

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>80A110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/14/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MARTIN AND EDITH STEIN ASSISTED LIVING RESIDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>350 DEMOTT LANE SOMERSET, NJ 08873</b>
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A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00172619</p> <p>CENSUS: 72</p> <p>SAMPLE SIZE: 3</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A 563	<p>8:36-5.10(a)(2) General Requirements</p> <p>(a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following:</p> <p>2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, any elopements; and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and</p>	A 563		

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

TITLE

(X6) DATE

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A 563	<p>Continued From page 1</p> <p>extent of damages;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172619</p> <p>Based on interview, and record review it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) within the required timeframe that a resident <small>NJ Ex Order 26.4b1</small> for 1 of 3 residents reviewed, Resident #2. This deficient practice is evidenced by the following:</p> <p>On 4/9/2024, the surveyor reviewed Resident #2's medical record and observed a move in date of <small>NJ ex order 26.4b1</small> with diagnoses which included <b>NJ ex order 26.4b1</b></p> <p>The surveyor reviewed the Facility Reportable Event Record (FRE) which indicated that the facility did not report the event of Resident #2's <b>NJ ex order 26.4b1</b>.</p> <p>On 4/11/2024 at 2:50 p.m., the surveyor interviewed the facility's Executive Director who acknowledged that the facility failed to report in a timely manner to the NJDOH.</p>	A 563		
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A 563	<p>Continued From page 2</p> <p>On <span style="background-color: black; color: black;">NJ ex order 26.4b1</span> the surveyor reviewed the facility's policy titled, "Reportable Events" effective 1/6/2020, revised on 4/11/2021, which indicated: "Policy: ... Assisted Living Program shall notify the Department of Health and Senior Services immediately by telephone ... after business hours, followed within 72 hours by written confirmation, of the following: ...5. Any deaths or accidents related to the program's services or activities ... 7. All deaths among residents resulting from accidents in the assisted living residence ..."</p> <p>On 5/14/2024 a revisit survey was conducted to confirm the implementation of the removal plan. The surveyor reviewed policies, pertinent documents and trainings that were conducted by the facility. The facility's removal plan was implemented.</p>	A 563		
A 735	<p>8:36-7.2(e)(1-5) Resident Assessments and Care Plans</p> <p>(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:</p> <ol style="list-style-type: none"> <li>1. Orders for treatment or services, medications, and diet, if needed;</li> <li>2. The resident's needs and preferences for himself or herself;</li> <li>3. The specific goals of treatment or services, if appropriate;</li> <li>4. The time intervals at which the resident's</li> </ol>	A 735		

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A 735	<p>Continued From page 3</p> <p>response to treatment will be reviewed; and</p> <p>5. The measures to be used to assess the effects of treatment.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172619</p> <p>Based on interview and record review, it was determined that the facility failed to develop and implement a written health service plan (HSP) for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 4/9/2024, the surveyor reviewed Resident #2's medical record (MR) which revealed that Resident #2 moved into the facility on [redacted] with diagnoses which [redacted] NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1.</p> <p>At 11:45 a.m., the surveyor reviewed Resident #2's Progress Notes (PN) dated [redacted] which indicated that the resident was started on [redacted] NJ ex order 26.4b1 [redacted]. The facility failed to develop a HSP for Resident #2 when he/she [redacted] NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1.</p> <p>Continued surveyor review of Resident #2's PN indicated that on [redacted] Resident #2 [redacted] NJ ex order 26.4b1 [redacted]. The facility failed to develop a HSP for Resident #2</p>	A 735		

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A 735	<p>Continued From page 4</p> <p><b>NJ ex order 26.4b1</b></p> <p>[REDACTED]</p> <p>On 4/11/2024 at 2:50 p.m., the surveyor interviewed the facility's Executive Director, who confirmed that there was not a HSP for Resident #2 when he/she <b>NJ ex order 26.4b1</b> <b>NJ ex order 26.4b1</b></p> <p>The surveyor reviewed a facility policy titled "Nursing Services", dated 2/16/2022, which indicated: "Procedure: 1. All residents who have a Service Plan will have their general service needs assessed at least semi-annually or more often if needed. Residents with Health Service Plans (HSP) will have the HSP evaluated at least quarterly... 4. The registered nurse shall assess the resident's need for referral to physician or community agencies, as appropriate."</p> <p>The facility failed to develop a HSP for Resident #2 when he/she <b>NJ ex order 26.4b1</b></p> <p>[REDACTED]</p>	A 735		
A 745	<p>8:36-7.2(f) Resident Assessments and Care Plans</p> <p>(f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice.</p>	A 745		

