

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82471	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2024
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NAME OF PROVIDER OR SUPPLIER ALLEGRIA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 70 STOCKTON AVENUE OCEAN GROVE, NJ 07756
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT#'s: NJ00174766, NJ00175006</p> <p>CENSUS: 82</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 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

08/28/24

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00175006</p> <p>Based on interview with facility staff, review of medical records, and other pertinent facility documents, it was determined that the facility failed to ensure the development, implementation and enforcement of a policy and procedure regarding resident safety for 1 of 3 residents reviewed, Resident #2 for which an [redacted] was identified.</p> <p>On 6/24/24 at 2:24 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 that indicated a date of [redacted] and a "Time of Event" of 1:50 p.m. The FRE indicated that Resident #2 had [redacted] during the morning and at 1:50 p.m., the staff checked on Resident #2 and was [redacted] in the [redacted] of his/her apartment, [redacted]. The FRE further revealed that [redacted] was initiated at approximately 1:55 p.m., and [redacted] was applied and analyzed for [redacted] before arrival of Emergency Medical Services (EMS). The FRE indicated that EMS arrived at approximately 2:07 p.m. and it was determined [redacted] should [redacted] as Resident #2 had [redacted]. The FRE additionally indicated that Resident #2 was last heard from the night before on [redacted] at 10:30 p.m., by a facility Licensed Practical Nurse (LPN) when Resident #2 [redacted] his/her evening medication through the apartment door. The [redacted] was reported to the</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>Licensed Assisted Living Administrator on ^{NJ Exec Order 26.4b1} at 12:30 p.m. The Administrator was presented with the ^{NJ} template that included information about the safety issue.</p> <p>On 6/27/24 at 9:52 a.m., the surveyor interviewed a facility Certified Medication Aide (CMA#1) who stated that most facility residents came to the medication room to receive their medication however, that some payed to have their medication brought to their rooms. CMA #1 further stated that Resident #2 was supposed to receive his/her medications in the medication room but did not like to come early, and on ^{NJ Exec Order 26.4b1}, Resident #2 never came for his/her 9:00 a.m. medications. CMA #1 stated that she called Resident #2's apartment three times but there was no answer, and that she also called the front desk to see if Resident #2 was ^{NJ Exec Order 26.4b1}, but the receptionist stated that she had not seen him/her that morning.</p> <p>During continued surveyor interview with CMA #1 she stated that when a resident does not come for their medications, that the CMA would call the resident on the phone, and if they didn't answer, the CMA would send a Care Manager (CM) to knock on the door or the CMA checked on the resident themselves. CMA #1 further stated that Resident #2 ^{NJ Exec Order 26.4b1} ^{NJ Exec Order 26.4b1}. When the surveyor asked CMA #1 if she, or anyone, had checked on Resident #2 that morning when he/she was unreachable by the phone and never came for his/her morning medications. CMA #1 stated, "no". CMA #1 further stated that when Resident #2 never came for his/her 1:00 p.m. medications, she then decided to check on him/her.</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>On 6/13/24 at 10:47 a.m., the surveyor interviewed a facility CMA (CMA#2) who stated that the staff was educated to check on all of their residents at the beginning and end of each shift, and at meal times to ensure that the residents were having their three meals a day. CMA #2 further stated that she did not think there was a policy but that this protocol was something that the facility care givers knew. CMA #2 stated that there was no formal attendance policy in the dining room for the residents however, each care manager made sure that the residents on their assignment were accounted for and had their meals.</p> <p>On 6/13/24 at 2:35 p.m., the surveyor interviewed the facility Executive Director (ED) who stated that she was unable to provide a policy on resident safety.</p> <p>On 7/25/24 the surveyor completed a revisit survey and verified the Removal Plan was implemented to include updating resident service plans to reflect special preferences and creating a new process for ensuring routine resident safety checks were done.</p>	A 310		
A 401	<p>8:36-4.1(a)(22) Resident Rights</p> <p>(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:</p> <p>22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can</p>	A 401		

