

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/07/2024
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NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 540 MULLICA HILL ROAD GLASSBORO, NJ 08028
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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 #: NJ 00175625</p> <p>Census: 36</p> <p>Sample Size: 4</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 235	<p>8:36-2.4(d) Licensure Procedures</p> <p>(d) Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and resident records and conferences with residents.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00174743</p> <p>Based on interview, record review, and review of</p>	A 235		

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

TITLE

(X6) DATE

New Jersey Department of Health

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A 235	<p>Continued From page 1</p> <p>pertinent facility documents it was determined that the facility failed to provide full access to all resident electronic medical records (EMR) to surveyor to complete investigation and surveyor process of the Department of Health for 3 of 3 residents reviewed, Resident's #1, #2, and #3 as evidenced by the following:</p> <p>On 8/7/24 at 9:20 a.m., the surveyor interviewed the Executive Director (ED), regarding access to resident medical records (MR). The ED stated that the facility used two EMR systems. In addition, the ED explained that EMR #1 contained records of medication, and its administration, as well as, interdisciplinary notes, including nursing progress notes. Further, the ED stated that EMR #2 included records of care, service plans, and personal information of residents. The surveyor then requested access to the two EMR systems for MR review. The ED stated that he would try to obtain surveyor access to the EMR.</p> <p>At 11:10 a.m., the ED provided the surveyor with access to the EMR #1 for review of Resident #1, Resident #2, and Resident #3's MR. The ED stated that he was working on obtaining access to EMR #2.</p> <p>At 11:56 a.m., the ED stated that he was unable to provide the surveyor with access to the facility EMR #2 system. However, the ED provided the surveyor with paper charts for review.</p> <p>At 2:00 p.m., the ED confirmed that he was unable to obtain access to resident EMR #2 from the corporate office for surveyor review.</p> <p>The surveyor reviewed the facility policy and procedure titled, "Inspection and Access to Authorized Agencies" dated 3/8/2024 which</p>	A 235		

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A 235	Continued From page 2 revealed "The Community will provide appropriate access as needed to state licensing agencies, ...The Community will cooperate with appropriate requests by authorized agencies. ..."	A 235		

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

TITLE

(X6) DATE

08/30/24

Summit Place

ASSISTED LIVING

Violation tag A235; code 8:36-2.4(d) Licensure Procedures

Plan of Correction:

1. Corrective action for all affected residents will be accomplished and ongoing at time of next due date for each Service Plan. Resident #1 & Resident #3 service plans have been merged and updated into 1 system(Caremerge) as of 9/5/24. Resident #2 moved out on NJ ex order 26.4b1
2. All NJDOH Surveyors have the potential to be affected by the same deficient practice.
3. Multiple electronic systems were being utilized to document Resident Care Plans and other various documentation. This was initiated for a company wide transition to a new electronic platform. The "transitioning platform" for electronic monitoring did not yet meet the access requirement for NJDOH. Summit Place will be reverting to the prior electronic platform("Caremerge") that had been being used before initiating partial transition. This will provide uniform access for surveyors and to regain regulatory compliance for survey visits.
4. The Director of Health and Wellness has started to utilize Caremerge for uniformity as of 9/5/24 for all resident documentation. Care Plan monitoring for completion in Caremerge will be reported weekly by Director of Health and Wellness reporting to Executive Director status updates. Results of status will be reviewed monthly during QI meeting until completed. All residents will be completed and updated into Caremerge for NJDOH Surveyor access by 10/31/24.

*accepted
9/18/24
WJ*

NJ Ex Order 26.4(b)(1)

*9/13/24
9/17/24
9/18/24*

Executive Director

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 90110	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 8/7/2024	Y2	Y3
NAME OF FACILITY SUMMIT PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 540 MULLICA HILL ROAD GLASSBORO, NJ 08028		

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	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix A0235	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:36-2.4(d)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	09/13/2024	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 _____	
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 8/7/2024

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