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A 745	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172619</p> <p>Based on interview and record review it was determined that the facility failed to ensure that the Registered Nurse (RN) assessed a resident when there was a change in condition for 1 of 3 residents reviewed, Resident #2. The deficient practice was evidenced by the following:</p> <p>The surveyor reviewed the medical record for Resident #2, who moved into the facility on [redacted] with diagnoses which included <b>NJ ex order 26.4b1</b>.</p> <p>On 4/9/2024, the surveyor reviewed Resident #2's facility Progress Notes (PNs) which indicated that on [redacted], the Licensed Practical Nurse (LPN) <b>NJ ex order 26.4b1</b> (used to <b>NJ ex order 26.4b1</b>). The LPN <b>NJ ex order 26.4b1</b> two RN's.</p> <p>At 2:25 p.m., the surveyor interviewed the acting Director of Nursing (DON), who stated that she was on the phone when the LPN came into the office to notify Resident #2's Nurse Practitioner (NP). The DON <b>NJ ex order 26.4b1</b> Resident #2.</p> <p>At 2:40 p.m., the surveyor interviewed the RN Supervisor who stated that she did not assess Resident #2 after the LPN <b>NJ ex order 26.4b1</b>, stated that she instructed the LPN to notify the NP, who was present at the facility during the incident. The RN</p>	A 745		

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A 745	<p>Continued From page 6</p> <p>Supervisor indicated that she believed it was the responsibility of the NP to assess Resident #2.</p> <p>Upon surveyor review of the RN supervisors signed job description, dated [redacted], it was indicated that the responsibilities of the RN supervisor included: "Notify ADON/DON of residents' change in status and notify physician and family of changes at the direction of the DON [Director of Nursing] ...Assist in the development and maintenance of Resident Assessment, Health Service Plans, General Service Plans, and any/all interdisciplinary documentation. Give verbal and written reports of Residents' condition to the ADON/DON ..."</p> <p>Surveyor review of the Acting DON's signed job description dated [redacted], it was indicated that the responsibilities of the Acting DON included: "...performs and documents resident assessments ... provides oversight of the community medication management program to promote resident safety in the medication use process."</p> <p>The surveyor reviewed the facility policy titled, "Charting and Documentation" dated 3/20/2024, which revealed: "Policy Interpretation and Implementation 1. All observations, medications administrations, services performed, etc., must be documented in the resident's clinical record... 3. All incidents, accidents, or changes in the resident's condition must be recorded.. 6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care;</p>	A 745		

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A 745	<p>Continued From page 7</p> <p>c. The assessment data and/or any unusual findings obtained during the procedure/ treatment;</p> <p>d. How the resident tolerated the procedure/treatment;</p> <p>e. Whether the resident refused the procedure/treatment;</p> <p>f. Notification of family, physician or other staff, if indicated; The signature and title of the individual documenting..."</p> <p>On 5/14/2024 a revisit survey was conducted to confirm the implementation of the removal plan. The surveyor reviewed policies, pertinent documents and trainings that were conducted by the facility. The facility's removal plan was implemented.</p>	A 745		
A 771	<p>8:36-7.4(c)(4) Resident Assessments and Care Plans</p> <p>(c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following:</p> <p>4. Assessment of the resident's need for referral to a physician, advanced practice nurse or physician assistant, or community agencies as appropriate;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172619</p> <p>Based on interview and record review, it was determined that the facility's Registered Nurse (RN) failed to assess a resident in order to</p>	A 771		

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A 771	<p>Continued From page 8</p> <p>appropriately refer the resident to a physician for 1 of 3 residents reviewed, Resident #2. The deficient practice was evidenced by the following:</p> <p>On 4/9/2024 the surveyor reviewed Resident #2 medical record (MR) which revealed the resident moved into the facility on [redacted] with diagnoses which included [redacted] and [redacted].</p> <p>Continued surveyor review of Resident #2's MR revealed Progress Notes (PN) which contained a late entry dated for [redacted]. The entry was written by a facility Licensed Practical Nurse (LPN) who indicated that around 1 p.m. on [redacted] she went to Resident #2's room to give a prescribed medication to the resident and noted [redacted] on Resident #2's nightstand. Continuation of the PN revealed that the LPN took the [redacted] and went to notify the Registered Nurse (RN) supervisor. The note indicated that the LPN was directed by the RN supervisor to notify Resident #2's Advanced Practice Nurse (APN), who was in the facility at the time.</p> <p>At 2:40 p.m., the surveyor interviewed the RN supervisor who stated that she did not assess the resident for nursing needs and/or medical interventions when the LPN reported finding the [redacted] in Resident #2's room.</p> <p>Continued surveyor review of Resident #2's PN indicated that Resident # [redacted] and [redacted] around 7 p.m. at which time [redacted]. Resident #2 [redacted].</p>	A 771		

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A 771	<p>Continued From page 9</p> <p>The surveyor reviewed a facility policy titled, "Nursing Services" dated 2/16/2022, which indicated: "Procedure: 1. All residents who have a Service Plan will have their general service needs assessed at least semi-annually or more often if needed. Residents with Health Service Plans (HSP) will have the HSP evaluated at least quarterly ... 3. Licensed personnel and resident attendants are responsible to notify the registered nurse of any significant changes in the resident's condition. 4. The registered nurse shall assess the resident's need for referral to physician or community agencies, as appropriate."</p> <p>The facility's RN failed to assess Resident #2 when [redacted] were found in the residents room to ensure there was not a change in Resident #2's [redacted] NJ ex order 26.4b1 [redacted] NJ ex order [redacted]</p> <p>On 5/14/2024 a revisit survey was conducted to confirm the implementation of the removal plan. The surveyor reviewed policies, pertinent documents and trainings that were conducted by the facility. The facility's removal plan was implemented.</p>	A 771		