STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05C001	A. BUILDING: _____ B. WING _____	C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE SENIOR LIVING	85 HARRETON ROAD ALLENDALE, NJ 07401

(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	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00171334, NJ00147345 CENSUS: 91 SAMPLE SIZE: 6 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.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint: NJ00171334

Citation Text for Tag 0310, Regulation 8IL1

Pecci, Christopher

Based on interview and record review it was determined that the Executive Director (ED) failed to ensure the implementation and enforcement of the facility's policy and procedure titled "Incident/Accident Reporting - Senior Living" in regards to the altercation between the Housekeeper and Resident #1 not being reported to an immediate supervisor as soon as practical and the policy and procedure titled, "Abuse Investigation and Reporting" in regards to an incident of alleged and/or suspected case of resident abuse not reported to local law enforcement within 24 hrs for 1 out of 3 sampled residents, Resident #1. This deficient practice was evidenced by the following:

On 2/09/2024 at 7:00 p.m., The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH, which revealed that on [redacted] a member of the facilities Housekeeping staff pushed Resident #1 who then [redacted] to the floor. A Home Health Aide present at the time helped the resident up off the floor and then the Housekeeper punched Resident #1 in the [redacted]

On 2/15/2024 at 9:30 a.m., the surveyor reviewed

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A 310	Continued From page 2	A 310		

the medical record (MR) of Resident #1 which revealed that Resident #1 moved into the facility on [redacted] with diagnoses which included NJ EX Order, 264b1 [redacted] A review of the "Comprehensive Nursing Evaluation" dated 1[redacted] indicates Resident #1 was NJ EX Order, 264b1 A review of the resident's Care Plan dated [redacted] revealed Resident #1 is at a risk for [redacted] and preferred staying in his/her room.

At 10:32 a.m., the surveyor reviewed a document titled, "Police Department Voluntary Statement" which revealed the Director of Nursing (DON) provided a written statement to local police regarding the alleged incident of resident abuse on [redacted].

On 2/16/2024 at 10:10 a.m., the surveyor interviewed the ED who stated she was notified on [redacted] that a Housekeeper sustained an injury to [redacted] or [redacted] The ED further stated she contacted the DON and advised the DON to take statements from employees involved as part of their workman's compensation investigation. The ED stated the DON became aware of the alleged resident abuse while reading a written statement by the HHA on [redacted].

At 10:27 a.m., the HHA stated, we are trained to notify the supervisor when an incident occurs, but everything happened so fast. The HHA also revealed that she did not have her walkie talkie with her in the room at the time of the incident. The HHA further stated since the Certified Medication Aide (CMA) had contacted the supervisor after the incident she didn't believe she needed to also report the altercation between the Housekeeper and Resident #1.

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A 310	Continued From page 3 At 12:10 p.m., The surveyor interviewed the CMA who stated she did not witness the incident. The CMA further stated she only reported that Resident #1 was very [redacted] toward the Housekeeper to the DON, because that's what she was told by the Housekeeper at the time. However, the CMA further stated the HHA later told her that the Housekeeper hit the resident, but she did not report this to the DON, because the HHA had already provided the information in her written statement. At 12:46 p.m., the surveyor interviewed the DON who stated, she was the immediate supervisor for the CMA's and HHA's. The DON further stated the HHA probably thought the CMA was her supervisor instead of reporting the event to her directly. The DON stated she asked the employees to write a statement regarding the incident, but some where not written until [redacted] after the incident occurred. At 11:28 p.m., the surveyor reviewed the policy and procedure titled, "Incident/Accident Reporting - Senior Living" which states: "1. Any accident or incident involving a resident, employee, or visitor must be reported to the immediate supervisor, and completion of the Incident Report via Risk Reporter during the shift the incident occurred. These include any unusual, improper or harmful occurrence to a resident, employee or visitor... 2. Employees witnessing an accident or incident involving a resident, employee or visitor must report such occurrence to his or her immediate supervisor as soon as practical...." The surveyor further reviewed the policy and procedure titled, "Abuse Investigation and	A 310		

