION OBSERVATION WORKSHEET" and was observed by an RN during medication administration. Upon further review, the surveyor observed out of the six CMT's, four were observed by the RN in December 2022 and 2 were observed by the RN in March 2023. During the review, the surveyor asked the DON for the medication observation worksheets for the prior months. The DON stated, he did not know where the CMT's	A 945		

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A 945	Continued From page 18 observation worksheets were located but he would look for the worksheets. During the survey, the surveyor did a follow up request of the aforementioned documents, and the DON stated that he could not find the documents. On 3/22/2023 at 9:30 a.m., the surveyor observed a medication pass performed by an agency Certified Medication Technician (CMT). The surveyor observed the agency CMT administer medications to Resident #7. Upon interview, the CMT stated, she worked for an agency and was not employed by the facility. The surveyor asked the CMT if the RN had observed her during a medication pass or directly provided any oversight or training; the CMT replied, "no." The surveyor interviewed the Executive Director (ED) at 12:40 p.m., who confirmed that the CMT was from an agency and provided the contract to the surveyor for review. The ED stated, the DON was the delegating Nurse, and should have done a medication pass observation with the agency CMT.	A 945		
A 985	8:36-11.7(b)(1) Pharmaceutical Services (b) All medications shall be kept in their original containers and shall be properly labeled and identified. 1. The label of each resident's prescription medication container shall be permanently affixed and contain the resident's full name, prescriber's name, prescription number, name and strength of medication, lot number, quantity, date of	A 985		

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A 985	Continued From page 19 issue, expiration date, manufacturer's name if generic, directions for use, and cautionary and/or accessory labels. Required information appearing on individually packaged medications or within an alternate medication delivery system need not be repeated on the label. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documentation, it was determined that the facility failed to consistently affix a permanent label onto medications in order to ensure the right resident received the right medication for four out of five residents, Resident #'s 8, 9, 11, and 12 reviewed for medication storage. This deficient practice was evidenced by the following: On 3/20/2023 at 9:45 a.m., the surveyor observed a medication cart that stored [NJ Exec Order 26.4b1] and treatment supplies. The medication cart contained plastic boxes with residents' names located on the outside of each box. The surveyor opened and observed Resident #8's plastic box which had [NJ ex order 26.4b1]. The surveyor observed [NJ ex order 26.4b1] [NJ ex order 26.4b1] with no resident identifier or prescription label affixed to the [NJ Exec]. The surveyor observed Resident #9's plastic box and saw [NJ ex order 26.4b1] with no resident identifier or prescription label affixed to the [NJ Exec].	A 985		

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A 985	Continued From page 20 The surveyor observed Resident #11's plastic box which contained NJ ex order 26.4b1 ; NJ ex order 26.4b1 with no resident identifier or prescription label affixed to the NJ Exec . The surveyor observed Resident #12's NJ ex order 26 stored within a plastic box; NJ ex order 26.4b1 unlabeled with no resident identifier or prescription label affixed to the NJ Exec . After the aforementioned observations the surveyor interviewed the Director of Nursing and the Executive Director and both stated the NJ Exec Orde should have labels on each NJ Exec . The DON stated that he would replace all of the NJ Exec Order 26.4b1 and ensure that each NJ Exec had labels affixed to the NJ Exec . The surveyor reviewed the facility's policy titled, " Blood Glucose Monitoring Policy" which indicated, "...1. Insulin pens shall be assigned to individual Residents and labeled appropriately. Insulin pens shall never be used for more than one person." Refer to A1297, 8:36-18.3(a)(4)	A 985		
A1047	8:36-14.3(d) Emergency Services and Procedures (d) Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable NFPA requirements and N.J.A.C. 5:70. Each fire	A1047		

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A1047	Continued From page 21 extinguisher shall be labeled to show the date of such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to conduct monthly fire extinguisher inspections. This deficient practice had the potential to affect all residents who currently reside in the facility. Findings included: During a tour of the facility with the Maintenance Director on 03/15/2023 at 9:46 AM, several fire extinguishers were inspected for compliance. The monthly inspection tag on all fire extinguishers were blank. The Maintenance Director stated he was not aware of the requirement to inspect the fire extinguishers monthly because the fire extinguisher contractor inspected the fire extinguisher every six months.	A1047		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice.	A1073		

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A1073	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to document in the medical record the diagnosis, condition, and treatment or care in accordance with the standards of professional practice for four of four residents reviewed that were NJ Exec Order 26.4b1, Resident #1, #2, #3, and #4. This deficient practice was evidenced by the following: On 3/16/2023, upon arrival to the facility the surveyor reviewed a facility provided document titled, "Resident and Staff Outbreak Line List," the document outlined resident and staff names, diagnosis dates, and tracked symptoms of NJ Exec Order 26.4b1 The Line List revealed that Resident #1, Resident #2, and Resident #3 NJ ex order 26.4b1 Upon review of Resident #1's medical record, it was revealed that Resident #1 was admitted to the facility on NJ ex order 26.4b1 with diagnoses which NJ ex order 26.4b1 . The surveyor reviewed a facility document titled, "Resident Assessment," dated NJ ex order 26.4b1, which specified that Resident #1 NJ ex order 26.4b1 Resident #2's medical record revealed the resident was admitted to the facility on NJ ex order 26.4b1 with diagnoses including NJ ex order 26.4b1 The surveyor reviewed a facility document titled "Resident Assessment" dated NJ ex order 26.4b1 which specified that Resident #2 NJ ex order 26.4b1 Resident #3's medical record revealed the	A1073		

