

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 02005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/01/2024
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NAME OF PROVIDER OR SUPPLIER NEW JERSEY ADULT MEDICAL DAY CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 290 CHESTNUT STREET NEWARK, NJ 07105
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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
M 000	<p>Initial Comments</p> <p>Type of Survey: Complaint</p> <p>Complaint#: NJ00175084</p> <p>Census: 70</p> <p>Sample Size: 3</p> <p>The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	M 000		
M 383	<p>8:43F-5.4(d)(1) Participant Assessment and Plan of Care</p> <p>The plans for discharge shall be in compliance with N.J.A.C. 8:86-1.5 regarding Medicaid eligibility criteria, if applicable.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	M 383		

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

TITLE

(X6) DATE

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M 383	<p>Continued From page 1</p> <p>Based on record review and interview, it was determined that the facility failed to ensure proper discharge planning was in compliance with regulation N.J.A.C. 8:43F-5.4 for 1 of 3 participants reviewed for discharge planning, Participant #2, for which an Imminent Danger (ID) was identified. The deficient practice was evidenced by the following:</p> <p>On 6/19/24 at 8:10 a.m., the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE) form, a document used by healthcare facilities to report incidents to the NJDOH. The report included a "date of event [redacted] a time of event: 8:10 a.m." The report revealed Participant #2 & Participant #3 had a [redacted] about [redacted] of the center. On [redacted] the two participants had an [redacted] Participant #2 [redacted] Participant #3 with [redacted] that he/she had in his/her possession. The ID was reported to the Licensed Adult Medical Day Care Administrator on 7/1/24 at 4:00 p.m. The Administrator was presented with the ID template that included information about the above issue. The FRE further indicated that Participant #2 was discharged from the program for this incident and for [redacted] another participant (Participant #3).</p> <p>On 7/1/2024 at 10:00 a.m., the surveyor interviewed the facility's Administrator who stated that Participant #2 was [redacted] from the program due to bringing [redacted] onto the property and [redacted] a fellow participant. The Administrator also stated that she placed a telephone call to Participant #2 to inform him/her of his/her discharge and Participant #2 did not want to participate with the telephone call.</p>	M 383		
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M 383	<p>Continued From page 2</p> <p>At 10:20 a.m., the surveyor interviewed the facility's Director of Social Services (DSS) who stated that she did not place a telephone call to Participant #2 in regard to discharge planning after Participant #2 was NJ Ex Order 26.4b1 from the facility.</p> <p>At 11:45 a.m., the surveyor reviewed Participant #2's medical record which revealed a document titled, "Admission Facesheet" which revealed the participant had an admission date of NJ Ex Order 26.4b1 and diagnoses which included NJ Ex Order 26.4b1</p> <p>At 1:49 p.m., the surveyor interviewed the facility's Administrator and DSS. During the surveyor interview, the facility's DSS stated that she attempted to call the participant's caregiver, who did not answer the DSS's phone call. During continued surveyor interview, the facility's Administrator and DSS denied providing Participant #2 with alternative resources or notifying the participant's caregiver by way of a written letter. The Administrator and DSS also denied providing Participant #2 of discharge in writing.</p> <p>Surveyor review of the facility's policy and procedure titled, "Participant Care Policies and Procedure - Discharge Policy" which revealed, "PROCEDURES: Discharge planning is an ongoing assessment process for program participants and an integral part of the plan of care ... 1. If the discharge is involuntary or emergency, the administrator will notify the participant and/or family of the decision to discharge in writing. This notice shall specify the reason for discharge and will offer a meeting with the administrator to appeal the decision. The</p>	M 383		

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M 383	<p>Continued From page 3</p> <p>notice will be entered into the participant's record ... 5. Significant discharge planning efforts (dialogue with the participant and/or family, referrals made, etc.) will be documented in the progress notes. 6. Participant who are involuntarily discharged from the program will be informed of such. At least one attempted telephone contact will be made and documented. In addition, a written letter will be made to the participant's last known address."</p> <p>On survey, the surveyor confirmed that the ID was removed through staff interviews, on 6/19/24, the facility removed the immediacy by [REDACTED] Participant #2 entrance to the facility.</p>	M 383		

New Jersey Adult Medical Day Care Inc.

DBA Life Adult Medical Day Care Inc.

290 Chestnut Street, Newark, NJ 07105

P: 973-578-2815 F: 973-589-0386

1. *How the corrective action will be accomplished for those residents found to be affected by the deficient practice.*

No additional residents were found to be affected by the deficient practice.

The participant found to be affected by the deficient practice was mailed a discharge plan that included services she can access for continuity of services.

Completed 7/20

2. *How the facility will identify other residents having the potential to be affected by the deficient practice.*

All discharge records in the past six months have been reviews and none were found to be affected. Discharge planning was found in each record.

Completed 7/19

3. *What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur.*

- a. The discharge plan has been placed in all medical records. To begin the process on admission
- b. Social Services has been in service on the process (completed)
- c. On the date of admission, the medical record will be audited by the Director of Nursing to ensure the discharge plan process has been initiated on all new admissions.
- d. Participants name identified to be discharged will be given to the director of nursing, social services and the administrator to ensure the discharge process is followed per the facility policy and procedure.

This process is ongoing and will be monitored by the Director of Social Services

- e. A template letter has been developed for the social service department to follow and complete as part of the discharge procedure
- f. Education on the discharge process will be ongoing and conducted quarterly by the administrator

4. *How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur.*

- a. Participants will receive via mail or in person 30 days notice for intent to discharge This discharge notice will include service the participant can access for continuity of services.

This process is ongoing and will be monitored by the Director of Social Services upon discharge.

Completion Date 7/20/2024

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 02005	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/25/2025
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NAME OF FACILITY NEW JERSEY ADULT MEDICAL DAY CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 290 CHESTNUT STREET NEWARK, NJ 07105
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0383	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43F-5.4(d)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/20/2024	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
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/1/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		