

NAME OF PROVIDER OR SUPPLIER

YOUNG AT HEART OF EATONTOWN

STREET ADDRESS, CITY, STATE, ZIP CODE

**139 GRANT AVENUE
EATONTOWN, NJ 07724**

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: 558110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/25/2023
NAME OF PROVIDER OR SUPPLIER YOUNG AT HEART OF EATONTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 139 GRANT AVENUE EATONTOWN, NJ 07724		
(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 221	Continued From page 1 Complaint #: NJ00154292 Based on interview, observation, and record review it was determined that the facility failed to ensure an Administrator (ADM) was on the premises during program hours for 18 Participants in attendance on 8/25/23. This deficient practice was evidenced by the following: On 8/25/23 at 10:20 a.m., the surveyor entered the facility and met with the Registered Nurse (RN) who explained the ADM was not currently at the facility. On 8/25/23 at 10:25 a.m., the surveyor interviewed the ADM over the telephone who explained she was out with a participant at an appointment and was on her way back to the facility. On 8/25/23 at 10:30 a.m., the surveyor interviewed the ADM who stated that her position at the facility was the ADM and the Activity Director. In addition, the ADM explained she occasionally went out on appointments with the Participants. On 8/25/23 at 10:40 a.m., the surveyor interviewed the Executive Director (ED) and owner of the facility over the telephone who confirmed the ADM's aforementioned positions. The ED stated that she explained to the ADM on more than one occasion that she had to always be in the facility and could not go out with Participants. On 8/25/23 at 11:00 a.m., the surveyor reviewed the facility staffing schedule titled "Weekly Schedule" dated from 8/7/23 to 8/25/23 and the ADM was listed as the "Act" [Activity] and not the	M 221		

New Jersey Department of Health

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M 221	Continued From page 2 ADM. The staffing schedule did not indicate an ADM was scheduled during program hours. The facility failed to ensure an ADM was always in the facility during program hours.	M 221			

accepted
9/19/23
DA

Young at Heart of Eatontown
139 Grant Avenue
Eatontown, NJ 07724
7323-578-1888

Plan of Correction for Survey of 8/25/23

M221, 8:43F-3.1 (a) Administration:

CORRECTIVE ACTION:

The job description of the administrator was reviewed with the appointed administrator and signed by the administrator and the Executive Director/Owner. The job description includes the responsibility to be available on the premises of the facility during the hours when participant care services are being provided. The Director of Nursing Services has been designated in writing to act in the absence of the administrator. The Director of Nursing Services, acting in the absence of the administrator, shall be available on the premises of the facility during the hours when the participant care services are provided.

IDENTIFICATION OF OTHER CLIENTS AFFECTED BY THIS DEFICIENT PRACTICE:

All clients have the potential to be affected by this deficient practice.

SYSTEMIC CHANGES:

A full time Director of Activities has been hired who is separate and apart from the administrator. The Director of Activities shall be responsible for the direction, provision, and quality of the activities service. The newly hired director of Activities Director fulfills the requirement of Qualifications of activities director under NJAC 8:43-13.2. The Activities Director shall report to the Administrator of the facility. Therefore, the administrator will then fulfill all requirements of 8:43F-3.1 (a). Administration.

QUALITY ASSURANCE:

Monitoring of the attendance and performance of the administrator, including adherence to the responsibilities as delineated in the administrator's job description, shall be the responsibility of the Executive Director who shall report any failures of the administrator to adhere to the responsibility to be available on the premises when participant care services are provided, directly to the Quality Assurance Committee and the Board of Directors.

Monitoring shall occur weekly times 3 months.

Date of completion 9/7/23

x iDae

9/7/23

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 558110	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 8/25/2023
NAME OF FACILITY YOUNG AT HEART OF EATONTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 139 GRANT AVENUE EATONTOWN, NJ 07724	

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 M0221	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43F-3.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/18/2023	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	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/25/2023

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

☐ YES ☐ NO