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A 310	Continued From page 4 Reporting" which states: "1. All alleged and/or suspected cases of resident abuse, neglect, or financial exploitation will be reported within 24 hours by the facilities Administrator or his/her designee to: ... c. A local law enforcement agency." On 2/21/24, the surveyor did a revisit and verified the facility implemented the removal plan.	A 310		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 16. The right to be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced by: Complaint: NJ00171334 Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure each resident's right to be free from abuse was enforced when 1 of 3 residents reviewed for abuse experienced staff-to-resident abuse, Resident #1. This deficient practice was evidenced by the following:	A 389		

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A 389	Continued From page 5 On 2/09/2024 at 7:00 p.m., The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH, which revealed that on [redacted] a member of the facilities Housekeeping staff pushed Resident #1 who then [redacted] to the floor. A Home Health Aide (HHA) present at the time helped the resident up off the floor and then the Housekeeper punched Resident #1 in the [redacted] On 2/15/2024 at 10:32 a.m., the surveyor reviewed the document titled, "Employee Performance Improvement Notification," a summary investigation by the facility, which revealed, on [redacted], while the HHA was supporting Resident #1 so he/she would not slip on the wet floor, the resident broke free and went towards the Housekeeper, who pushed Resident #1 to the ground hitting [redacted]. The HHA picked the resident off the floor and the Housekeeper started to punch Resident #1 in the [redacted] The HHA urged the Housekeeper to stop and got the resident back towards the bed for safety while the floor was wet for fear that the resident would [redacted] again. The summary conclusion by the facility indicated both the HHA and the Housekeeper were initially suspended pending an investigation on [redacted] The conclusion further stated the HHA had no wrongdoing as they were supporting the resident not to [redacted]. The Housekeeper was terminated on [redacted] and the incident was reported to the local police department. The surveyor also reviewed a document titled, "Police Department Voluntary Statement, " which revealed a police report was filed by the DON on [redacted] at 2:05 p.m. at the local police station.	A 389		

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A 389	Continued From page 6 At 9:30 a.m., the surveyor reviewed the medical record (MR) of Resident #1 which revealed that Resident #1 moved into the facility on [redacted] with diagnoses which included [redacted]. A review of the Comprehensive Nursing Evaluation on [redacted] indicates Resident #1 is alert and forgetful. A review of the resident's Care Plan dated [redacted] revealed Resident #1 is at a risk for [redacted], prefers staying in his/her room. At 12:10 a.m., the Surveyor took a tour of the Memory Unit accompanied by a CMA. The CMA knocked on Resident #1's door and asked permission to enter; however, the resident did not give permission and stated the Surveyor could only enter the apartment if they were from the Bergen County Sherif's Office. On 2/16/2024 at 10:10 a.m., the surveyor interviewed the ED who stated she was notified on [redacted] that a Housekeeper sustained an injury to [redacted] or [redacted]. The ED further stated she contacted the DON and advised the DON to take statements from employees involved as part of their workman's compensation investigation. The ED stated the DON became aware of the alleged resident abuse while reading a written statement by the HHA regarding the incident on [redacted] At 10:27 a.m., the HHA stated she entered Resident #1's room on [redacted] with the Housekeeper to offer support and calm the resident down. The resident was [redacted] towards the Housekeeper to leave the room and the Housekeeper punched the resident in the [redacted] with a [redacted]. The HHA further stated since the Certified Medication Aide (CMA) had contacted the supervisor after the incident, and	A 389		

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A 389	Continued From page 7 she didn't believe she needed to also report the event. The HHA further stated we are taught to notify the supervisor when an incident occurs, but everything happened so fast. The HHA also revealed that she did not have her walkie talkie with her in the room at the time of the incident to call for assistance. At 12:10 p.m., The Surveyor interviewed the CMA who stated she did not witness the altercation between the Housekeeper and Resident #1. The CMA further stated she only reported that Resident #1 was very [redacted] toward the Housekeeper to the DON, because that's what she was told by the Housekeeper at the time. However, the CMA further stated the HHA later told her that the Housekeeper hit the resident, but she did not report this to the DON, because the HHA had already provided the information in her written statement. Surveyor review of the facility policy and procedure titled, "Resident Rights" which states, "...P. "The right to be free from physical and mental abuse and/or neglect." On 2/21/24, the surveyor did a revisit and verified the facility implemented the removal plan.	A 389		
A 735	8:36-7.2(e)(1-5) Resident Assessments and Care Plans (e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following: 1. Orders for treatment or services, medications, and diet, if needed;	A 735		