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A1073	Continued From page 23 resident was admitted to the facility on NJ ex order 26.4b1 with NJ ex order 26.4b1 he surveyor reviewed a facility document titled, "Resident Assessment," dated NJ ex order 26.4b1 which specified that Resident #3 NJ ex or The surveyor reviewed the facility's documents titled, "Progress Note" (PN) on NJ ex order 26.4b1 for Resident #1, #2, and #3, which failed to indicate that Resident #1, #2, and #3 NJ ex order 26.4b1 The facility also failed to document the notification of the registered professional nurse and the physician for Resident #1, #2 and #3. On 3/20/2023 at 11:47 a.m., the Director of Nursing (DON) stated that he was unsure if the staff documented on residents that were NJ Exec Order 26.4b1 and where the staff would document. The DON also revealed that he was not aware if the residents' family members were being notified regarding a NJ Exec Order 26.4b1. The DON stated that the information regarding which residents has tested NJ Exec Order 26.4b1 may be in the 24-Hour Report, which is used for shift-to-shift communication between the nursing staff. The DON acknowledged that the 24-Hour Report is not part of the resident's medical record. The DON revealed that he does not audit staff documentation. The facility produced a copy of the 24-hour report for 3/7/2023 for surveyor to review. At 2:17 p.m., the Executive Director (ED) stated that the PN is all that is documented and that if it is not documented in the PN, then it was not done. Upon surveyor review of Resident #4's medical record, revealed the resident was admitted to the	A1073		

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A1073	Continued From page 24 facility on NJ ex order 26.4b1 with diagnoses including NJ ex order 26.4b1 Resident #4 was NJ ex order 26.4b1 on the facility's document titled, "24 Hour Report," Resident #4 was not listed on the aforementioned Line List. The surveyor reviewed the facility's documents titled, "Progress Note," on NJ ex order 26.4b1 for Resident #4, which failed to reveal that Resident #4 NJ ex order 26.4b1 The facility also failed to document the notification of the registered professional nurse and the physician for Resident #4. The surveyor reviewed the facility's policy and procedure titled, "Documentation" which revealed the following: "Policy and Procedure: 1. Documentation will be completed in accordance with the assisted living regulations. 2. The Administrator and/or Coordinator shall be accountable for the documentation and insure that all information is held in a confidential manner. 3. Residence staff, contracted agencies and other health service providers shall complete documentation. 4. Documentation shall be done in a timely and accurate manner in accordance with the policies and procedures of assisted living. 5. All records shall be made available to appropriate individuals and accessible to related staff in accordance with the policies and procedures established for assisted living. The surveyor also reviewed a facility produced document titled "Resident Record" which states: " ... d. All assessments and treatments by the health and service providers ... ... Documentation and/or notes from the health care and service providers shall be entered at least quarterly, or more frequently based on the	A1073		

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A1073	Continued From page 25 individual needs of the resident ..."	A1073		
A1185	8:36-17.2(b) Housekeeping-Sanitation-Safety-Maintenance (b) Housekeeping personnel shall be trained in cleaning procedures, including the use and care of equipment. This REQUIREMENT is not met as evidenced by: Based on interview and observation it was determined that the facility failed to ensure housekeeping staff followed proper cleaning procedures to reduce potential cross contamination of the resident's environment in response to an outbreak of [redacted] as evidenced by the following: On 3/15/2023 at 11:56 a.m., the surveyor observed a Housekeeper (HK) in the hallway with a cleaning cart that included a yellow mop bucket containing a large string mop head with a handle. The surveyor interviewed the HK who explained when cleaning residents' rooms, the mop head and the water were not changed between rooms. The HK stated that she changed the water when it appeared dirty, which she stated it could include the entire hallway, which contained over 10 resident rooms. On 3/20/2023 at 12:41p.m., the surveyor interviewed the Housekeeping Supervisor (HKS) who revealed that the mop head and mop water	A1185		

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A1185	Continued From page 26 should be changed after cleaning every three rooms. Upon surveyor request for the facility's documentation of housekeeping staff training, the facility's ED stated the facility utilizes an online system to provide and track staff in-services/trainings. The ED provided the surveyor with online in-service logs titled, "User Learning" for each individual housekeeping staff member. Review of the User Learning documents revealed that five of five housekeepers reviewed for completing the "Housekeeping Procedures in Residential Care Setting (HPRCS)" education, did not complete the in-service. In addition, the ED was unable to provide documentation that the HKS and Maintenance Director (MD) completed the HPRCS online in-service. On 3/20/2023 at 12:28 p.m., the surveyor interviewed the MD who informed the surveyor that the HKS supervisor is responsible for training housekeeping staff on proper cleaning procedures. At 12:41 p.m. on 3/20/2023, the surveyor interviewed the HKS who informed the surveyor that she does not have access to the policy and procedures for housekeeping. The HKS also stated that training for HK staff was from an online in-service system. At 1:25 p.m., the surveyor interviewed the MD who stated that he was responsible for ensuring the training prior to HKS returning to work. The MD stated that there is no written documentation for training that was done for housekeepers, and that in-services are not provided to housekeeping staff prior to them completing cleaning tasks in the facility. The MD stated that the housekeeping staff had a lot of previous experience and knowledge prior to starting at facility, therefore no	A1185		

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A1185	Continued From page 27 in-services were conducted. Upon surveyor review of the Relias (training document) titled, "Housekeeping Procedures in Residential Care Settings" description, it was revealed the in-service states: " ... In general, you should change the water when you can no longer see the bottom of the bucket, after mopping every 3 patient rooms, or at least every 60 minutes, whichever comes first. (CDC, 2017b)." The surveyor reviewed a facility document titled, "Housekeeping Services" which states: "Policy and Procedure: The Residence shall provide adequate housekeeping services to maintain a clean, safe and orderly surrounding for residents, personnel and visitors. 1. Housekeeping personnel shall be trained in acceptable procedures of cleaning ..."	A1185		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.	A1249		

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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
A1249	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to keep fire doors closed to prevent the spread of fire, smoke, and hot gases in the event of a fire. This had the potential to affect all residents. Findings included: On 03/15/2023 at 10:04 AM, the self-closing fire door to the basement mechanical room was observed propped open with a large traffic cone. On 03/15/2023 at 10:08 AM, the self-closing fire door to the basement boiler room was observed propped open with a cinder block. In an interview on 03/25/2023 at 10:08 AM, the Maintenance Director stated a contractor must have propped the door open when the contractor replaced the lightning. The surveyor did not observe any contractors or other persons in the basement during the survey.	A1249		
A1275	8:36-18.2(a)(1) Infection Prevention and Control Services (a) The facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications and OSHA standards, incorporated herein by reference, as amended and supplemented: 1. Guidelines for Hand Hygiene in Health Care Settings, MMWR/51 (RR-16),	A1275		