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A 401	<p>Continued From page 4</p> <p>safely accommodate while providing services and care;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00175006</p> <p>Based on interview with facility staff, review of medical records, and other pertinent facility documents, it was determined that the facility failed to ensure the resident right to safety, by not ensuring that there was a system in place for safety checks of the facility residents, for 1 of 3 residents reviewed, Resident #2 for which an NJ Exec Order 26.4b1 was identified.</p> <p>On 6/24/24 at 2:24 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, that indicated a date of NJ Exec Order 26.4b1 and a "Time of Event" of 1:50 p.m. The FRE indicated that at approximately 1:50 p.m., the staff attempted to check on Resident #2 who had not been seen by the staff during that shift, and was NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 of his/her apartment, NJ Exec Order 26.4b1. The FRE further revealed that NJ Exec Order 26.4b1 was initiated at approximately 1:55 p.m., and the NJ Exec Order 26.4b1 was applied and analyzed for NJ Exec Order 26.4b1 before arrival of Emergency Medical Services (EMS). The FRE indicated that EMS arrived at approximately 2:07 p.m. and it was determined that NJ Exec Order 26.4b1 as Resident #2 had NJ Exec Order 26.4b1. The FRE additionally indicated that Resident #2 was last heard from the night before on NJ Exec Order 26.4b1 at 10:30 p.m., by a facility Licensed Practical Nurse (LPN) when Resident #2 NJ Exec Order 26.4b1.</p>	A 401		

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A 401	<p>Continued From page 5</p> <p>his/ her evening medication through the apartment door. The [REDACTED] was reported to the Licensed Assisted Living Administrator on [REDACTED] at 12:30 p.m. The Administrator was presented with the [REDACTED] template that included information about the safety issue.</p> <p>The surveyor reviewed the medical record (MR) which revealed that Resident #2 had a Move-In-Date of [REDACTED] and diagnoses that included NJ Exec Order 26.4b1 [REDACTED]</p> <p>On 6/27/24 at 9:10 a.m., the surveyor interviewed the facility Director of Nursing (DON) who stated that she was familiar with Resident #2 and that he/she was a [REDACTED], often went [REDACTED] and was [REDACTED] with all of his/her care. The DON also stated that the [REDACTED] of Resident #2's [REDACTED] was determined to be [REDACTED]. During continued surveyor interview, the DON stated that on the morning of [REDACTED] Resident #2 did not show up for his/her morning medications and the Certified Medication Aide (CMA#1) called Resident #2 on the phone but there was no answer. The DON further stated that the CMA did not have someone check on Resident #2 and the last time the facility staff heard from the resident was 10:30 p.m. the evening before, when Resident #2 refused his/her medication through the door.</p> <p>On 6/27/24 at 9:52 a.m., the surveyor interviewed a facility CMA (CMA#1) who stated that most facility residents came to the medication room to receive their medication however some payed to have their medication brought to their rooms. CMA #1 further stated that Resident #2 was supposed to receive his/her medications in the</p>	A 401		
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A 401	<p>Continued From page 6</p> <p>medication room but did not like to come early, and on NJ Exec Order 26, Resident #2 never came for his/her 9:00 a.m. medications. CMA #1 stated that she called Resident #2's apartment three times but there was no answer, and that she also called the front desk to check if Resident #2 was NJ Exec Order 26, but the receptionist stated that she had not seen Resident #2 that morning.</p> <p>During continued surveyor interview with CMA #1 she stated that when a resident did not come for their medications, the CMA would call the resident on the phone, and if they didn't answer, the CMA would send a Care Manager (CM) to knock on the door, or the CMA would check on the resident themselves. CMA #1 further stated that Resident #2 liked to NJ Exec Order 26.4b1.</p> <p>When the surveyor asked CMA #1 if she or anyone had checked on Resident #2 that morning when he/she was unreachable by the phone and never came for his/her morning medications, the CMA #1 stated no. CMA #1 further stated that when Resident #2 never came for his/her 1:00 p.m. medications, she then decided to check on him/her.</p> <p>At 10:30 a.m., the surveyor interviewed the facility Memory Care Director (MCD), who is also a CMA, who stated that in the facility Memory Care which encompasses the second floor, that safety checks of the residents were conducted every 2 hours. The MCD stated that she also worked on the assisted living floors and that rounds for resident safety were done at the beginning of each shift and more often depending upon the individual resident. The MCD further stated that for example if a resident had frequent falls or a certain medical issue, that they would be checked on more frequently. The MCD stated that if a</p>	A 401		