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A 735	Continued From page 8 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services, if appropriate; 4. The time intervals at which the resident's response to treatment will be reviewed; and 5. The measures to be used to assess the effects of treatment. This REQUIREMENT is not met as evidenced by: Complaint: NJ00171334 Based on interview and record review it was determined that the facility failed to implement the written health service plan (HSP) when a resident, Resident #1 became verbally aggressive for 1 out of 3 residents reviewed, Resident #1. This deficient practice was evidenced by the following: On 2/15/2024 at 9:30 a.m., the Surveyor reviewed the medical record (MR) of Resident #1 which revealed that Resident #1 moved into the facility on [redacted] with diagnoses which included [redacted]. A review of the resident's HSP dated [redacted], revealed Resident #1 was at a risk for [redacted] related to balance issues, preferred staying in his/her room and has the potential to be [redacted].	A 735		

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A 735	Continued From page 9 On 2/15/2024 at 10:32 a.m., the surveyor reviewed the document titled, "Employee Performance Improvement Notification," a summary investigation by the facility, which revealed, on NJ EX Order: 26401 while the HHA was supporting Resident #1 so not to slip on the wet floor, the resident broke free and went towards the Housekeeper, who pushed Resident #1 to the ground hitting his/her [redacted] The HHA picked the resident off the floor and the Housekeeper started to punch Resident #1 in the [redacted]. The HHA urged the Housekeeper to stop and got the resident back towards the bed for safety while the floor was wet for fear that the resident would [redacted] again. On 2/16/2024 at 10:27 a.m., the HHA stated she entered Resident #1's room on [redacted] with the Housekeeper to offer support and calm the resident down. The resident was NJ EX Order: 26401 towards the Housekeeper and asked her to leave the room and the Housekeeper punched the resident in the [redacted] with a [redacted] The facility failed to implement the interventions/tasks in Resident #1's HSP which states, if Resident #1's response is [redacted] "team member to calmly walk away, ask other resident's to leave the area, ensure that the resident and other residents and team members are safe, and immediately report this to the nurse..." On 2/21/24, the surveyor did a revisit and verified the facility implemented the removal plan.	A 735		
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM	H5790		

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H5790	Continued From page 10 A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: Complaint: NJ00171334 Based on interview and record review it was determined that the facility failed to ensure that the policy and procedure that addressed the utilization and completion of a Universal Transfer Form (UTF), was implemented for 1 of 3 residents reviewed, Resident #1. On 2/09/2024 at 7:00 p.m., The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. On 2/15/2024 at 9:30 a.m., the surveyor reviewed the medical record (MR) of Resident #1 which revealed that Resident #1 moved into the facility on [redacted] with diagnoses which included [redacted]. A review of the Comprehensive Nursing Evaluation on [redacted] indicates Resident #1 is [redacted]. A review of the resident's Care Plan dated [redacted] revealed Resident #1 is at a risk for [redacted], prefers staying in his/her room. A	H5790		

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H5790	Continued From page 11 further review of the Progress Notes dated [redacted] reveal Resident #1 was very combative towards staff members, the Director of Nursing (DON) called 911, and the resident was taken to the hospital for evaluation. On 2/16/2024 at 2:52 p.m., the surveyor interviewed the DON who stated she did not have a copy of the UTF for Resident #1's hospital transfer on [redacted] The DON further stated the UTF was sent to the hospital but a copy was not made and put in the chart. Surveyor review of the policy and procedure titled, "New Jersey Universal Transfer Form" states "3. A completed copy of the New Jersey Universal Transfer Form sent with the patient will be maintained as part of the patient's medical record. The facility failed to retain a completed copy of the UTF sheet in Resident #1's MR when the resident was transferred from the facility to the hospital on [redacted].	H5790		

ALLENDALE
SENIOR LIVING

Complaint

State visit February 15th, 16th 21st and 22nd

A310 Administration

1. Identified perpetrator (housekeeper) was suspended pending investigation on [redacted] at 2:45pm. HHA was suspended pending investigation on [redacted] 2:50pm. Upon conclusion of investigation, the perpetrator (housekeeper) was terminated on [redacted] Resident #1 continues to reside at the facility.

