

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35a003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/21/2021
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NAME OF PROVIDER OR SUPPLIER TERRACES AT PARKE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 661 DELSEA DRIVE SEWELL, NJ 08080
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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 00145490, NJ 00137629</p> <p>CENSUS: 47</p> <p>SAMPLE SIZE: 4</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		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00137629</p> <p>Based on interview and record review it was determined that the facility failed to implement its policy and procedure titled, "Weights: Resident" for 1 of 4 residents reviewed for weight loss and weight gain, Resident #3, and failed to complete an investigation of a [REDACTED] of unknown origin, to rule out abuse, for 1 of 4 residents reviewed for abuse, Resident #3. This deficient practice was evidenced by the following:</p> <p>1. On 5/21/21 at 9:30 a.m., the surveyor reviewed Resident #3's closed medical record, which revealed that the resident, who no longer resided at facility, was admitted to the facility in [REDACTED]. According to the form titled, "History and Physical," dated [REDACTED] Resident #3 had diagnoses which included [REDACTED].</p> <p>Surveyor review of the "Service Plan," dated [REDACTED] revealed that Resident #3 was [REDACTED] and required complete assistance with Activities of Daily Living (ADLs).</p> <p>Further review of Resident #3's medical record revealed a document titled, "Monthly Vital Signs and Weights," which indicated the weights as follows:</p> <p>a. In [REDACTED], upon admission to the facility the weight was [REDACTED] (lbs). b. In [REDACTED] the weight was [REDACTED] lbs. c. In [REDACTED] the weight was [REDACTED] lbs. d. In [REDACTED] the weight was [REDACTED] lbs.</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>e. In [REDACTED] the weight was [REDACTED] lbs. f. In [REDACTED] the weight [REDACTED] lbs. g. In [REDACTED] the weight was [REDACTED] lbs. h. In [REDACTED] the weight was [REDACTED], a total of [REDACTED] pound (lb) weight gain from [REDACTED] to [REDACTED].</p> <p>During continued surveyor review of Resident #3's medical record, the surveyor did not observe documented evidence that the nursing staff, including the Registered Nurse (RN), addressed Resident #3's [REDACTED] lb weight gain from [REDACTED] to [REDACTED].</p> <p>At 10:50 a.m., the surveyor interviewed the Administrator and the RN regarding the facility's protocol for weight loss and weight gain. The Administrator stated that each month, she reviewed the residents weights with the RN to address any weight discrepancies, which included weight losses and weight gains. The Administrator added that a Dietician was consulted when there were issues with weights. The surveyor then asked the Administrator if a Dietician was consulted about Resident #3's weight gain. The Administrator stated that the Dietician was not consulted. The surveyor then requested for review the facility's policy on weights.</p> <p>Surveyor review of the facility policy and procedure titled, "Weight: Resident," dated July 30, 2020 revealed the following, "... The nurse will check the resident's previous monthly/weekly weight for comparison and report any fluctuations of an unexplainable weight loss or gain to the RN Assessment Nurse for assessment." And, "Appropriate interventions are taken in response to significant weight gain or loss if necessary and the Consultant Dietician will be contacted."</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>During continued interview with the Administrator confirmed that a [REDACTED] lb weight increase from [REDACTED] to [REDACTED] was a significant weight gain. Additionally, the Administrator was not able to provide the surveyor with documented evidence that a Dietician, or Resident #3's Physician were made aware of the [REDACTED] lb weight gain.</p> <p>2. The surveyor continued to review of Resident #3's medical record and observed in the "Integrated Progress Notes (IPN)," a note dated [REDACTED], on 7-3 shift, written by a Licensed Practical Nurse (LPN), which indicated that Resident #3 had been medicated with [REDACTED] for [REDACTED] with positive results. The LPN documented that she observed that the resident was [REDACTED] during transfer and that a Registered Nurse (RN) was made aware.</p> <p>On that same day at 10:30 p.m., the IPN, written by an LPN, documented that Resident #3 complained of [REDACTED] and e resident yelled during care. The LPN documented that the resident was medicated with [REDACTED] at 4 p.m., and that [REDACTED] was effective for [REDACTED].</p> <p>The IPN dated 4/30/20, on the 7-3 shift, written by an LPN also documented that an [REDACTED] of [REDACTED] was obtained and that the results were faxed to the Physician, and that the RN and the family were notified. Additionally, the LPN documented that the resident was medicated with [REDACTED] with, "little" effect.</p> <p>On the same day, [REDACTED] during the 3-11 shift, an LPN documented that a new order for [REDACTED] ([REDACTED]) was received for 3 days for Resident #3.</p> <p>The surveyor reviewed the [REDACTED] result dated</p>	A 310		
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A 310	<p>Continued From page 4</p> <p>██████████ and timed at 11:40 a.m., of ██████████, and the ██████████ report indicated that there was no evidence of an ██████████.</p> <p>The IPN dated ██████████, at 9:30 p.m., written by an LPN, documented that Resident #3 required maximum assistance of 2 persons for repositioning. Additionally, the LPN documented that the resident yelled and screamed and stated, ██████████. The LPN documented that the resident had been medicated with ██████████ at 4 p.m., and received some relief.</p> <p>The IPN dated ██████████ at 9 a.m., written by an LPN, documented that the LPN received the resident in ██████████ and the ██████████) and that the Physician, and the resident's Responsible Party (RP) were made aware of the resident's condition. The LPN documented that the resident's RP requested that the resident be transferred to the hospital for further evaluation.</p> <p>Later that same day at 9:50 p.m., an LPN documented that the RN placed a telephone call to the hospital and Resident #3 had been admitted with a ██████████. The LPN documented that the RP was notified.</p> <p>At 1:05 p.m., the surveyor interviewed the Administrator and the Director of Nursing (DON) regarding Resident #3's ██████████. The DON stated that she was new to the facility, and the Administrator stated that an ██████████ was completed and was ██████████. The Administrator explained that she was not sure how the ██████████ occurred. The surveyor then asked the Administrator if she investigated the fracture of unknown origin to rule out abuse when the facility became aware of it on ██████████. The Administrator stated that she was not sure, and</p>	A 310		