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 03/22/2023

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A1275	Continued From page 29 October 25, 2002; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to perform proper hand hygiene technique in accordance with the Centers for Disease Control (CDC) and the facility's policy for four of four staff members observed for handwashing: two (2) Cooks, one (1) Server, one (1) Home Health Aide (HHA). The deficient practice was evidence by the following: On 3/15/2023 during the tour of the facility for a Focused Infection Control Survey due to an outbreak of [redacted] the surveyor observed the following staff members for hand hygiene: On 3/15/2023 at 11:25 a.m., the surveyor observed the facility's Cook washing his hands at the handwashing sink located in the facility's kitchen. The Cook turned on the sink and applied soap to his hands prior to wetting his hands with water, which is not in accordance with the facility's handwashing policy and procedure. The surveyor also observed the Cook retrieve napkins from across the kitchen to dry his hands. The Cook then used napkins to turn off the sink and discarded the napkins in an open trashcan next to the sink. The surveyor observed an automatic paper towel dispenser above sink, the Cook stated that it did not work consistently. Post handwashing interview, the Cook stated that he was educated on how to properly wash his hands.	A1275		

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A1275	Continued From page 30 At 11:30 a.m., the surveyor observed a Dietary Server washing her hands at the handwashing sink located in the facility's kitchen. The Server scrubbed her hands under running water for 10 seconds, which is not in accordance with the facility's handwashing policy and procedure. Post handwashing interview, the Dietary Server stated that she counts to 50 or sings the ABC (alphabet) song and that she received education on how to wash his/her hands. At 11:35 a.m., the surveyor observed Cook #2 washing her hands at the handwashing sink located in the facility's kitchen. Cook #2 applied soap onto her hands prior to running her hands under water, and washed for 15 seconds, which is not in accordance with the facility's handwashing policy and procedure. Cook #2 stated that she had not been given education on proper hand hygiene upon hire, or during [redacted] outbreak. On 3/16/2023 at 11:33 a.m., the surveyor observed a HHA washing her hands at the sink located in the facility's Assisted Living television room. The HHA turned on the faucet, wet her hands, rubbed her hands together without soap and then turned off the sink with bare hand, which is not in accordance with the facility's handwashing policy and procedure. The HHA did not dry her hands. The surveyor observed there were no paper towels or hand soap at the sink. Post handwashing interview, the HHA revealed that there is often no hand soap or paper towels available therefore she brings hand soap from home to wash her hands. The surveyor interviewed a Certified Nursing Assistant (CNA) on 3/16/2023 at 11:39 a.m., who stated that she brought her own hand soap, or	A1275		

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A1275	Continued From page 31 she goes home on her break to wash her hands. The CNA stated that there was no hand soap or paper towels in the memory care unit. During surveyor interview with the facility's Assisted Living Program Administrator (ALPA), it was revealed that no handwashing in-services were done prior to 3/17/2023. The surveyor reviewed the facility's policy and procedure titled "Standard Precautions" which states: " ... Hand washing shall be indicated: 1. After contact with blood/ body fluid; 2. In between resident contact; 3. Before and after any procedure; 4. After contact with contaminated items or surfaces and 5. After removal of gloves ..." The surveyor reviewed the facility's policy titled "CDC infection control" which stated: " ...Clean hands often with an alcohol-based hand sanitizer that contains at least 60-95% alcohol, or wash hands with soap and water for at least 20 seconds. Soap and water should be used preferentially if hands are visible dirty ..."	A1275		
A1297	8:36-18.3(a)(4) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 4. Surveillance techniques to minimize sources and transmission of infection;	A1297		

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A1297	Continued From page 32	A1297		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of pertinent documents it was determined that the facility failed to implement an infection prevention and control program regarding the use and storage of glucometers and insulin pens and failed to develop and implement infection control surveillance techniques to minimize transmission of infection. This deficient practice was evidenced by the following:

1. On 3/20/2023 at 9:30 a.m., the surveyor observed 3 unlabeled glucometers on top of a medication cart, two glucometers were "One Touch", and 1 glucometer was, "TRUE METRIX." Glucometers are a device used for measuring the concentration of glucose in the blood. The glucometers were not stored in its' own case or bag. The surveyor asked the Certified Medication Technician (CMT) if she was able to identify the glucometers. The CMT stated that she was unable to identify the glucometers because there were no names or labels on the glucometers.

In addition, the surveyor continued to observe the medication cart which stored insulin pens and treatment supplies. The medication cart contained plastic boxes with residents' names located on the outside of each box. The surveyor opened the plastic boxes and observed that there were insulin pens with no resident identifier or prescription label affixed to the pen.

At 10:30 a.m., the surveyor interviewed the Director of Nursing (DON) who could not identify

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A1297	Continued From page 33	A1297		

the three glucometers on top of the medication cart. The glucometers had the potential to be used on multiple residents that received blood glucose monitoring (BGM). The surveyor pointed out the insulin pens without labels or identifiers on the pen. The DON stated that the insulin pens should have labels on each pen.

Later that day the Executive Director (ED) stated that the Nurse Practitioner was at the facility and that new glucometers would be ordered for each resident that receive BGM and insulin pens were replaced.

The ED provided a removal plan on 3/20/2023, which included removal of unlabeled glucometers and unlabeled insulin pens from the medication cart. The facility replaced glucometers to the resident's that received BGM and ensure that labels with resident identifier were affixed to the insulin pens. The removal plan was accepted.

On 3/23/2023 the surveyor observed labeled glucometers in the medication cart along with insulin pens that had labels affixed to the insulin pens.

The surveyor reviewed the facility's policy titled, "Blood Glucose Monitoring Policy" which indicated, "...Blood Glucose Meters ...1. Blood glucose meters shall be assigned to an individual Resident and not to be shared...Insulin Administration...1. Insulin pens shall be assigned to individual Residents and labeled appropriately. Insulin pens shall never be used for more than one person."