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

3. All employees of the facility will be in service on the community's abuse reporting policy and all supervisors to be educated on suspension of any employee alleged in abuse by the Executive Director or designee prior to their next working shift. Education began on 2/16/24 and was completed on 3/25/2024. We will choose 5 random staff interviews which will be conducted weekly by the Executive Director or Designee for 4 weeks, monthly for 3 months, then quarterly to ensure compliance with the abuse reporting policy.

4. The Executive Director or designee will report the findings of the audits to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 4 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the community remains in compliance.

Completion date May 15, 2024

ALLENDALE
SENIOR LIVING

A389 Resident Rights

1. Identified perpetrator (housekeeper) was suspended pending investigation on [redacted] at 2:45pm. HHA did not work after [redacted] and was suspended pending investigation on [redacted] 2:50pm. Upon conclusion of investigation, the perpetrator (housekeeper) was terminated on [redacted] Resident #1 continues to reside at the facility.

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

3. Identified as residents were assessed by an RN on 2/17/2024. Each service plan on psychosocial behavior was reviewed and updated as needed. Education on Abuse, Abuse Reporting, Resident Rights, Behaviors, and de-escalation techniques was started immediately on 2/16/2024 with staff on duty and continued with employees prior to working their next shift. Supervisors will be educated on suspension of any employee alleged in abuse by the Executive Director. Education was completed on 3/25/2024 and will continue quarterly.

4. The Director of Wellness or designee will audit and interview 5 residents to ensure residents are free from abuse. 5 random staff interviews will be conducted weekly by the Executive Director or Designee for 4 weeks, then monthly for 3 months to ensure compliance with the abuse reporting policy. The Executive Director or designee will report the findings of the audits to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 4 months and continue quarterly. Reporting findings to the Quality Assurance and Performance Improvement Committee can modify this plan to ensure the community remains in compliance.

Completion date May 15, 2024

ALLENDALE
SENIOR LIVING

A 735 Resident Assessments and Care Plans

1. Resident was sent out to the hospital on [redacted] for evaluation and seen by [redacted] on [redacted]. RN assessed Resident #1 on [redacted] for [redacted] and [redacted] and a full assessment completed on 2/15/2024. Resident #1's service plan was updated on 2/18/2024 with new interventions to address [redacted] behavior and other identified problems. Resident #1's physician assessed the resident on 2/11/2024 and evaluated on 2/14/2024 by a [redacted] and medication adjustment recommendation was made. The psychiatrist will see the resident monthly. Resident #1 continues to reside at the facility.

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

3. Identified like residents will be randomly audited 1 time per week for 4 weeks to ensure psychosocial behaviors and other identified problems are being addressed and interventions implemented. Then the audit will continue quarterly.

4. Health Service Plans will be audited for residents with documented agitation. The Wellness Director or Designee will conduct a visual audit of residents with documented agitation for 4 weeks, 3 months, then quarterly to ensure that staff are using proper de-escalation techniques during times of agitation. The Executive Director or designee will report the findings of the audits to the Quality Assurance and Performance Improvement Committee to ensure the community remains in compliance.

Completion date May 15, 2024

ALLENDALE
SENIOR LIVING

H5790 Universal Transfer form

1. On 4/12/2024 the Executive Director placed a call to hospital to request a copy of the Universal Transfer Form sent with Resident #1 and it was unable to be obtained. Resident #1 continues to reside in the facility.

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

3. The Wellness Director will complete an audit of residents who had a transfer out in the last 30 days to ensure there is a copy of the completed UTF in their medical records. Then an audit will continue quarterly.

4. The Executive Director/designee will educate the nurses and medication technicians on regulation H5790 – Universal Transfer Form to ensure staff responsible for transfers are keeping a copy of the completed UTF in the resident's medical record.
   The Executive Director/designee will audit resident transfers 1 time per 4 weeks, than quarterly to ensure there is a completed copy available in the resident's chart.

Completion date May 15, 2024.

Kathleen Kelly Malaver, Executive Director

Jennifer Tuttle, Wellness Director