

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 000	Initial Comments Type of Survey: Standard with Complaint Complaint #: NJ 00173073 Census: 11/18/24 was 82 11/19/24 was 83 Sample Size: 9 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 223	8:43F-3.1(b)(1-7) Administration (b) The administrator shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including participant rights; 2. Planning and administering the managerial, operational, fiscal, and reporting components of the facility; 3. Participating in the quality improvement program for participant care and staff performance;	M 223		

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

TITLE

(X6) DATE

12/17/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 223	Continued From page 1 4. Ensuring that all personnel are assigned duties based upon their education, training, competencies, and job descriptions; 5. Ensuring the provision of staff orientation, staff education, and ongoing staff training in accordance with N.J.A.C. 8:43F-6.3; 6. Establishing and maintaining liaison relationships and communication between facility staff and services providers and with participants and their caregivers; and 7. Verifying that each Medicaid-eligible participant is eligible to receive services available at the adult day health services facility prior to the participant's entry into the program. For the purposes of this section, the administrator shall be entitled to rely on any prior authorization performed by the Department for the participant in accordance with N.J.A.C. 8:86. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility's Administrator failed to ensure all annual and ongoing mandatory staff education was completed in accordance with N.J.A.C 8:43F-6.3 for 7 of 15 employee files reviewed: Employees #'s: 2, 3, 5, 7, 9, 10, and	M 223			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 223	Continued From page 2 13. This deficient practice was evidenced by the following: On 11/18/2024 at 11:11 a.m., while conducting a standard survey, the surveyor requested the sampled employee personnel files and their mandatory annual and ongoing mandatory trainings. On 11/19/2024 at 11:10 a.m., the surveyor reviewed the facility provided employee files and mandatory trainings. Upon review of the provided mandatory training sign-in sheet, the surveyor was unable to identify what employees were present during the mandatory training due to the illegible employee signatures. At 1:10 p.m., the surveyor interviewed the facility's Administrator who stated he would provide the surveyor with a document to identify the illegible signatures of the employees on the mandatory trainings. During continued surveyor interview, the Administrator stated that the facility preformed one emergency drill a year and that he would provide the surveyor with the facility's emergency drill sign-in sheets for the last year. At 10:08 p.m., the surveyor received an email from the facility's Administrator that included documents that identified the employee signatures on the mandatory training attendance sign-in sheet. On 11/27/2024 at 10:00 a.m., the surveyor reviewed the mandatory training attendance sign-in sheet which revealed the following: Employee #2 had a Date of Hire (DOH) of NJ Ex Order 28.4(b)(1) and the title of Driver. Surveyor review of the mandatory annual and ongoing training sign-in sheets provided by the facility's	M 223		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 223	Continued From page 3 Administrator revealed Employee #2 did not attend the facility's Emergency Drill training. Employee #3 had a DOH of [NJ Ex Order 26.4(b)(1)] and the title of Social Worker. Surveyor review of the mandatory annual and ongoing training sign-in sheets provided by the facility's Administrator revealed Employee #3 did not attend the facility's Emergency Drill training, nor did Employee #3 attend mandatory annual and ongoing training related to Emergency protocols, Infection control, Abuse, Participant Rights, and Pain. Employee #5 had a DOH of [NJ Ex Order 26.4(b)(1)] and the title of Program Aide. Surveyor review of the mandatory annual and ongoing training sign-in sheets provided by the facility's Administrator revealed Employee #5 did not attend the facility's Emergency Drill training, nor did Employee #5 attend mandatory annual and ongoing training related to Infection Control. Employee #7 had a DOH of [NJ Ex Order 26.4(b)(1)] and the title of Registered Nurse. Surveyor review of the mandatory annual and ongoing training sign-in sheets provided by the facility's Administrator revealed Employee #7 did not attend the facility's Emergency Drill training. Employee #9 had a DOH of [NJ Ex Order 26.4(b)(1)] and the title of Director of Nursing. Surveyor review of the mandatory annual and ongoing training sign-in sheets provided by the facility's Administrator revealed Employee #9 did not attend the facility's Emergency Drill training. Employee #10 had a DOH of [NJ Ex Order 26.4(b)(1)] and the title of Program Aide. Surveyor review of the mandatory annual and ongoing training sign-in sheets provided by the facility's Administrator	M 223			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 223	Continued From page 4 revealed Employee #10 did not attend the facility's Emergency Drill training. Employee #13 had a DOH of NJ Ex Order 26.4(b)(1) and the title of Program Aide. Surveyor review of the mandatory annual and ongoing training sign-in sheets provided by the facility's Administrator revealed Employee #13 did not attend the facility's Emergency Drill training.	M 223		
