

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JUNIPER VILLAGE AT WILLIAMSTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 1640 S. BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094
--	---

(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 COMPLAINT #: NJ144652 and NJ155760 CENSUS: 25 SAMPLE SIZE: 6 SURVEY DATE: 02/08/2024 to 02/09/2024</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, based on this Complaint Survey.</p> <p>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 755	<p>8:36-7.3(d) Resident Assessments and Care Plans</p> <p>(d) The resident shall participate in and, if the resident agrees, family members shall be invited to participate in, the development of the resident service plan and health service plans, if plans are needed. Participation shall be documented in the resident's record.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and interviews, the facility failed to ensure the residents and their family members or</p>	A 755		

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

TITLE

(X6) DATE

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JUNIPER VILLAGE AT WILLIAMSTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 1640 S. BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094
--	---

(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 755	<p>Continued From page 1</p> <p>representatives were invited to care plan meetings and that their participation was documented in the resident's record for 2 (Resident #1 and Resident #2) of 6 sampled residents.</p> <p>Findings included:</p> <p>A review of an undated facility policy titled, "Care Plan Meetings," revealed "Purpose: To assist in maintaining quality care delivery. To ensure communication among the resident's stakeholders to encourage the resident and family to take an active role in care and service activation and engagement. Procedure: 1. Resident Service Plan meetings are held quarterly." According to the policy "3. Residents and their responsible party will be invited by the Executive Director or Wellness Director to participate in Resident Service Plan Meetings. 4. The Executive Director or Wellness Director is encouraged to make personal invitations to the responsible party during family calls." Further review of the policy revealed "7. Participation by the resident, family and all team members will be documented in the medical record using the Multidisciplinary Care Conference Form in PCC [Point Click Care]."</p> <p>1. A review of Resident #2's "Multidisciplinary Care Conference - V2," with an effective date of [redacted] revealed the facility admitted the resident on [redacted] with diagnoses that included [redacted], [redacted], [redacted].</p> <p>During an interview on 02/08/2024 at 12:39 PM, Resident #2's family member (FM) stated the quarterly meetings stopped when Resident #2's</p>	A 755		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JUNIPER VILLAGE AT WILLIAMSTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 1640 S. BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094
--	---

(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 755	<p>Continued From page 2</p> <p>payor source changed.</p> <p>During an interview on 02/08/2024 at 3:10 PM, the Nursing Manager (NM) stated care conferences for each resident were held quarterly or sooner, if needed. The NM stated she would call the power of attorney (POA) seven days in advance to set up the care conference. According to the NM, if she could not reach the POA, she would continue trying until she either reached them or sent them an email notification. Per the NM, this communication would be documented in the resident's progress notes.</p> <p>2. A review of Resident #1's "Move In Record," revealed the facility admitted the resident on NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4b1</p> <p>During an interview on 02/08/2024 at 4:30 PM, the responsible party (RP) for Resident #1 stated they had not been notified of a care plan meeting for the last couple of years or received a telephone call to schedule a meeting.</p> <p>During an interview on 02/08/2024 at 4:55 PM, Resident #1 NJ ex order 26.4b1</p> <p>During an interview on 02/08/2024 at 5:22 PM, the Director of Wellness and Executive Director (ED) both confirmed there were no notes of a multidisciplinary care conference for Resident #1 for the past year. The ED stated the best practice would have been to call and document the telephone calls, e-mails, or the use of regular mail for contacting the power of attorney for care</p>	A 755		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER JUNIPER VILLAGE AT WILLIAMSTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 1640 S. BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094
--	---

(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 755	Continued From page 3 meetings.	A 755		



400 Broadacre Dr. #4 Bloomfield, NJ 07003

4/1/24
OK
Ⓟ

Plan of Correction

Facility: Juniper Village at Williamstown

Address: 1640 S. Black Horse Pk. Williamstown, NJ 08094

Administrator: NJ Exec Order 26.4b1 Executive Director

Date of Survey: 02/08/23-02/09/23

COMPLAINT #: ~~NJ14452~~ and NJ155760 +144658

Date Plan Submitted: 03/04/2024

Facility License Number: 35A005

Resident Census: 30

Completed POC Submitted: 03/04/2024

Standards of Licensure for Assisted Living N.J.A.C. 8:36

Prefix Tag ID	Summary Statement of Deficiency	Plan of Correction	Date to Be Corrected By	Date Completed
	This visit was for a complaint survey.			
A755	<p style="text-align: center;">Administration</p> <p>Facility is not in substantial compliance with 8:36-7.3(d) Resident Assessments and Care Plans</p>	<p>1) Corrective action will be accomplished for these residents by contacting the POA and resident to schedule a care conference to review their latest service plan. Our medical concierge will be responsible for contacting the family via phone, email or mail and will document in PCC progress notes on attempts to schedule care conference.</p> <p>2) Other residents have been identified as having the potential to be affected, by reviewing the care conference report in PCC and researching which residents have not had recent care conferences documented and why.</p>	04/04/2024	

		<p>3) Measures put into place to ensure the deficient practice does not occur again include assigning our medical concierge to the task of scheduling care conferences and documenting attempts to reach the POA and/or discussions with the resident. Our new procedure is as follows: The nurse manager will email the medical concierge at the beginning of each month the residents that are due for care conferences, along with suggested dates and times for the meeting. The medical concierge will document the calls, schedule the conference if requested, and inform the nurse manager through a calendar invite in outlook. If a resident or family chooses not to participate in the conference, the medical concierge will let the nurse manager know. The nurse manager will then complete the</p>		
--	--	---	--	--

		<p>multidisciplinary care conference evaluation in PCC when the care conference is declined or completed.</p> <p>4) The facility will monitor the effectiveness of the corrective action by reviewing care conference evaluations that were completed or not completed each month at our QAPI meeting. This monthly meeting continues indefinitely. Our Director of Wellness will monitor documentation in PCC to ensure all care conferences are documented.</p> <p>Responsibility to Correct: NJ Ex Order 26.4b1</p> <p>Responsibility to Maintain: NJ Ex Order 26.4b1</p> <p>Responsibility to Oversee: NJ Ex Order 26.4b1 Executive Director</p>		
--	--	--	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35A005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2024
NAME OF PROVIDER OR SUPPLIER JUNIPER VILLAGE AT WILLIAMSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 1640 S. BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094		
(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)	(X6) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ144652 and NJ155760 CENSUS: 25 SAMPLE SIZE: 6 SURVEY DATE: 02/08/2024 to 02/09/2024</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, based on this Complaint Survey.</p> <p>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 755	<p>8:36-7.3(d) Resident Assessments and Care Plans</p> <p>(d) The resident shall participate in and, if the resident agrees, family members shall be invited to participate in, the development of the resident service plan and health service plans, if plans are needed. Participation shall be documented in the resident's record.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and interviews, the facility failed to ensure the residents and their family members or</p>	A 755		

NJ Exec Order 26.4b1

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

TITLE

(X6) DATE

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 35A005	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/1/2024
NAME OF FACILITY JUNIPER VILLAGE AT WILLIAMSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 1640 S. BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

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 A0755	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:36-7.3(d)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	04/01/2024	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 2/9/2024		<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 		