Refer to A 0985 8:36-11.7(b)(1)

2. At the time of the survey, the facility's Director

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A1297	Continued From page 34 of Nursing provided the survey team with a line listing that indicated that 5 residents were [redacted]. It was later revealed that an additional resident was also [redacted] at the time of the survey. On 3/15/2023 at 10:00 a.m., upon entering the facility and while conducting the facility tour, the survey team did not observe postings or signage that would have alerted visitors, facility staff and residents of the [redacted] outbreak that was ongoing at the time of the survey. On 3/16/2023, during the surveyor tour of the facility, the surveyor was unable to identify what apartments housed residents that were [redacted] and maintained [redacted] precautions. The surveyor was unable to locate postings or signage pertaining to the type of [redacted] precautions the 6 identified [redacted] residents were maintained on at their apartment doors. The surveyor was unable to locate postings or signage to indicate what type of Personal Protective Equipment (PPE) staff were to utilize when providing care to the facility's [redacted] residents. Also, the required PPE was not stationed near the [redacted] residents' apartments. On 3/16/2023 at 11:36 a.m., the surveyor interviewed the facility's home health aide (HHA), HHA #1 who stated the facility did not utilize postings or signage on resident's apartments to alert staff to which residents were maintained on [redacted] precautions and what PPE to utilize while providing care. HHA#1 stated she was not alerted at the beginning of her shift that there were residents who tested [redacted]. HHA #1 stated [redacted] residents were able to walk throughout the facility and go outside	A1297		

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A1297	Continued From page 35	A1297		

because all nursing staff were not aware of which residents tested NJ Exec Order 26.4b1. HHA #1 also stated PPE was not readily available in the case of an emergency.

At 11:39 a.m., the surveyor interviewed Certified Nursing Aide (CNA #1), who stated the facility did not utilize positing or signage on resident's apartments to alert staff to which residents were maintained on NJ Exec Order 26.4b1 precautions. CNA #1 also stated PPE was not readily available at the NJ Exec Order 26.4b1 resident apartment doors and that nursing staff had to go to the nursing station to retrieve required PPE. CNA #1 stated she was notified of who was NJ Exec Order 26.4b1 during the beginning of shift report.

At 11:46 a.m., the surveyor interviewed the facility's Licensed Practical Nurse (LPN) who stated the facility did not utilize postings or signage to alert the staff of which residents were maintained on NJ Exec Order 26.4b1 precautions and that she was informed of who was NJ Exec Order 26.4b1 during the beginning of shift report. The LPN stated she was able to retrieve PPE from the nursing station.

At 11:52 a.m., the surveyor interviewed the facility's agency hired Certified Nursing Aide (CNA), Agency CNA #2 who stated she was not informed that there were NJ Exec Order 26.4b1 residents in the facility until the facility's kitchen staff requested the HHA to obtain the breakfast orders from the NJ Exec Order 26.4b1 residents. Agency CNA #2 stated at times the facility's unit clerk would inform her of which residents were NJ Exec Order 26.4b1. Agency CNA #2 also stated she has provided care to a NJ Exec Order 26.4b1 resident without utilizing PPE due to not receiving notification that the resident was NJ Exec Order 26.4b1

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A1297	Continued From page 36 NJ Exec Order 26.4 At 1:09 p.m., the surveyor interviewed the facility's Director of Nursing (DON) who stated the facility's staff is notified of which residents are NJ Exec Order 26.4b1 upon arrival to the facility and during the beginning of shift report. The DON stated the facility did not utilize postings or signage to alert the facility's staff of which residents were maintained on NJ Exec Order 26.4b1 precautions or to inform the staff on what PPE to utilize while providing care to NJ Exec Order 26.4b1 residents. The DON also stated the facility did not station PPE near the resident's room who were NJ Exec Order 26.4b1. The DON stated during a medical emergency the staff would have to go to nursing station to retrieve the proper PPE. The DON also stated the facility only utilized postings and signage on residents' apartments doors to alert staff to which residents were maintained on NJ Exec Order 26.4 precautions and what PPE to utilize for more NJ Exec Order 26.4b1, not NJ Exec Order 26.4b1. The DON also stated the residents were not screened daily for NJ Exec Order 26.4b1. At 1:19 p.m., the surveyor interviewed the facility's Certified Medication Tech (CMT), CMT #1, who stated the facility did not utilize postings or signage to alert the facility's staff of which residents were maintained on NJ Exec Order 26.4b1 precautions and that she was informed of who was NJ Exec Order 26.4b1 from the beginning of shift report. The CMT stated she was able to obtain PPE from the nursing station. 3. On 3/15/2023 at 1:27 p.m., the surveyor interviewed the facility's Assisted Living Program Administrator (ALPA) who stated the facility's staff body temperature was measured upon entering the facility, but staff did not complete a NJ Exec Order 26.4b1	A1297		

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A1297	Continued From page 37	A1297		

questionnaire. The ALPA was unable to provide documentation that the facility's staff temperature was being measured upon entering the facility.

On 3/16/2023 at 11:36 a.m., the surveyor interviewed the facility's HHA #1 who stated she did not complete a [redacted] questionnaire or take her temperature upon entering the facility.

On 3/16/2023 at 11:52 p.m., the surveyor interviewed the facility's Agency CNA #2, who stated she did not take her temperature or complete a [redacted] questionnaire upon entering the facility.

On 3/21/2023 at 12:48 p.m., the surveyor interviewed the facility's CMT #1, who stated she did not take her temperature or complete a [redacted] questionnaire upon entering the building or starting her shift. CMT #1 stated she was not instructed to complete the [redacted] questionnaire or take her temperature prior to the survey team entering the building.

At 12:50 p.m., surveyor conducted an interview with the facility's CMT #2, who stated she did not complete a [redacted] questionnaire or take her temperature prior to entering the building.

The surveyor reviewed the facility's Policy and procedure titled "Disease Outbreak Plan" which revealed,

" ...Emergency Procedure Outbreak-Communication
The following procedure must be utilized in the event of an outbreak ...