M 511	8:43F-9.2(b) Pharmaceutical Services Medications shall be accurately administered by properly authorized individuals who shall ensure that the right medication is administered to the right person in the right dose through the right route of administration at the right time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of records and facility documentation, it was determined that the facility failed to ensure that a scheduled medication was administered within the proper timeframe according to the time specified on the Medication Administration Record for █ of 9 Participants, Participant #3. This deficient practice is evidenced by the following: On 11/18/24 at 11:17 a.m., the surveyor observed the facility's Registered Nurse (RN) administer medications to the participants. The surveyor observed the RN administer NJ Ex Order 26.4B1 , a medication	M 511		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 511	Continued From page 5 used to treat <u>NJ Ex Order 26. 4B1</u> tablet by mouth to Participant #3. After the Medication observation was completed, the RN provided the surveyor with a printed document titled "MARS DETAILS", which revealed that the medication was administered to Participant #3 at 11:29 a.m. On 11/19/24 at 10:07 a.m., the surveyor reviewed Participant #3's medical record (MR) which indicated Participant #3 was admitted to the program on <u>NJ Ex Order 26.4(b)(1)</u>, with diagnoses that included <u>NJ Ex Order 26. 4B1</u>. The surveyor reviewed Participant #3's Medication Administration Record (MAR) and observed that the participant's scheduled time for the <u>NJ Ex Order 26. 4B1</u> was at 1:00 p.m. On 11/19/24 at 12:33 p.m., the surveyor interviewed the RN and inquired about Participant #3's medication regimen. The RN confirmed with the surveyor that Participant #3 was scheduled to receive the <u>NJ Ex Order 26. 4B1</u> at 1:00 p.m. Furthermore, the surveyor inquired about the timeframe in which medication must be administered in accordance with regulations to Participant #3. The RN explained that medication should be administered within one hour before or after the medication was scheduled. On 11/19/24 at 12:36 p.m., the Director of Nursing (DON) reviewed Participant #3's electronic record with the surveyor. The DON confirmed with the surveyor that the electronic record for Participant #3's <u>NJ Ex Order 26. 4B1</u> revealed that the medication was scheduled at 1:00 p.m. On 11/19/24 at 11:51 a.m., the surveyor reviewed	M 511		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 511	Continued From page 6 the facility's undated policy titled, "Medications" which revealed, " ...All medications administered must be prescribed, in writing, and can only be dispensed in accordance with all Federal and State laws by authorized nursing personnel after the correct consumer has been identified."	M 511			
M 575	8:43F-11.2(c) Rehabilitation Services If the facility provides physical therapy on-site, physical therapy equipment available to the participants shall include at least parallel bars, stairs, mats, and padded tables. This REQUIREMENT is not met as evidenced by: Based on observations on 11/18/2024, in the presence of facility management, it was determined that the facility failed to provide the minimum Physical Therapy equipment required by regulation for providing these services on-site. The evidence includes the following: During the survey entrance at 9:15 a.m. the surveyor requested that the Administrator (Admin.) provide a copy of the facility lay-out which identifies the various rooms in the facility. Starting at approximately 9:35 AM, a tour of the facility was performed. At approximately 11:05 AM, an inspection of the Physical Therapy room was performed. The surveyor observed inside the room one (1) padded table, two (2) over the bed tables fourteen (14) chairs and two (2) counters. The surveyor observed no evidence of parallel bars, mats and stairs in the room.	M 575			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 575	Continued From page 7 The facility failed to meet the requirements of this regulation by not providing the parallel bars, mats and stairs. The Admin. confirmed the findings at approximately 12:26 PM. The Administrator was in formed of the deficiency at approximately 1:10 PM. during the survey exit. NJAC 8:43 F -11.2 (c)	M 575			
M 577	8:43F-12.1 Social Work Services All social workers shall be licensed or certified by the New Jersey State Board of Social Work Examiners, pursuant to N.J.S.A. 45:15BB-1 et seq. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of pertinent facility documentation provided by the administrator, it was determined that the Administrator hired a social worker (SW) who was not certified or licensed by the State of New Jersey Board of Social Work Examiners (BSWE) as evidenced by the following: On 11/18/24 at 11:15 a.m., the surveyor inquired about the facility Social Worker (SW) from the Administrator and the Administrator stated that SW #1 was NJ Ex Order 26.4(b)(1) and had left for the day and that SW #2 was not available.	M 577			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 577	Continued From page 8 On 11/19/24 at 10:45 a.m., the surveyor again inquired about a SW and the Administrator stated that SW #1 was [REDACTED] and that he did not have [REDACTED] and was not sure when she would return to work. The surveyor then inquired about SW #2. The Administrator stated that SW #2 had [REDACTED] and worked from home and could not recall the last time that SW #2 was at the facility. The Administrator stated that SW #1 was available full time and was also present at the facility from Monday through Friday to meet the social service needs for the participants. The surveyor requested the personnel files of SW #1 and SW #2 for review. SW # personnel file provided by the Administrator revealed that SW #1 was employed at the facility on [REDACTED], had no documented evidence in her personnel file to indicate that she was certified or licensed by the New Jersey State Board of Social Work Examiners (BSWE). Review of SW #2's file revealed that she was a Licensed Social Worker (LSW), licensed by the New Jersey State BSWE. The surveyor attempted to reach SW #1 multiples times via telephone and left a voice message but SW #1 never returned the surveyor's call. At 2:35 p.m., the surveyor interviewed SW #2 via telephone and inquired about her physical presence at the facility and she stated that she had not been at the facility since beginning of [REDACTED] of [REDACTED]. SW #2 explained that she worked from home and averaged 5 hours a week and that SW #1 was a Full-time social worker at the facility. Additionally, SW #2 confirmed that she sometimes reviewed and signed off participants assessment and care plan completed by SW #1.	M 577		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 577	Continued From page 9 SW #2 also confirmed that she was aware that SW #1 was not certified or licensed. SW #2 explained that she was told by the Administrator that SW #1 was in school to obtain her social work license. The survey further interviewed the Administrator who stated that SW #1 was in school studying to be a social worker and worked with SW #2 who was licensed in completing all the required social work needs of the program. The Administrator provided the surveyor with SW #1's school transcript which showed that she was still in school. The surveyor reviewed the "Social Worker Job Description" provided by the Administration, signed by the un-licensed SW and the Administrator, which indicated under, F. Qualifications, "Must have a CSW [Certified SW] or LSW [Licensed SW]. The facility failed to provide a licensed or certified social worker to provide services to participants as required by the regulation. Refere to 8:43F-12.2(c) (M0583)	M 577			