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A 310	Continued From page 5 was not able to provide the surveyor documented evidence that the [REDACTED] of unknown origin was investigated and that abuse was ruled out. Surveyor review of the facility's policy and procedure titled, "Accident and Incident Reports: Resident," dated April 30, 2021, revealed, "An incident is any happening not consistent with the routine operation of the facility or routine care of a resident. This includes but is not limited to falls, cuts, bruises, suspected abuse, other injuries..." Additionally, "Unwitnessed or of unknown origin - each staff member assigned to the resident for the previous 9 shifts will be required to complete an Other Event Witness Questionnaire."	A 310		
A 563	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, elopements, and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages;	A 563		

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A 563	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00137629</p> <p>Based on interview and record review it was determined that the facility failed to report to the Department of Health (DOH) an injury of unknown origin for 1 of 4 residents reviewed for injury and abuse, Resident #3. This deficient practice was evidenced by the following:</p> <p>On 5/21/21 at 9:30 a.m., the surveyor reviewed Resident #3's closed medical record, which revealed that the resident, who no longer resided at facility, was admitted to the facility in [REDACTED] [REDACTED] According to the form titled, "History and Physical," dated [REDACTED] Resident #3 had diagnoses which included [REDACTED].</p> <p>Surveyor review of the "Service Plan," dated [REDACTED], revealed that Resident #3 was [REDACTED] and required complete assistance with Activities of Daily Living (ADLs). According to surveyor review of the "Integrated Progress Notes" (IPN), dated [REDACTED], Resident #3 required maximum assistance of 2 persons for repositioning.</p> <p>During continued review of the resident's medical record, the surveyor observed an IPN dated [REDACTED], at 9:30 p.m., written by a Licensed Practical Nurse (LPN), which documented that the resident yelled and screamed and stated, "[REDACTED]" The LPN documented that the resident had been medicated with [REDACTED] [REDACTED] at 4 p.m., with some relief.</p>	A 563		

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A 563	<p>Continued From page 7</p> <p>The IPN dated [REDACTED] at 9 a.m., written by an LPN, documented that the LPN received Resident #3 in [REDACTED] and that the Physician and the resident's Responsible Party (RP) were made aware of the resident's condition. The LPN also documented that the resident's RP requested that the resident be transferred to the hospital for further evaluation.</p> <p>Later that same day at 9:50 p.m., an LPN documented that the RN placed a telephone call to the hospital and that Resident #3 had been admitted with the diagnoses of [REDACTED]. The LPN documented that the RP was notified.</p> <p>At 1:05 p.m., the surveyor interviewed the Administrator and the Director of Nursing (DON) regarding the [REDACTED]. The DON stated that she was new to the facility and was not aware of the [REDACTED]. The Administrator stated that an [REDACTED] was completed on [REDACTED] and that the [REDACTED] was [REDACTED] and was not sure how the [REDACTED] occurred. The surveyor then asked the Administrator if she reported the [REDACTED] of unknown origin to the DOH when the facility became aware of it on 5/4/20. The Administrator replied that she did not.</p>	A 563		
A 615	<p>8:36-5.15(b) General Requirements</p> <p>(b) Notification of any occurrence noted in (a) above shall be documented in the resident's record. The documentation with regard to an occurrence noted in (a)4 above shall include confirmation and written documentation of that notification.</p>	A 615		