4. Residents, employees, contract employees, and visitors should be evaluated daily for

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A1297	Continued From page 38 symptoms. 5. Employees should be instructed to self-report symptoms and exposure ... 7. Adherence to infection prevention and control policies and procedure is critical. Post signs for cough etiquette. Adherence to droplet precautions during the care of a resident with symptoms or a confirmed case of an outbreak is a must ... Surveillance and Detection ... 2. Protocol will be developed to monitor potential outbreak illnesses in residents and staff, which tracks illness trends ... b. A system is implemented to daily monitor residents and staff for symptoms of outbreak illness as well as confirmed cases of outbreak illness. c. Information from the monitoring systems is utilized to implement prevention interventions, such as isolation or co-horting. Communication ... 3. Communication efforts must be made, such as phone calls and posted signage to alert visitors, family members, volunteers, vendors, and staff members about the status of the outbreak in the community. Education and Training The D.O.N and other Department Managers are responsible for coordination education and training on outbreak for their department staff a. Education and training of staff members regarding infection prevention and control	A1297		

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A1297	Continued From page 39 precaution, standard and droplet precautions, as well as respiratory hygiene/cough etiquette should be ongoing to prevent the spread of infections, but particularly at the first point of contact with a potentially infected person with outbreak illness ... Infection Prevention and Control ... 2. Infection prevention and control policies require staff to use Standard and Droplet Precautions (i.e, PPEs for close contact with symptomatic residents) .... 3. Respirator hygiene/cough etiquette should be practiced at all times. a. Isolating symptomatic residents and their exposed roommates to their room. b. Ensure visitor and vendors know of the outbreak by posting notices at entrance doors, asking them to fill the screening questionnaire and taking their temperatures ... Monitoring Procedure 1. Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have the resident wear a facemask (if tolerated). Director of Resident Care will follow the CDC criteria to guide evaluation of PUI [Person Under Investigation] for COVID-19. 2. In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless suspected diagnosis required Airborne Precautions (e.g., COVID-19, Influenza, and Tuberculosis.) ..."	A1297		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
15C000 Y1	A. Building B. Wing Y2	8/7/2023 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 A0310	Correction	ID Prefix A0473	Correction	ID Prefix A0517	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.1(g)	Completed	Reg. # 8:36-5.6(b)(1-7)	Completed
LSC	05/01/2023	LSC	04/03/2023	LSC	09/08/2023
ID Prefix A0547	Correction	ID Prefix A0783	Correction	ID Prefix A0907	Correction
Reg. # 8:36-5.7(a)(6)	Completed	Reg. # 8:36-7.5(e)	Completed	Reg. # 8:36-10.5(c)(7)	Completed
LSC	08/31/2023	LSC	08/31/2023	LSC	04/23/2023
ID Prefix A0945	Correction	ID Prefix A0985	Correction	ID Prefix A1047	Correction
Reg. # 8:36-11.5(b)(5)	Completed	Reg. # 8:36-11.7(b)(1)	Completed	Reg. # 8:36-14.3(d)	Completed
LSC	06/30/2023	LSC	03/26/2023	LSC	06/05/2023
ID Prefix A1073	Correction	ID Prefix A1185	Correction	ID Prefix A1249	Correction
Reg. # 8:36-15.6(b)	Completed	Reg. # 8:36-17.2(b)	Completed	Reg. # 8:36-17.7	Completed
LSC	07/31/2023	LSC	06/30/2023	LSC	05/30/2023
ID Prefix A1275	Correction	ID Prefix A1297	Correction	ID Prefix	Correction
Reg. # 8:36-18.2(a)(1)	Completed	Reg. # 8:36-18.3(a)(4)	Completed	Reg. #	Completed
LSC	05/01/2023	LSC	04/30/2023	LSC	

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/22/2023	☐ YES ☐ NO

Ivy Stone Senior Living
NJ#15C000
7999 Route 130 North
Pennsauken, New Jersey 08110

Complaint visit dated: 03/22/2023

St- A 310- 8:36-3.4(a) Failure to implement and enforce the facility's policy and procedure titled, "Sanitation requirements".

1 Immediate Correction of Deficiency

04/10/23: Reviewed and revised hand hygiene policy by administration & consultants.
04/10/23: Reviewed and revised Employee Hand Hygiene Competency Sheet.
04/10/23: Hand Hygiene in-services for **all** staff including individual demonstration of competency on all shifts.100% compliance achieved by 4/27/2023.

2. **Residents with the potential to be affected**

When handwashing resources are not available and when hand soaps and paper towels are not available, infections can be easily transmitted to the residents or from residents to staff, and staff to residents.

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

Written policies and procedures developed for techniques to be used during each resident contact, including handwashing before and after caring for the resident. Additionally, hand hygiene (HH) policy and Employee Hand Hygiene Competency Sheet were reviewed and revised
HH in-services for all staff including individual demonstration of competency completed.

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**

Handwashing protocol has been taught to all new hires effective May 15, 2023. Completed by NJ Exec Order 26.4b1, RN who is Infection Preventions (IP). Managers will be educated by June 15th to conduct surveillance in their departments. Results will be reported in QA meetings.
All employees will be given in-service annually. IP will spot check employees weekly to ensure compliance. Written policies and procedures for techniques to be used during each resident contact, including handwashing before and after caring for the resident will be norm.

Facility has contracted with Cintas company. Cintas already installed dispensers and hand towels and they will be restocking to ensure there is availability of these needed resources. The IP has started to ensure the checklist is being filled out as part of environmental rounds. The compliance findings will be presented at the quarterly Quality Assurance meetings.

St-A 473- 8:36-5.1 (g)Failure to employ or enter into contract with an infection Control Preventionist

1.Immediate Correction of Deficiency

NJ Exec Order 26.4b1: A registered nurse (RN) was hired full time for both IP and as an adjunct to the DON. The IP completed the CDC course in infection prevention, as did the new Director of Nursing. The Infection Preventionist –Consultant was present full time for over a month, as she worked with managers and the new IP to develop policy and surveillance protocols. The IP-Consultant continues currently in a support role.

2**. Residents with the potential to be affected**

If there is no trained/ designated person to oversee the infection prevention program, all residents are in danger of being impacted by cross-contamination ailments and not benefit from Infection Preventionist protocols and surveillance.

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

NJ Ex.Order 26.4(b)(1): Infection Preventionist (IP) is on board as full time employee. The expert IP-Consultant will be overseeing the program into the future.