M 583	8:43F-12.2(c) Social Work Services A social worker shall provide social work services in the facility for at least 30 minutes per week per participant equivalent, calculated on the basis of the daily census.	M 583			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 583	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide the minimum required Social Worker (SW) hours of 30 minutes per participant per week. The facility employed a LSW who provided only 5 hours per week. This deficient practice was evidenced by the following: On 11/18/24 during interview with the facility Administrator, the surveyor asked for the facility Social Worker (SW). The Administrator stated that the SW #1 who was not qualified and licensed was not feeling well and had gone home for the day. On 11/19/24, the surveyor inquired about the SW again and the Administrator stated that the SW was still sick. The surveyor then inquired about the second SW and the Administrator stated that the second SW just had a baby and worked from home and could not recall the last time SW #2 was at the facility. The surveyor reviewed the personnel files of SW #1 and SW #2, provided by the Administrator which revealed that SW #1 had no documented evidence in her personnel file to indicate that she was certified or licensed by the New Jersey State Board of Social Work Examiners (BSWE). Review of SW #2's file revealed that she was a Licensed Social Worker (LSW), licensed by the New Jersey State BSWE. At 2:35 p.m., the surveyor interviewed the LSW via telephone and inquired about her physical	M 583			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 583	Continued From page 11 presence at the facility and she stated that she had not been at the facility since beginning of [REDACTED] of [REDACTED]. The LSW explained that she worked from home and averaged 5 hours a week. The surveyor requested the facility's daily census and the LSW's work hours for the month of [REDACTED] through [REDACTED] for review and the Administrator stated that the LSW was salaried and there was no punch card for the LSW. The surveyor reviewed the staffing schedule from [REDACTED] through [REDACTED] which indicated that the LSW worked full time from 8 a.m. - 4 p.m. However, on 11/19/24, during interview with the LSW, she stated that her averaged hours per week was 5 hours. Additionally, the Administrator only provided the surveyor with [REDACTED] through [REDACTED] facility's daily census. Review of the "daily census" records for revealed that the SW did not meet the required social work hours based on the Average Daily Census (ADC) as follows: 1. The week of 10/1/24, the ADC was 94 participants and the SW hours required was 47, however, the SW hours provided was [REDACTED] hours, a difference of [REDACTED] SW's hours short. 2. The week of 10/7/24, the ADC was 92 participants and the SW hours required was 46, however, the SW hours provided was [REDACTED] hours, a difference of [REDACTED] SW's hours short. 3. The week of 10/14/24, the ADC was 90 participants and the SW's hours required was 45, however, the SW hours provided was [REDACTED] hours, a difference of [REDACTED] hours short.	M 583		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 583	Continued From page 12 4. The week of 10/21/24, the ADC was 98 participants and the SW's hours required was 46, however, the SW hours provided was 44 hours, a difference of 2 hours short. 5. The week of 10/28/24, the ADC was 89 participants and the SW's hours required was 44, however, the SW hours provided was 42 hours, a difference of 2 hours short. 6. The week of 11/4/24, the ADC was 89 participants and the SW's hours required was 44, however, the SW hours provided was 42 hours, a difference of 2 hours short. 7. The week of 11/11/24, the ADC was 90 participants and the SW's hours required was 45, however, the SW hours provided was 43 hours, a difference of 2 hours short. 8. The week of 11/18/24, the ADC was 83 participants and the SW's hours required was 42, however, the SW hours provided was 40 hours, a difference of 2 hours short. Refer to 8:43F-12.1 (M0577)	M 583			
M 651	8:43F-14.10(a)(1)(i) Physical Plant Requirements (a) Each adult facility shall provide a quiet room or a separate, quiet area for participants who wish to rest or recline. The quiet room/area shall not be counted as activity or dining space. 1. The facility shall provide at least one item of comfortable furniture, such as a bed, lounge, recliner, or equivalent, selected in accordance with assessments of participants'	M 651			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 651	Continued From page 13 needs to rest or recline, for every 10 adult day health services participant equivalents, calculated on the basis of the licensed capacity. This comfortable furniture shall be available for use in the quiet room/area. i. A minimum of 40 square feet shall be provided for each bed, lounge, recliner, or equivalent. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided pertinent documentation on 11/18/2024 in the presence of facility management, it was determined that the facility failed 1) To ensure the approved space for quiet rooms/areas was not counted as activity space and failed to ensure a minimum of 40 square feet was provided for each recliner, 2) To provide the required one (1) recliner/ comfortable furniture for every ten (10)Participants, as evidenced by: During the entrance conference at approximately 9:15 AM, the surveyor made a request to the Administrator (Admin.) to provide a copy of the facility lay out which identifies the various rooms in the facility. A review of the facility provided lay-out identified	M 651			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 651	Continued From page 14 the facility had four (4) quiet rooms/ areas that participants could use to rest or recline. Starting at approximately 9:15 AM, a tour of the facility was conducted. During the tour the surveyor observed the following, 1) The 1st. quiet room had 2 recliners. The surveyor measured and recorded the room to be 10 feet by 8 feet which is 80 square feet. 2) The 2nd. quiet room had 2 recliners. The surveyor measured and recorded the room to be 10 feet by 8 feet which is 80 square feet. 3) The 3rd. quiet room had had a scale for weighing 3 computers, 3 chairs and 2 tables. there were no recliners or comfortable furniture for Participants to rest. The surveyor measured and recorded the room to be 10 feet by 13 feet which is 130 square feet. 4) The 4th. quiet room/ area identified on the facility provided lay-out is adjacent to the TV room. There was no separation between the 4th. quiet room/ area and TV area. There was a flat screen television mounted on the wall across from the recliners. The television was on the day of survey. There were 2 recliners in the open area with one Participant was observed sitting one recliner NJ Ex Order 26.4(b)(1) The facility failed to provide the nine (9) recliners/ comfortable furniture for the 90 Licensed Participant slots. The facility failed to provide the required 40 square feet per recliner which is 360 square feet. The Admin. confirmed the findings.	M 651		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 651	Continued From page 15 The Administrator was in formed of the deficiency at approximately 1:10 PM. during the survey exit. NJAC 8:43F -14.10 (a).	M 651			
M 691	8:43F-14.17(h) Physical Plant Requirements Fire extinguishers shall be examined annually and maintained in accordance with manufacturers' and National Fire Protection Association (NFPA) requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observation on 11/18/2024 in the presence of facility management, it was determined that the facility failed, 1) To provide one (1) fire extinguisher on a company vehicle used for the transportation of Participants, 2) To perform and document a monthly examination for 1 of 11 fire extinguishers observed and inspected, as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads,	M 691			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 691	Continued From page 16 - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following: On 11/18/2024 during the survey entrance at approximately 9:15 AM, a request was made to the Administrator (Admin.) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked if the facility had a Contracted Service or Facility Vehicles to transport the Participants. The Admin. told the surveyor that there are Facility Vehicles for transportation of the Participants. Starting at approximately 9:31 AM a tour of the building was conducted. Along the tour, the surveyor observed and inspected eleven (11) portable fire extinguishers in various locations with the following results, 1) At approximately 11:30 AM, the surveyor observed on Facility Van #7, license plate NJ Ex Order 26, 4B1, no evidence of a fire extinguisher on	M 691			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 691	Continued From page 17 the 14 Participant seats vehicle. 2) At approximately 11:35 AM, the surveyor observed on Facility Bus #1, license plate [NJ Ex Order 26. 4B1], one (1) ABC type fire extinguisher last annually inspected July 2024. There was no evidence of monthly visual examinations be performed and documented on the tag attached to the extinguisher for August, September and October [NJ Ex Order 26. 4B1]. The Administrator was in formed of the deficiency at approximately 1:10 PM. during the survey exit. NFPA 10 NJAC 8:43F -14.17 (h).	M 691		
M 799	8:43F-16.3(b) Infection Control, Santation, Housekeeping The facility shall develop and implement policies and procedures to ensure that all volunteers and students who have direct participant care responsibilities on a routine basis provide documentation that they have received, at a minimum, a Mantoux tuberculin skin test and either a physical examination or a certification of health status from a physician, advanced practice nurse or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to provide documented evidence of [NJ Ex Order 26. 4B1] testing ([NJ Ex Order 26. 4B1] [NJ Ex Order 26. 4B1]) or completed [NJ Ex Order 26. 4B1] questionnaires annually for all 4 out of 15 employees health files reviewed, Employee	M 799		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 799	Continued From page 18 #'s: 1, 6, 12, and 13. This deficient practice was evidenced by the following: On 11/18/2024 at 11:11 a.m., while conducting a standard survey, the surveyor requested the sampled employee personnel files, including their health files from the facility's Administrator. At 1:15 p.m., the surveyor reviewed the sampled employee health files that revealed the following: Employee #1 had a NJ Ex Order 26. 4B1 and the title of Program Aide. Surveyor review of Employee #1's health file revealed that Employee #1 did not have an up-to-date NJ Ex Order 26. 4B1 questionnaire completed. During continued surveyor review of Employee #1's personnel health file revealed that Employee's last test for NJ Ex G was completed on 2/17/2022, the result was NJ Ex Order 26. 4B1. Employee #6 had a NJ Ex Order 26. 4B1 and the title of Director of Activities. Surveyor review of Employee #6's health file revealed that Employee #6 did not have an up-to-date NJ Ex G questionnaire completed. During continued surveyor review of Employee #6's personnel health file revealed that Employee #6's last test for NJ Ex G was completed on 2/7/2020, which yielded a NJ Ex Order 26. 4B1. Employee #12 had a NJ Ex Order 26. 4B1 and the title of Program Aide. Surveyor review of Employee #12's health file revealed that Employee #12 did not have an up-to-date NJ Ex G questionnaire completed. During continued surveyor review of Employee #12's personnel health file revealed that the employees last test for NJ Ex G was completed on 11/15/2023, which yielded a NJ Ex Order 26. 4B1.	M 799		