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A 401	<p>Continued From page 7</p> <p>resident did not show up for a meal, that the care manager checked on them. The MCD stated that she was familiar with Resident #2 and knew that he/she NJ Exec Order 26.4b1 [REDACTED]</p> <p>During continued surveyor interview with the MCD, she stated that when a resident did not come for their medication that the staff would call the resident on the phone and if they didn't answer, that staff would go to the resident's room to check on them. The MCD additionally stated that Resident #2 sometimes preferred not to be disturbed.</p> <p>On 6/13/24 at 10:47 a.m., the surveyor interviewed a facility CMA (CMA#2) who stated that the staff was educated to make rounds and check on all of their residents at the beginning and end of each shift; and, at meal times to ensure that the residents were having their three meals a day. CMA #2 further stated that she did not think there was a policy but that this protocol was something that the facility Care Managers (CM) knew. CMA #2 stated that there was no formal attendance taken at meals in the diningroom for the residents however, each CM made sure that the residents on their assignment were accounted for and had their meals.</p> <p>The CMA#2 also stated that if a resident did not come for their medication, they were called on the phone, and if they did not answer the phone, then the staff checked on them in their rooms. The CMA #2 stated that some of the CM's carried a master key that opened the residents rooms, and although not every CM had a key, that there was always a key available in the medication room if</p>	A 401		

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A 401	Continued From page 8 the staff needed to open a resident door in an emergency. On 7/25/24 the surveyor completed a revisit survey and verified the Removal Plan was implemented to include updating resident service plans to reflect special preferences and creating a new process for ensuring routine resident safety checks were done.	A 401		
A 749	8:36-7.3(a) Resident Assessments and Care Plans (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00175006 Based on interview with facility staff, review of medical records, and other pertinent facility documents, it was determined that the facility failed to ensure that the resident General Service Plan was updated to reflect the individualized needs for 1 of 3 residents reviewed, Resident #2 for which an NJ Exec Order 26.4b1 was identified. On 6/24/24 at 2:24 p.m., the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document	A 749		

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A 749	<p>Continued From page 9</p> <p>used by healthcare facilities to report incidents to the NJDOH, that indicated a date of [redacted] and a "Time of Event" of 1:50 p.m. The FRE indicated that at approximately 1:50 p.m., the staff attempted to check on Resident #2 who had [redacted] by the staff during that shift, and was [redacted] in the [redacted] of his/her apartment, [redacted]. The FRE further revealed that [redacted] was initiated at approximately 1:55 p.m., and the [redacted] was applied and analyzed for [redacted] before arrival of Emergency Medical Services (EMS). The FRE indicated that EMS arrived at approximately 2:07 p.m. and it was determined that [redacted] as Resident #2 had [redacted] and was [redacted] at 2:14 p.m. The FRE additionally indicated that Resident #2 was last heard from the night before on [redacted] at 10:30 p.m., by a facility Licensed Practical Nurse (LPN) when Resident #2 refused his/ her evening medication through the apartment door. The [redacted] was reported to the Licensed Assisted Living Administrator on [redacted] at 12:30 p.m. The Administrator was presented with the [redacted] template that included information about the safety issue.</p> <p>The surveyor reviewed the medical record (MR) which revealed that Resident #2 had a Move-In-Date of [redacted] and diagnoses that included [redacted]</p> <p>On 6/27/24 at 9:10 a.m., the surveyor interviewed the facility Director of Nursing (DON) who stated that she was familiar with Resident #2 and that he/she was a [redacted]</p> <p>The DON further stated that the last time</p>	A 749		