4. **Monitoring in place to ensure that the deficient practice is being corrected and will not reoccur. (Including frequency of monitoring, person responsible and a completion date**

Facility will ensure we always have an IP who is qualified for the position.
IP will have a permanent role in facility, and will oversee education and surveillance of staff and procedures to ensure compliance.

St- A- 517-8:36-5.6 (b) (1-7) Failure to provide documented evidence of orientation and annual training for 9 employees

1 **Immediate Correction of Deficiency**

New ownership acquired Ivystone, now Oasis at the Crescent, approximately 6 months ago and identified that the orientation program offered at that time was not sufficient to meet current standard of new employee requirements. Immediately, Human Resource management created orientation manual, made copies of packet, purchased and mounted a large screen TV, identified CDC videos appropriate for orientation, and utilized IP or available manager to teach handwashing.

2. What Residents have the potential to be affected

Residents will always benefit from staff who are uniformly oriented, and committed to a high standard of care.

3. What Measures were put into place to ensure the deficient practice will not occur
As noted above, an entire orientation program has been created, approved, and all staff will be re-oriented. All folders have been updated, including job description and educational components of orientation.

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

Human resource in conjunction with IP and any other designee will ensure annual in-services are up to date. All staff will be notified to sign up for an orientation and complete onboarding, including mandatory inservicing.

St- A- 547-8:36-5.7: Failure to maintain employee files to include records of physical examinations

1 Immediate Correction of Deficiency

Oasis is under new management and ownership. Staff formerly employed must be re-oriented and employee files created following the policies of Oasis at the Crescent. Physical examination form will be distributed to employees for completion. To facilitate compliance, nurse practitioners will be made available to staff during work hours on-site. Staff will also have the option of having the form completed by their private primary healthcare provider.

2. What Residents have the potential to be affected

If physical examinations are not complete, all residents could be potentially being impacted by communicable conditions or physical limitations that employees might have.

3. **What Measures were put into place to ensure the deficient practice will not occur**

We will ensure all existing employees provide H&P by July 30th 2023. During orientation, this will be required of all new onboarding employees.

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 orientation, this will be required of all onboarding employees and will be a requirement of employment. Human Resources will be monitoring compliance.

St- A- 783-8:36-7.5(e)Failure to ensure residents received an annual physical examination and certification to confirm that resident's needs could continue to be met at the comprehensive Personal Care Home(CPCH)

1 Immediate Correction of Deficiency

New ownership acquired Ivystone, now Oasis at the Crescent, approximately 6 months ago and identified that the primary care program offered at that time was not sufficient to meet resident needs including annual physical examination and certification. A new primary provider company was sought and started as of 04/10/23. Current Nurse Practitioner is conducting physical examination and certification for every resident. Completion date set for August 31st 2023.

2.Residents with the potential of being affected

Residents in the facility can have detrimental impact if not assessed periodically by a certified provider to ensure that the facility is still capable to meet their needs.

3. **What Measures were put into place to ensure the deficient practice will not occur**

NP will keep a spreadsheet with all residents and when the H&P date was completed and when next one is due.

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 keep a copy of NP spreadsheet to monitor and surveil for continued compliance of resident physical examination and certification for CPCH needs.

St- A- 907 8:36-10.5 (c)(7) Dining services: Failure ensure that snacks and beverages were always available for each resident.

1 Immediate Correction of Deficiency

Snack trays are assigned to a dietary aide to ensure these trays are delivered to the units and available at all times. Additionally, it is posted on menus so that residents are aware of the availability of the snacks. 2 water-stations accessible to all residents were put in place as of April 30th 2023. Snack trays which include half sandwiches, cookies, crackers, rice cakes, oranges, juices and yogurt containers are on each unit and at the front receptionist desk, and available to all residents.

2. What Residents have the potential to be affected

All residents need be assured of the availability and accessibility of snacks at all times.

3. What Measures were put into place to ensure the deficient practice will not occur

Awareness was created to all residents to ensure that they are all aware of the availability of snacks. Availability of snacks is also reflected on the daily menus.

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)

Dietary staff prepares snack trays and gives them to the front desk whereby receptionist gives it out in between meals to any resident who need snacks. Additionally, evening snack trays are given to assisted living, assisted living program and Rose Lane (memory unit) nursing stations @6pm where they are given out by a nurse or aide after dinner.

St- A- 945-8:36-11.5 Failure to ensure the facility's registered nurse made appropriate delegation of medications administered by an agency Certified Medication Technician(CMT)

1**. Immediate Correction of Deficiency**

After the survey, the temporary agency was discharged. New agency currently provides only licensed nurses for med pass. To ensure safe med pass with agency CMTs, agency has agreed to provide a current, completed med pass observation sheet that will accompany the agency CMT. Then our DON or designee will observe a med pass to make appropriate delegation of medication within 30 days.
In the past, the DON attempted to complete a Med Pass Observation on employee CMT staff. The DON was replaced effective April 15, 2023. The current DON is reviewing medication administration process and completing documented observations of CMT staff. Currently all CMT observations of medication administration pass are up to date. Currently there is no agency CMT on-site providing care.

2**. Residents with potential to be affected**

If the facility RN does not supervise the ancillary nursing personnel, there could be errors that would affect residents whose medication is managed by the facility

3. **Measures in place to ensure the deficient practice will not occur**

Medication Pass observation will remain consistent and re-evaluated every 6 months by DON or designee for employees and any CMT from agency. It is preferred that agency will provide licensed nurses to facility for med pass, as is currently the case.

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

DON or designee will keep a track of medication pass observation for CMTs and ensure review done every 6 months. Med Pass observation will be completed for all new CMTs prior to their assuming the CMT position. DON/ designee will keep a spreadsheet on when observations are due. The DON or designee have registered for the Train the Trainer workshop to enhance the depth and breadth of knowledge important for context when observing and evaluating the CMT medication administration.