If continuation sheet 20 of 24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 805	Continued From page 20 Based on observation and interview on 11/18/2024, in the presence of facility management, it was determined that the facility failed to maintain 1 of 3 battery back-up emergency lights and 4 of 5 battery back up illuminated exit signs/ emergency lights in proper working condition when tested. This was evidenced by the following: During the entrance conference at approximately 9:15 AM,, the surveyor interviewed the Administrator (Admin.) and asked if the facility have an emergency generator or if the facility have battery back-up systems for the Illuminated Exit Signs, Emergency Lights, and Fire Alarm panel. The Admin. told the surveyor that there was no generator and that they have battery back-up systems. Starting at approximately 9:31 AM, a tour of the facility was conducted. During the tour the surveyor observed the following battery back up systems that did not function properly in the following locations, 1. At approximately 10:30 AM, one combination battery back up emergency light/ illuminated exit sign across from the reception desk when tested did not function properly. 2. At approximately 10:35 AM, one combination battery back up emergency light/ illuminated exit sign to the left of the large TV in the living room area when tested did not function properly. 3. At approximately 12:26 PM, one combination battery back up emergency light/ illuminated exit sign inside the service corridor (next to the kitchen) when tested did not function properly.	M 805		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 805	Continued From page 21 4. At approximately 12:27 PM, one battery back up emergency light inside the service corridor (next to the kitchen) when tested did not function properly. 5. At approximately 12:36 pm, one combination battery back up emergency light/ illuminated exit sign in the corridor leading to the side entrance door (near the Physical Therapy room) when tested did not function properly.. The Admin. confirmed the findings at the times of observations. The Administrator was informed of the deficiency at approximately 1:10 PM. during the survey exit. Participant Safety Hazard. NJAC 8:43 F -16.5	M 805			
M 815	8:43F-16.7(a)(24) Infection Control, Sanitation, Housekeeping (a) The following housekeeping, sanitation, and safety conditions shall be met: 24. The temperature of the hot water used for bathing and handwashing shall not exceed 120 degrees Fahrenheit. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/18/2024 in the presence of facility	M 815			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 815	Continued From page 22 management, it was determined that the facility failed to ensure that the temperature of the hot water used for hand washing did not exceed 120 degrees Fahrenheit (dF) for one (1) of five (5) sinks tested. This failure placed all participants and staff at risk for potential harm/burns. This deficient practice was evidenced by the following: During the entrance conference at approximately 9:15 AM, the Surveyor #1 made a request to the Administrator (Admin) and asked if the facility monitored the Domestic Hot Water (DHW) and what was the temperature range. The Admin stated, he was not sure about the temperature of the hot water. During the tour of the building, the Surveyor #1 observed and recorded the DHW temperatures in five (5) Participant bathrooms with following: 1. At approximately 9:59 AM, in the Participant bathroom #7, the Surveyor #1 recorded the DHW in the hand washing sink with the Surveyor #1 digital thermometer at 138 dF. At this time the Surveyor #1 made a request the Administrator to obtain a facility thermometer and asked Surveyor #2 to accompany Surveyor #1 and Administrator back to participant bathroom #7. 2. At approximately 10:06 AM Surveyor observed and recorded the following DHW temperatures in Participant bathroom #7 sink, - Surveyor #1 digital thermometer 143.3 PDF. - Surveyor #2 digital thermometer 142.7 dF. - Facility dial thermometer 109 dF. At this time Surveyor #1 asked the Administrator when was the last time the dial thermometer was	M 815		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2024
NAME OF PROVIDER OR SUPPLIER AMBASSADOR MEDICAL DAY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701		
(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 815	Continued From page 23 calibrated. The Administrator said, he did not know. Surveyor #1 made a request to the Administrator to lower the temperature of the hot water. The Administrator told the surveyor that he would lock the door to Participant bathroom #7 and call a plumber. The Administrator locked the door and put a sign up , do not use. The Admin. confirmed the findings at approximately 10:06 AM. The Administrator was in formed of the deficiency at approximately 1:10 PM. during the survey exit. Participant Safety Hazard. NJAC 8:43 F -16.7 (a) 24.	M 815			



