

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20A014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/30/2024
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NAME OF PROVIDER OR SUPPLIER SUNRISE OF SUMMIT	STREET ADDRESS, CITY, STATE, ZIP CODE 26 RIVER ROAD SUMMIT, NJ 07901
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ 00151503</p> <p>CENSUS: 73</p> <p>SAMPLE SIZE: 3</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A1073	<p>8:36-15.6(b) Resident Records</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	A1073		

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

TITLE

(X6) DATE

New Jersey Department of Health

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A1073	<p>Continued From page 2</p> <p>At 12:00 p.m., the surveyor interviewed a Lead Care Manager (LCM) regarding residents' NJ Ex Order 26.4(b)(1) schedules and documentation. The LCM stated that the resident's NJ Ex Order 26.4(b)(1) schedule was in the resident's General Service Plan (GSP). The LCM explained that staff would sign out when the resident's NJ Ex Order 26.4(b)(1) and/or NJ Ex Order 26.4(b)(1) was given or refused in the electronic MR on the CM note pad.</p> <p>At 12:40 p.m., the surveyor interviewed the Regional Director of Nursing (RDON) regarding the NJ Ex Order 26.4(b)(1) documentation in Resident #3's MR. The RDON stated that she was not aware that the resident's NJ Ex Order 26.4(b)(1) status were not documented in the MR by staff.</p> <p>At 12:45 p.m., the surveyor interviewed the Executive Director (ED) regarding the missed showers/baths documentation for Resident #2. The ED stated that the procedure was for the CM to initial the shower or bath status in the MR.</p> <p>The surveyor reviewed the facility policy and procedure titled, "General service Plan" which revealed "...The Care Manager: ...b. Provides the services written on the General Service Plan. c. Signs the General Service Plan once to enable initial identification. d. Documents in the Daily log care not completed from the General Service Plan. ...The lead Care Manager: Follows up on documentation in the daily log. ..."</p>	A1073		

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

TITLE

(X6) DATE

07/11/24

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 20A014	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/30/2024
Y1	Y2	Y3
NAME OF FACILITY SUNRISE OF SUMMIT		STREET ADDRESS, CITY, STATE, ZIP CODE 26 RIVER ROAD SUMMIT, NJ 07901

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 A1073	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:36-15.6(b)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	06/30/2024	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 5/30/2024
 CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
 YES NO