St- A- 985-8:36-11.7 Failure to consistently affix a permanent label onto medications in-order to ensure the right resident received the right medication

1 Immediate Correction of Deficiency

The day after the survey the facility executive director purchased new glucometers, had them individually labeled, and put securely in their own individually-labeled cases.
Daily monitoring of proper glucometer labeling started as of April 2nd by DON/staff. Policy was reviewed to also reflect labeling requirements. Pharmacy had been providing insulin pens in a container with full prescription information, but not including full labels on the individual pens sent for the residents. An immediate meeting was conducted with pharmacy clinical administration. Pharmacy is now providing pre-labeled individual pens for all residents. In-service material was created and in-services were completed, covering all CMT and licensed nurse staff.

2. Residents with potential to be affected

All residents who are on insulin pens and with an order for blood sugar check would be affected.

3. What Measures were put into place to ensure the deficient practice will not occur

100% glucometer labeling compliance as of 03/26/23. 100% of nurses/CMTs completed glucometer labeling and insulin pen labeling in-services as of 4/20/2023. Weekly verification of proper labeling of glucometers and insulin pens are completed by medication administration staff.

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).

The IP will check the sign-off sheets for compliance of proper labeling and storage of insulin pens and glucometers as part of environmental rounds. Results will be reported at the quarterly Quality Assurance meeting

St- A- 1047: 8:36-14.3(d) Emergency services and procedures. Failure to conduct monthly fire extinguisher inspections

1 Immediate Correction of Deficiency

As of (date), the corrective action was accomplished as Maintenance Department scheduled a Fire Extinguisher inspection that was performed by (company). A Monthly checklist has been implemented to ensure all extinguishers are examined on a monthly basis.

2. Residents with a potential of being affected by this deficient practice

All residents are potential victims if there is fire and fire extinguishers are not in good condition

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

The Maintenance Director and Administrator(s) will review all items on the inspection checklist on a monthly basis specifically regarding the fire extinguisher examination, as per the NFPA requirements and N.J.A.C 5:70. This will be completed by June 5th, 2023.

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

Monthly, as part of the Maintenance Director(MD) duties, The MD will ensure that all Maintenance Assistants are trained on the monthly plant inspections and assigned duties based upon their ability and competency to perform the job. Additionally, there will be weekly review by the Administrators to ensure monthly plant inspection completion. This will be reviewed at the quarterly QA meetings.

St- A- 1073-8:36-15.6(b). Failure to document in the medical record the diagnosis, condition, and treatment or care in accordance with the standards of professional practice for 4 reviewed residents

1 Immediate Correction of Deficiency

As stated in previous standard, the resident Nurse Practitioner has been completing Histories & Physicals since she started in NJ ex order 26.4b1 and will be documenting diagnosis, condition and treatment in the electronic health record.
24 Hour nursing Report was revised: Documentation now includes:

- Residents with Covid-19 or on Isolation

Covid-19 results handouts were developed. All nurses and CMTs were educated on the new form.

2. What Residents have the potential to be affected

All resident charts should contain diagnosis, condition and treatment to support the provision of the best standard of care. Additionally, all residents are potentially susceptible if those who are Covid-19 positive, or those with communicable infections are not noted and proper measures put in place.

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

IP will create and surveil random spot checks of the resident medical record, and compile data for the quarterly Quality Assurance meetings. Goal is 100% compliance from the Nurse Practitioner provider.
Covid-19 results sheet was developed and nursing personnel (nurses and CMTs) education completed as of 4/20: (n=13) 100%.

24 Hour nursing Report was revised: Documentation now includes:

- Residents with Covid-19 or on Isolation
- Compliance with door sign policy
- PPE cart placement

nursing was educated on revised 24-hour report form.

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

IP to spot check resident health records weekly to ensure diagnosis, condition or change in condition, and treatment is included in electronic record. All residents are planned to have completed a current New DON was hired as of NJ Exec Order 26.4b1. New DON is being monitored by an experienced D.O.N consultant. Also, hired a full-time RN, BSN to serve as DON support and to serve as the Infection Preventionist. Both have completed the CDC's "TRAIN" Nursing Home Infection Preventionist Training Course and both will continue to monitor compliance.

St- A- 1185 8:36-17.2(b) Housekeeping Sanitation-Safety Maintenance: Failure to ensure housekeeping staff followed proper cleaning procedures to reduce potential cross-contamination of the resident's environment in response to an outbreak of Covid-19

1 Immediate Correction of Deficiency

On 4/11/2023, all housekeeping staff were in-serviced by the (ICP) Infection Control Preventionist on proper care of equipment and cross contamination prevention regarding their mops and clean water. A new mop procedure has been implemented. The facility has purchased Microfiber Mops and reusable Microfiber pads for every cleaning cart. The housekeeping staff will use one pad for each room. A regular mopping system will be utilized for all common areas as staff will store extra clean mop-heads to ensure zero cross-contamination

2. Residents with the potential to be affected

If proper cleaning procedures are not followed, all residents are in potential danger as a result of potential cross-contamination

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

The Maintenance Director or designee will surveil housekeeping staff regularly for proper procedure of required cleaning and regular attendance at in-services. The Maintenance Director will provide staff with written updated procedures and ensure annual housekeeping in-services. Data will be presented at quarterly meetings.

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

The Maintenance Director or designee will create form and surveil housekeeping staff regularly for proper procedure of required cleaning and regular attendance at in-services. The Maintenance Director will provide staff with written updated procedures and ensure annual housekeeping in-services. Data will be presented at quarterly meetings.

St- A1249 8:36-17.7 Failure to keep fire doors closed to prevent the spread of fire, smoke, and hot gases in the event of fire

1 Immediate Correction of Deficiency

At the time of inspection, there was work being performed in the basement of the facility. As a result, door have been left propped open. The Maintenance Director was advised to check all grounds for safety before and after contractors conduct work or repairs.

2. Residents in potential to be affected

This deficient practice can affect all residents in case of fire

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

The Maintenance Director will monitor all repairs performed by contractors and ensure all fire doors are closed after any repair or inspection.

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

Maintenance Director or designee will create and surveil fire doors that are secured and locked after contractors are in the building, and collect data to be presented at the quarterly Quality Assurance meetings.