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A 615	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00137629</p> <p>Based on interview and record review it was determined that the facility failed to maintain documented evidence that the Responsible Party (RP) was notified of a change in condition of a resident's skin integrity (skin health) for 1 of 4 residents reviewed for [REDACTED], Resident #3. This deficient practice was evidenced by the following:</p> <p>On 5/21/21 at 9:30 a.m., the surveyor reviewed Resident #3's closed medical record which revealed that the resident, who no longer resided at the facility, was admitted to the facility in [REDACTED]. According to the "History and Physical" form dated [REDACTED] the resident had diagnoses which included [REDACTED]</p> <p>Surveyor review of the "Service Plan," dated 12/4/19, indicated that Resident #3 was incontinent of bowel and bladder, bed bound and required complete assistance with Activities of Daily Living. According to the "Integrated Progress Notes" (IPN), dated 5/1/20, Resident #3 required the maximum assistance of 2 persons for repositioning.</p> <p>The IPN dated [REDACTED] at 9:10 p.m., written by an LPN, documented that Resident #3's RP called the facility and was concerned about some [REDACTED] on the resident's [REDACTED]. The surveyor also observed documented on [REDACTED] in the IPN that an LPN documented that the [REDACTED] were measured and were approximately [REDACTED] each, and that the resident's RP requested treatment for the [REDACTED]</p>	A 615		

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A 615	<p>Continued From page 9</p> <p>The surveyor did not observe documented that the LPN identified the location, or the number of [REDACTED] to Resident #3's [REDACTED]. The surveyor observed, in the medical record, that Resident #3 received treatment of barrier cream to the [REDACTED], but that it was not effective and the Physician was notified. The surveyor did not observe documented evidence that the facility notified Resident #3's RP of the change in skin integrity until [REDACTED], when the resident's RP called the facility and requested treatment for the [REDACTED].</p> <p>At 1:30 p.m., the surveyor informed the Administrator of the above concerns and lack of documentation of RP notification of Resident #3's change in skin integrity to the prior to [REDACTED] when the RP called the facility and requested treatment to the now [REDACTED]. The ED acknowledged that there was no documented evidence that Resident #3's RP was notified of the [REDACTED].</p> <p>On 6/4/21 at 11:38 a.m., the surveyor conducted a post survey telephone interview with the facility LPN regarding her documentation in Resident #3's medical record, and asked the LPN when she first became aware of the [REDACTED]. The LPN stated that she could not recall the description of the [REDACTED] and if she was aware of the [REDACTED] prior to [REDACTED], when the RP called the facility and requested that the [REDACTED] be treated.</p>	A 615		
A 779	<p>8:36-7.5(c) Resident Assessments and Care Plans</p> <p>(c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs</p>	A 779		

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A 779	<p>Continued From page 10</p> <p>or medical needs and for needed nursing care intervention or medical care.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00137629</p> <p>Based on interview and record review it was determined that the facility failed to notify a Registered Nurse (RN) of a change in condition of a residents skin integrity (skin health) when 1 of 4 residents developed [REDACTED], Resident #3. This deficient practice was evidenced by the following:</p> <p>On 5/21/21 at 9:30 a.m., the surveyor reviewed Resident #3's closed medical record which revealed that the resident, who no longer resided at the facility, was admitted to the facility in [REDACTED] [REDACTED] According to the, "History and Physical" form dated [REDACTED], Resident #3 had diagnoses which included [REDACTED]</p> <p>Surveyor review of the "Integrated Progress Notes" (IPN) dated [REDACTED], indicated that Resident #3 required the maximum assistance if 2 persons for repositioning.</p> <p>Further review of the "Integrated Progress Notes" (IPN), dated [REDACTED] at 9:10 p.m., written by an LPN, documented that Resident #3's Responsible Party (RP) called the facility and was concerned about some [REDACTED] on the resident's [REDACTED].</p> <p>The IPN dated [REDACTED] at 9:10 p.m., written by an</p>	A 779		

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A 779	<p>Continued From page 11</p> <p>LPN, documented that Resident #3's RP called the facility and was concerned about some [REDACTED] on the resident's [REDACTED]. The surveyor also observed documented on [REDACTED] in the IPN that an LPN documented that the [REDACTED] were measured and were approximately [REDACTED] each, and that the resident's RP requested treatment for the [REDACTED] and that the barrier cream was not effective and the Physician was notified.</p> <p>Further surveyor review of the resident's IPN, revealed that there was no documented evidence that the facility's RN was notified of the resident's change in skin integrity from [REDACTED] of the [REDACTED] of the skin or [REDACTED] when the LPN received a call from the resident's RP regarding the [REDACTED] and first became aware of the [REDACTED].</p> <p>At 11:30 a.m., during interview with the facility's RN, she stated that she was newly employed at the facility and was not aware of the [REDACTED].</p> <p>On 6/4/21 at 11:38 a.m., the surveyor conducted a post survey telephone interview with the LPN regarding Resident #3's [REDACTED] and asked the LPN if an RN was notified when she, the LPN, became aware of the [REDACTED]. The LPN stated that she could not recall if the facility had an RN at that time.</p> <p>The facility failed to ensure that an RN was notified on [REDACTED] when the LPN became aware of a change in the skin condition of Resident #3 and the skin on the [REDACTED].</p>	A 779		