

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8HEV7E	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/04/2025
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NAME OF PROVIDER OR SUPPLIER BEAR CREEK ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 291 VILLAGE ROAD EAST WEST WINDSOR, NJ 08550
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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 Survey</p> <p>COMPLAINT #: NJ00186735</p> <p>CENSUS: 87</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 401	<p>8:36-4.1(a)(22) Resident Rights</p> <p>(a) Each assisted living provider shall 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 safely accommodate while providing services and care;</p>	A 401		

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

TITLE

(X6) DATE

08/08/25

New Jersey Department of Health

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A 401	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00186735</p> <p>Based on interview and record review, it was determined that the facility failed to ^{NJ Ex Order 26. 4B1} [REDACTED]</p> <p>The Department of Health (DOH) received a Facility Reportable Event (FRE) (A document used by health care facilities to report events) dated ^{NJ Ex Order 26. 4B1} [REDACTED], regarding a resident ^{NJ Ex Order 26. 4B1} [REDACTED]. According to the FRE, during rounds, at approximately 11:55 a.m., the staff nurse was ^{NJ Ex Order 26. 4B1} [REDACTED]. The FRE further indicated that ^{NJ Ex Order 26. 4B1} [REDACTED]. "The resident was ^{NJ Ex Order 26. 4B1} [REDACTED]."</p> <p>On 6/4/25 at 10:15 a.m., the surveyor investigated the above FRE and was accompanied on tour by the Director of Nursing (DON), to tour the secured ^{NJ Ex Order 26. 4B1} [REDACTED], where Resident #2 resided. The surveyor observed that the entrance to the ^{NJ Ex Order 26. 4B1} [REDACTED] had a keypad which required a code for entrance to, and exit from, the ^{NJ Ex Order 26. 4B1} [REDACTED]. During tour of the ^{NJ Ex Order 26. 4B1} [REDACTED], the DON accompanied the surveyor to an outside courtyard that was attached to the ^{NJ Ex Order 26. 4B1} [REDACTED]. The surveyor observed that the courtyard had a fence around the entire perimeter which was</p>	A 401		
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A 401	<p>Continued From page 2</p> <p>approximately six (6) feet tall. The surveyor observed that there was also a gate which was secured with a padlock. The DON confirmed that there were two gated doors in the courtyard and that both gates were secured with padlocks at all times.</p> <p>During tour of the [redacted] outdoor courtyard, the DON stated that [redacted] NJ Ex Order 26. 4B1 [redacted], Resident #2 resided in the [redacted] NJ Ex Order 26. 4B1 [redacted], not in the secured [redacted] NJ Ex Order 26. 4B1 [redacted]. The DON further stated that since admission to the facility, the resident enjoyed daily walks outside and that there were never any concerns until [redacted] NJ Ex Order 26. 4B1 [redacted] when Resident #2 was [redacted] NJ Ex Order 26. 4B1 [redacted]. The DON explained that a neighboring resident from the [redacted] NJ Ex Order 26. 4B1 [redacted], which was located next door to the facility, called to let the facility know that Resident #2 was there. The [redacted] NJ Ex Order 26. 4B1 [redacted] (RP) was visiting at the time and accompanied the resident safely [redacted] NJ Ex Order 26. 4B1 [redacted]. The DON stated that the resident was then moved into the secured [redacted] NJ Ex Order 26. 4B1 [redacted] when the resident could not find his/her [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>During continued surveyor interview, the DON explained that on [redacted] NJ Ex Order 26. 4B1 [redacted], Resident #2 wanted to go out for some fresh air, and the charge nurse opened the secured door to the [redacted] NJ Ex Order 26. 4B1 [redacted] and let the resident out into the secured courtyard. The nurse was checking on the resident and the last time the nurse checked on Resident #2, the resident was [redacted] NJ Ex Order 26. 4B1 [redacted]. The DON explained that the staff observed a chair up against the fence and realized that the resident must [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>The surveyor observed that there were two metal benches in the courtyard and the surveyor</p>	A 401		