St- A- 1275-8:36-18.2 Failure to perform proper hand hygiene technique in accordance with the Centers for Disease Control (CDC) and the facility's policy for four of the four staff members observed for handwashing

1. **Immediate Correction of Deficiency**

Hand Hygiene policy (HH) as well as Employee Hand Hygiene Competency hand-out was reviewed and revised. HH in-services for all staff including individual demonstration of competency was completed as of 4/10/2023. Compliance percentages as of 4/27/2023

- Nursing (n=31) 100%
- Dietary (n=19) 100%
- Housekeeping (n=7) 100%
- Security (n=2) 100%

Total 100%

2. Residents with the potential to be affected

Handwashing is the number one line of defense towards infections transmission. Failure to perform proper hand hygiene can affect all residents

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

Handwashing competency handout was revised and staff educated. Return demonstration was implemented. Spot-checking to ensure compliance by IP will continue

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 orientation, return demonstration of handwashing established as the standard and the competency will be completed. Spot-checking to ensure compliance by IP will continue, and data collected will be presented at the quarterly Quality meeting.

Housekeeping supervisor/designee will monitor all common bathroom areas to ensure soap and paper towels are readily available. A daily checklist has been created and compliance being monitored by housekeeping supervisor.

St- A- 1297-8:36-18.3 (a)(4) Failure to implement an infection prevention and control program regarding the use and storage of glucometers and insulin pens and failure to develop and implement infection control surveillance techniques to minimize transmission of infection

1 Immediate Correction of Deficiency
New glucometers were ordered to ensure every resident on blood-sugar check has a glucometer. Policy and procedure of infection control reviewed and revised. Laminated signs available at the

nursing stations for distribution in-case of a need. Portable storage carts (3) purchased and stocked with PPEs and kept in accessible place.
24 Hour Nursing Report was revised. Documentation now includes:

- Residents with Covid-19 or on Isolation
- Compliance with door sign policy
- PPE cart placement

Nursing personnel education on the revised 24-hour report form completed on
4/27/2023 (n=13) 100%

2. Residents with the potential to be affected

All residents on blood sugar- checks were in danger of cross-contamination

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

Insulin pens are now being delivered from pharmacy with affixed labels. Monitoring continues to show 100% glucometer labeling compliance.

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

The IP will check the sign-off sheets for compliance of proper labeling and storage of insulin pens and glucometers as part of environmental rounds. Proper use of 24-Hour report will be monitored and documented by IP. IP will also spot-check handwashing. Results will be reported at the quarterly Quality Assurance meetings. Signage to alert facility staff of the presence of an infection has been created and laminated and included on the PPE carts. All nursing staff have been educated as to the whereabouts of signage and carts. Worksheets have been developed, and the IP has been taught by the DON Consultant and the Infection Preventionist Consultant proper infection control surveillance techniques. Policy and procedures of infection control were revised, and will be reviewed annually.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
15C000 Y1	A. Building B. Wing Y2	8/7/2023 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 A0310	Correction	ID Prefix A0473	Correction	ID Prefix A0517	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.1(g)	Completed	Reg. # 8:36-5.6(b)(1-7)	Completed
LSC	05/01/2023	LSC	04/03/2023	LSC	09/08/2023
ID Prefix A0547	Correction	ID Prefix A0783	Correction	ID Prefix A0907	Correction
Reg. # 8:36-5.7(a)(6)	Completed	Reg. # 8:36-7.5(e)	Completed	Reg. # 8:36-10.5(c)(7)	Completed
LSC	08/31/2023	LSC	08/31/2023	LSC	04/23/2023
ID Prefix A0945	Correction	ID Prefix A0985	Correction	ID Prefix A1047	Correction
Reg. # 8:36-11.5(b)(5)	Completed	Reg. # 8:36-11.7(b)(1)	Completed	Reg. # 8:36-14.3(d)	Completed
LSC	06/30/2023	LSC	03/26/2023	LSC	06/05/2023
ID Prefix A1073	Correction	ID Prefix A1185	Correction	ID Prefix A1249	Correction
Reg. # 8:36-15.6(b)	Completed	Reg. # 8:36-17.2(b)	Completed	Reg. # 8:36-17.7	Completed
LSC	07/31/2023	LSC	06/30/2023	LSC	05/30/2023
ID Prefix A1275	Correction	ID Prefix A1297	Correction	ID Prefix	Correction
Reg. # 8:36-18.2(a)(1)	Completed	Reg. # 8:36-18.3(a)(4)	Completed	Reg. #	Completed
LSC	05/01/2023	LSC	04/30/2023	LSC	

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/22/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
15C000 Y1	A. Building B. Wing Y2	8/7/2023 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 A0310	Correction	ID Prefix A0473	Correction	ID Prefix A0517	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.1(g)	Completed	Reg. # 8:36-5.6(b)(1-7)	Completed
LSC	05/01/2023	LSC	04/03/2023	LSC	09/08/2023
ID Prefix A0547	Correction	ID Prefix A0783	Correction	ID Prefix A0907	Correction
Reg. # 8:36-5.7(a)(6)	Completed	Reg. # 8:36-7.5(e)	Completed	Reg. # 8:36-10.5(c)(7)	Completed
LSC	08/31/2023	LSC	08/31/2023	LSC	04/23/2023
ID Prefix A0945	Correction	ID Prefix A0985	Correction	ID Prefix A1047	Correction
Reg. # 8:36-11.5(b)(5)	Completed	Reg. # 8:36-11.7(b)(1)	Completed	Reg. # 8:36-14.3(d)	Completed
LSC	06/30/2023	LSC	03/26/2023	LSC	06/05/2023
ID Prefix A1073	Correction	ID Prefix A1185	Correction	ID Prefix A1249	Correction
Reg. # 8:36-15.6(b)	Completed	Reg. # 8:36-17.2(b)	Completed	Reg. # 8:36-17.7	Completed
LSC	07/31/2023	LSC	06/30/2023	LSC	05/30/2023
ID Prefix A1275	Correction	ID Prefix A1297	Correction	ID Prefix	Correction
Reg. # 8:36-18.2(a)(1)	Completed	Reg. # 8:36-18.3(a)(4)	Completed	Reg. #	Completed
LSC	05/01/2023	LSC	04/30/2023	LSC	

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/22/2023	☐ YES ☐ NO