AMBASSADOR

Adult Medical Day Care Center

619 River Avenue
Lakewood NJ 08701
732-367-1133

POC #3
received 1/7/25
Accepted

M223 (8:43-3.1(b)(1-7) Administration

1. Identified employees (#2, #3, #5, #7, #9, #10, #13) with incomplete mandatory education started mandatory in-services on 11/25/2024 and completed all required In-services on 12/11/2024. Documentation of completion is maintained in the Inservice file. The Administrator has also completed a Master Signature Sheet for employees, in case of illegible signatures.
2. All participants have the potential of being affected by the lack of Employee Fire Drills.
3. The Administrator implemented a staff education tracking system to monitor completion of all mandatory initial, annual and ongoing education. The tracking system will include alerts for due dates and deadlines.
4. The Administrator will conduct a quarterly review of the staff in-services to ensure compliance. Results of the reviews will be discussed during the monthly quality assurance meeting. The Administrator will also ascertain that all new employees are added to the Master Signature List.

Completion Date: 12/11/2024

Accepted 1/7/25



AMBASSADOR

Adult Medical Day Care Center

619 River Avenue
Lakewood NJ 08701
732-367-1133

M511 8:43F-9.2(b) Pharmaceutical Services

1. On 11/20/2024 the medication administration record (MAR) was reviewed and completed. The affected floor Registered Nurse (RN) was educated and in-service on policies and procedures related to medication administration including medication administration to participant #3 according to physician orders.
2. All participants that are administered medications in the center have the potential of being affected by untimely medication administration.
3. The Director of Nursing (DON) will implement monthly training to Floor RNs on timely medication administration and accurate MAR documentation.
4. DON will perform daily audits of MARs for the next three months to ensure compliance. Findings will be reviewed during the monthly QA meeting. After three months (if MARS are documented correctly), monthly audits of MARS will be audited by the DON. All documentation will be reviewed by the Administrator.

Completion Date: 11/20/2024

Accepted 1/7/25



AMBASSADOR

Adult Medical Day Care Center

619 River Avenue
Lakewood NJ 08701
732-367-1133

M575 (8:43-11.2(c) Rehabilitation Services

1. Therapy purchased the required rehabilitation equipment, parallel bars, stairs, and mats. These items are available for immediate use by all participants requiring rehabilitation services.
2. All participants receiving therapy services have a potential of being affected by the lack of equipment.
3. The Administrator implemented a procurement review system to ensure that all required rehabilitation equipment is available and maintained. A checklist of required items will be reviewed monthly by the Director of Therapy.
4. The Director of Therapy will conduct monthly audits for the next three months to confirm the availability and condition of all the required equipment. Results will be presented at the Quality Assurance meeting, with ongoing monitoring conducted quarterly thereafter.

Completion Date: 11/20/2024

Accepted 1/7/25



AMBASSADOR

Adult Medical Day Care Center

619 River Avenue
Lakewood NJ 08701
732-367-1133

M577 8:43F-12.1 Social Work Services

1. As of 11/20/2024 a licensed Social Worker, certified by the New Jersey Board of Social Work Examiners is employed in-person by the facility and is scheduled to work 7 hours a week.
2. All participants have the potential of being affected by a lack of Social Work hours.
3. The Administrator has updated the hiring policy to include mandatory verification of licensure and certification through the New Jersey Board of Social Work Examiners prior to hiring social work staff. Documentation of credentials will be retained in employee files.
4. The Administrator will maintain a licensure tracking system to ensure all licensed staff hold active certifications. Additionally, an annual audit of all staff licenses will be conducted to ensure ongoing compliance with state regulations.

Completion Date: 11/20/2024

Accepted 1/1/25



AMBASSADOR

Adult Medical Day Care Center

619 River Avenue
Lakewood NJ 08701
732-367-1133

M583 8:43F-12.2(c) Social Work Services

1. As of November 20, 2024, the Administrator began actively interviewing qualified candidates for a second social worker position to meet the required social worker hours in accordance with the census ratio. Scheduling adjustments will ensure that all participants receive the mandated hours of service.
2. All participants have the potential of being affected by a lack of Social Worker hours.
3. The Administrator established a system to calculate the required social work hours based on census and ensure adequate staffing is scheduled to meet these requirements. The Administrator will oversee social work scheduling, ensuring compliance with regulations.
4. The Administrator will review social work schedules bi-monthly to verify compliance with service requirements. This will be documented in the two-week staffing schedule. Findings will be discussed at monthly quality assurance meetings, and any issues identified will be addressed promptly.

Completion Date: 1/15/2025

Accepted 1/7/25



AMBASSADOR

Adult Medical Day Care Center

619 River Avenue
Lakewood NJ 08701
732-367-1133

M651 8:43-14.10(a)(1)(i) Physical Plant Requirements

1. An office space adjacent to one of the quiet rooms, approximately 115 ft², has been converted into a designated quiet room. Additionally, each of the nine recliners or comfortable furniture pieces provides a minimum of 40 ft² of space, ensuring compliance with the required physical space standards for all affected participants.
2. All participants have the potential to be affected if not enough comfortable furniture is available.
3. The Administrator developed a space assessment protocol to ensure that all new furniture and room layouts are evaluated for compliance with space requirements before being implemented. This protocol will be part of the facility's regular planning process for physical plant adjustments.
4. Administrator will assign a staff member to perform quarterly audits of all recliners and/or comfortable furniture and quiet room spaces to ensure compliance with the 40' requirement. Results will be tracked and reviewed by the Administrator, and any necessary adjustments will be made immediately to maintain compliance.

Completion Date: 11/20/2024

Accepted 1/1/25



AMBASSADOR

Adult Medical Day Care Center

619 River Avenue
Lakewood NJ 08701
732-367-1133

M691 (8:43-14.17(h) Physical Plant Requirements

1. The Administrator has ensured that a fire extinguisher is now placed in every company vehicle used for participant transportation. Additionally, un-inspected fire extinguisher has been properly documented.
2. All participants have the potential of being affected by a lack of properly inspected fire extinguishers in the company vehicles.
3. The Administrator implemented a monthly driver check for fire extinguisher inspections in each vehicle. The Transportation Coordinator will be responsible for verifying the presence of fire extinguishers and ensuring inspections are documented.
4. The Transportation Coordinator will conduct quarterly audits to ensure that all company vehicles are equipped with fire extinguishers and that inspections are being performed and documented as required. Any discrepancies will be addressed to the Administrator.