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A 749	<p>Continued From page 10</p> <p>Resident #2 was heard from was the evening before on [redacted] at 10:30 p.m., when the Licensed Practical Nurse (LPN) went to his/her apartment to administer his/her bedtime medication NJ Exec Order 26.4b1 [redacted] and Resident #2 refused the medication through the door. The DON additionally stated that it was not unusual for Resident #2 to refuse that medication.</p> <p>On 6/27/24 at 9:52 a.m., the surveyor interviewed a facility Certified Medication Aide (CMA#1) who stated that Resident #2 was on the facility medication program and was supposed to come to the medication room for medications, but didn't NJ Exec Order 26.4b1 [redacted] CMA #1 also stated that sometimes Resident #2 would ask that the medication be brought to his/her room, and that the staff accomodated his/her requests. CMA #1 additionally stated that Resident #2 was often NJ Ex Order 26.4(b)(1). During interview with CMA #1, CMA #2 entered the medication room and stated that she was familiar with Resident #2 and knew that he/she NJ Exec Order 26.4b1 [redacted] CMA #2 additionally stated that if Resident #2 was not in his/her room that he/she was usually NJ Exec Order 26.4b1 [redacted]</p> <p>At 10:30 a.m., the surveyor interviewed the facility Memory Care Director (MCD) who was also a CMA, who stated that she was familiar with Resident #2 and knew that he/she preferred to NJ Exec Order 26.4b1 [redacted]</p> <p>During continued surveyor interview with the MCD, she stated that when a resident did not</p>	A 749		

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A 749	<p>Continued From page 11</p> <p>come for their medication that the staff would call the resident on the phone, and if they didn't answer, that staff would go to the resident's room to check on them. The MCD additionally stated that Resident #2 sometimes preferred not to be [REDACTED]</p> <p>The surveyor reviewed a facility document titled, "Service Description-Full (SDF)" that included the following categories: Orientation, Behaviors. Communication, Life Enrichment/ Socialization, Smoking, Dressing/ Grooming, Sensory Assistive Devices, Bathing, Bathroom Assistance, Special Needs Care, General Mobility, Assistive Devices, Incidents, Diet, Dining, Chronic Illness, Acute Illness Needs, Medication/Treatments, Medication Assistance and Third Party Providers.</p> <p>The surveyor interviewed the DON in the presence of the ED and clarified that the General Service Plan, Health Service Plan and Resident Assessment are captured within the facility document titled SDF.</p> <p>The surveyor reviewed the SDF however did not observe the individual preferences for Resident #2 that included: Resident #2 [REDACTED]</p> <p>On 7/25/24 the surveyor completed a revisit survey and verified the Removal Plan was implemented to include updating resident service plans to reflect special preferences and creating a new process for ensuring routine resident safety checks were done.</p>	A 749		