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A 401	<p>Continued From page 3</p> <p>inquired how the resident could have moved the bench by him/herself. The DON explained that there was a party over the weekend for the residents and that there were extra chairs put in place to provide additional seating and that the resident must have used one of those chairs. The DON stated that the chairs were removed <i>NJ Ex Order 26. 4B1</i>.</p> <p>At 10:20 a.m., the surveyor interviewed a Certified Home Health Aide (CHHA) who worked in the <i>NJ Ex Order</i>, and inquired about residents going outside to the courtyard. The CHHA stated that residents in the <i>NJ Ex Order</i> were not allowed to go outside alone. The CHHA further stated that usually the Activity staff took the residents outside as a group.</p> <p>The surveyor interviewed a Certified Medication Aide (CMA) who stated that the residents who lived in the <i>NJ Ex Order</i> were not allowed to go outside unsupervised.</p> <p>At 11:00 a.m., the surveyor reviewed Resident #2's medical record (MR), which revealed that Resident #2 was admitted in October of <i>NJ Ex Order 26. 4B1</i>.</p> <p>Further review of the MR revealed that after <i>NJ Ex O</i>, Resident #2 was assessed which revealed that the resident had a <i>NJ Ex Order 26. 4B1</i>.</p> <p><i>NJ Ex Order 26. 4B1</i>; and, additionally the resident's <i>NJ Ex Order 26. 4B1</i>.</p> <p>The surveyor reviewed a facility policy titled. "Environmental Safety", dated 6/7/25 which revealed the following: "Memory Care Community staff will provide a safe and healthy</p>	A 401		

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A 401	Continued From page 4 environment for residents residing in the Memory Care Community ..."	A 401		
A1051	<p>8:36-15.2 Record Availability</p> <p>The records required by this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ 00186735</p> <p>Based on observation and interview, it was determined that the facility failed to ensure that full access to the Electronic Medical Records (EMRs) was available for review to the Department of Health surveyors upon request, for 3 of 3 residents, Resident #'s 1, 2 and 3. This deficient practice was evidenced by the following:</p> <p>On 6/4/25 at 9:45 a.m., during entrance conference with the Director of Nursing (DON), the surveyor requested full access to the facility's EMR, and other pertinent documents for review. The DON stated that the facility had just switched to a new EMR system called "NJ Ex Order 26, 4B1" and that she would send an email to request full access to the EMR for the surveyors.</p> <p>At 10:20 a.m., the surveyor asked the DON about the status of the EMR access and the DON replied that she had sent several emails requesting access.</p>	A1051		

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A1051	<p>Continued From page 5</p> <p>At 11:45 a.m., the surveyor informed the DON that the surveyors required access to the EMR to conduct the survey.</p> <p>At 12:30 p.m., the surveyors still had not received access to the EMR. The surveyor requested printed copies of the medical records (MR) for Resident #'s 1, 2 and 3.</p> <p>At the time of the survey, the surveyor was not granted full access to the EMR; and the DON provided paper copies of the requested MR. The surveyor was unable to access the EMRs of residents for review, which prevented the surveyors from completing the investigation and the survey process of the Department of Health.</p>	A1051		



POC # 2 Received
8/13/25 +
Acceptable

Plan of Correction

Bear Creek Assisted Living

Survey Date- 06/04/2025

A401-8:36-4.1(a)(22) Resident Rights

- 1) The Assisted Living Provider failed to ensure Memory Care Community staff to provide a safe environment for residents in the Memory Care Community. Resident # 2 was **NJ Ex Order 26. 4B1** Training initiated on 5/25/25- Each Nurse, CMA, CHHA and Staff Member has been in-serviced on Memory Care Outdoor protocols. No residents should be outside without a team member present, and no removable chairs should be placed in the courtyard.
- 2) All Memory Care residents have the potential to be affected by this deficient practice.
- 3) To ensure that the deficient practice will not recur, the community will include this Inservice in our monthly town hall meetings as a reminder to the signed in-service that everyone has received and acknowledged. Each Nurse, CMA, CHHA and Staff Member has been in-serviced on Memory Care Outdoor protocols. In service- was conducted by Wellness Director and Wellness Supervisor. No residents should be outside without a team member present, and no removable chairs should be placed in the courtyard.
- 4) The Memory Care Director, Director of Wellness and Executive Director will monitor the corrective actions to ensure this deficient practice is being corrected and therefore will not recur. Our Memory Care Director and Activities Assistant will be responsible for daily walk-throughs of courtyard to ensure no removable furniture is

POC # 2 Received
8/13/25 +
Acceptable



in the courtyard. This has been completed and ongoing will be documented on our weekly memory care safety checklist.

- 5) The deficiency in-service documentation has been completed as of 8/12/2025. The documentation regarding the courtyard and removable furniture will be ongoing during daily checks.

A10518:36-15.2

- 1) The Assisted Living Provider failed to ensure that full access to the Electronic Medical Records for the Departments review. NO residents were affected by this deficient practice, and the community gave printed copies of the medical records. This deficiency was corrected later that evening and the community now has state surveyor access uploaded onto [NJ Ex Order 26.4B1](#)
- 2) No residents have the potential to be affected by this deficiency. The Department was given paper copies due to the technological issues the company was having in giving access.
- 3) To ensure the deficient practice will not recur, the community was granted access to create users for The Department. Director of Wellness, Executive Director and Wellness Supervisor all have access to create user access.
- 4) The community will monitor any changes with access and keep written instructions for creating Department access.
- 5) Records are now readily available for the State. This deficiency has been rectified since 6/5/2025