Completion Date: 11/20/2024

Accepted 1/7/25



AMBASSADOR

Adult Medical Day Care Center

619 River Avenue
Lakewood NJ 08701
732-367-1133

M799 8:43F-16.3(b) Infection, Control, Sanitation, Housekeeping

1. All affected staff members completed the tuberculosis questionnaires on 11/26/2024. The documentation is updated and maintained for all relevant personnel.
2. All participants have a potential of being affected by a lack of employee tuberculosis screening.
3. The Administrator implemented a tracking system to ensure that the annual tuberculosis questionnaires are completed for all staff. The system will include reminders and verification processes to ensure compliance.
4. The Administrator will conduct quarterly audits to verify that all staff have completed the required tuberculosis questionnaires. The results will be reviewed at the facility's monthly infection control meeting to ensure ongoing compliance.

Completion Date: 11/26/2024

Accepted 1/1/25



AMBASSADOR

Adult Medical Day Care Center

619 River Avenue
Lakewood NJ 08701
732-367-1133

M805 8:43F-16.5(a)(b)(c) Infection, Control, Sanitation, Housekeeping

1. All the non-functioning battery pack emergency light and illuminated exit sign have been repaired or replaced, ensuring that all affected areas are now fully operational and compliant with safety standards.
2. All participants have the potential of being affected by a non-functioning emergency light.
3. A preventive maintenance program has been implemented to ensure all emergency lighting and exit signs are inspected and tested monthly by the housekeeper. This will include a process for immediate reporting to the Administrator and resolution of any issues that arise.
4. The Administrator will designate the housekeeper to maintain a log of all inspections and repairs, which will be reviewed quarterly to ensure ongoing compliance. Any failures or maintenance delays will be addressed in real-time to prevent recurrence.

Completion Date: 11/20/2024

Accepted 1/1/25



AMBASSADOR

Adult Medical Day Care Center

619 River Avenue
Lakewood NJ 08701
732-367-1133

M815 8:43F-16.7(a)(24) Infection Control, Sanitation, Housekeeping

1. The plumbing issue is corrected, and thermostatic mixing valve (TMV) are applied to all facility boilers. This ensures the hot water temperature does not exceed 120°F, eliminating the risk to participants and staff.
2. All participants have a potential of being affected by water temperatures that exceed 120 degrees.
3. A daily monitoring system is implemented, where the housekeeping staff records the hot water temperature of all sinks in the facility. If any temperatures exceed the 120°F threshold, corrective actions are taken immediately.
4. The housekeeper will track the daily logs of water temperatures, reviewing them weekly to ensure compliance. The Administrator will be responsible for addressing any discrepancies, with follow-up actions and corrective measures taken promptly.

Completion Date: 11/20/2024

Accepted 1/7/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 080187	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/13/2025
NAME OF FACILITY AMBASSADOR MEDICAL DAY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 619 RIVER AVENUE LAKEWOOD, NJ 08701	

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 M0223	Correction	ID Prefix M0511	Correction	ID Prefix M0575	Correction
Reg. # 8:43F-3.1(b)(1-7)	Completed	Reg. # 8:43F-9.2(b)	Completed	Reg. # 8:43F-11.2(c)	Completed
LSC	01/07/2025	LSC	01/07/2025	LSC	01/07/2025
ID Prefix M0577	Correction	ID Prefix M0583	Correction	ID Prefix M0651	Correction
Reg. # 8:43F-12.1	Completed	Reg. # 8:43F-12.2(c)	Completed	Reg. # 8:43F-14.10(a)(1)(i)	Completed
LSC	01/07/2025	LSC	01/07/2025	LSC	01/07/2025
ID Prefix M0691	Correction	ID Prefix M0799	Correction	ID Prefix M0805	Correction
Reg. # 8:43F-14.17(h)	Completed	Reg. # 8:43F-16.3(b)	Completed	Reg. # 8:43F-16.5(a)(b)(c)	Completed
LSC	01/07/2025	LSC	01/07/2025	LSC	01/07/2025
ID Prefix M0815	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43F-16.7(a)(24)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/07/2025	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 11/19/2024		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			