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(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
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A 963	<p>8:36-11.5(f) Pharmaceutical Services</p> <p>(f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00174766</p> <p>Based on staff interview, review of medical records, and other pertinent facility documents it was determined that the facility failed to ensure that medications were accurately administered in accordance with prescriber orders for 1 of 3 facility residents, Resident #3. The deficient practice was evidenced by the following:</p> <p>On 6/17/24 at 10:09 a.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 that indicated a date of [redacted] and a "Time of Event" of 12:00 a.m. The FRE indicated that Resident #3 had a [redacted] NJ Exec Order 26.4b1 on [redacted] NJ Exec Order 26.4b1 and "Continuous Care" protocol was initiated that included standing orders for [redacted] NJ Exec Order 26.4b1 every 3 hours to begin at 12:00 a.m., and additionally [redacted] NJ Exec Order 26.4b1 every hour as needed for [redacted] NJ Exec Order 26.4b1. The FRE indicated that the standing [redacted] NJ Exec Order 26.4b1 orders were not administered as ordered, instead, the PRN doses were administered by the [redacted] NJ Exec Order 26.4b1 Nurse on [redacted] NJ Exec Order 26.4b1 at 10:30 p.m., [redacted] NJ Exec Order 26.4b1 at 1:30</p>	A 963		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82471	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2024
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NAME OF PROVIDER OR SUPPLIER ALLEGRIA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 70 STOCKTON AVENUE OCEAN GROVE, NJ 07756
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(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
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A 963	<p>Continued From page 13</p> <p>a.m., 4:30a.m., 7:30 a.m. and by the facility CMA #3 at 10:15 a.m., 12:28 p.m. and 1:22 p.m., and by facility CMA #4 at 5:01 p.m. The FRE also indicated that the [redacted] Nurse administered the as needed [redacted] on [redacted] at 7:30 p.m., 9:00 p.m., and on [redacted] at 12:01 a.m., 3:00 a.m., 5:00 a.m., and 7:00 a.m. The FRE further indicated that the facility CMA #5 administered the standing dose of [redacted] at 12:00 a.m. on [redacted].</p> <p>On 6/27/24 the surveyor reviewed the medical record (MR) and observed that Resident #3 had an initial Move-in-date of [redacted] and diagnoses that included [redacted] and [redacted]. Resident #3's MR that revealed a physician order entered on [redacted] to be started on [redacted] for [redacted] for [redacted] by mouth every three hours. The surveyor also observed a physician's order for [redacted] by mouth every 1 hour as needed for [redacted] with a start date of [redacted].</p> <p>On 6/27/24 at 10:30 a.m., the surveyor interviewed a facility Certified Medication Aide (CMA#3) who was also the facility Memory Care Director (MCD), who stated that she worked the morning shift on Friday, [redacted] and administered the as needed dose of the [redacted] which she stated was the order that was on the Medication Administration Record (MAR). The MCD/CMA#3 stated that she was not sure what happened, but that she must have given the as needed order for the [redacted] before the standing order started.</p> <p>The surveyor reviewed the MAR which revealed documentation of staff initials that indicated Resident #3 received the as needed order for the</p>	A 963		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82471	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2024
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NAME OF PROVIDER OR SUPPLIER ALLEGRIA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 70 STOCKTON AVENUE OCEAN GROVE, NJ 07756
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A 963	<p>Continued From page 14</p> <p>NJ Exec Order 26.4b1 or NJ Exec Order 26 at 10:15 a.m., 12:28 p.m., 1:33 p.m and 5:01 p.m. The surveyor observed that there was no documentation on the MAR that indicated the standing order of NJ Exec Order was administered on the date of NJ Exec Order 26.</p> <p>On 6/24/24 at 2:35 p.m., the surveyor interviewed the facility Director of Nursing (DON), in the presence of the Administrator, who stated that on NJ Exec Order 26 the facility CMA #5 administered the standing order of NJ Exec Order at midnight and the NJ Exec Order 26.4b1 administered the as needed dose of NJ Exec Order shortly after midnight. The DON further stated that CMA #5 did not check the 24 report book when she arrived to work, and was therefore unaware that there was NJ Exec Order in place for Resident #3. The DON further explained that the NJ Exec Order was with another facility resident who was also on NJ Exec Order 26.4b1 so when CMA #5 administered the standing order of NJ Exec Order she did not see the NJ Exec Order at Resident #3's bedside.</p> <p>During continued surveyor interview with the facility DON, she stated that when she conducted an investigation, she observed that the standing order for NJ Exec Order was transcribed, however it did not populate onto the MAR.</p>	A 963		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 82471	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 8/28/2024
NAME OF FACILITY ALLEGRIA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 70 STOCKTON AVENUE OCEAN GROVE, NJ 07756	

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 A0310	Correction	ID Prefix A0401	Correction	ID Prefix A0749	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-7.3(a)	Completed
LSC	08/28/2024	LSC	08/28/2024	LSC	08/28/2024
ID Prefix A0963	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-11.5(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/28/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/25/2024

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO