

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90117	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2025
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NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF MORRIS PLAI	STREET ADDRESS, CITY, STATE, ZIP CODE 209 LITTLETON ROAD MORRIS PLAINS, NJ 07950
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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 # NJ00184290, NJ00184447</p> <p>CENSUS: (67) 4/9/25, (68) 4/10/25</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

06/04/25

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 # NJ 00184447</p> <p>Based on interview and record review, it was determined that the Administrator failed to ensure the implementation and enforcement of the facility policy titled, "Abuse, Neglect & Exploitation - Prevention, Reporting and Investigation" for 2 of 3 residents, Residents #1 and Resident #3. This deficient practice was evidenced by the following:</p> <p>The Department of Health (DOH) received a Facility Reportable Event (FRE) (a report used by facilities to report events to the DOH) on [redacted] regarding a Certified Home Health Aide (CHHA) [redacted] from two residents, Residents #1 and Resident #3. The FRE documented that the CHHA told a [redacted] at the facility that she had [redacted] from residents on or around [redacted]. According to the FRE, the [redacted] reported this to administration on [redacted].</p> <p>1. On 4/9/25 at 10:44 a.m., the surveyor reviewed Resident #1's medical record (MR) which revealed a move-in date of [redacted], and diagnoses of [redacted] and [redacted].</p> <p>The surveyor reviewed a "LATE ENTRY" progress note (PN) dated [redacted] at 4:02 p.m., written by the Executive Director (ED), which indicated, "... Resident's [Responsible Party] stated "my [redacted] and my [redacted] has been keeping a [redacted] - first week in [redacted] of missing [redacted] totaling [redacted]"</p>	A 310		
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A 310	<p>Continued From page 2</p> <p>2. On 4/9/25 at 11:08 a.m., the surveyor reviewed Resident #3's MR which revealed a move in date of [redacted], and a diagnosis of [redacted].</p> <p>The surveyor reviewed the "LATE ENTRY" PN dated [redacted] at 3:49 p.m., written by the ED, which indicated, "... Resident's [Responsible Party] stated "I am unable to find one of my [redacted] and I will review [redacted] for [redacted] activities."</p> <p>On 4/9/25 at 12:06 p.m., the surveyor reviewed the facility's "Summary and Conclusion of Reportable Event" (SCRE) for this incident, which indicated that the CHHA told the [redacted] on or about [redacted] that [redacted] from residents. The [redacted] informed the Assisted Living Coordinator (ALC) of the CHHA's report of [redacted] from residents on [redacted].</p> <p>On 4/10/25 at 10:36 a.m., the surveyor interviewed the ALC and inquired about the CHHA [redacted] from residents. The ALC stated that during a scheduled meeting with the [redacted] on [redacted] the [redacted] informed her that the CHHA was [redacted] from residents. The ALC and [redacted] then immediately went to the ED and reported the situation.</p> <p>At 11:07 a.m., the surveyor interviewed the [redacted] and inquired about the CHHA [redacted] from the residents. The [redacted] explained that she was on lunch break with the CHHA when the CHHA told her that [redacted] from Resident #1 and Resident #3. The [redacted] stated that she did not report the incident immediately and [redacted] she did not have any</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>evidence of the CHHA [redacted] from residents.</p> <p>The surveyor continued to interview the [redacted] and inquired about when she reported the incident to administration. The [redacted] stated that she was off from work for a few days, and she saw that the CHHA [redacted] of [redacted] she had made on her [redacted]. The [redacted] took [redacted] of the CHHA's [redacted] and reported it to the ALC when she returned to work.</p> <p>The surveyor reviewed a facility policy, dated 5/08, with a revision date of 2/16/22, titled, "Abuse, Neglect & Exploitation - Prevention, Reporting and Investigation" which indicated, " ... c. In addition, team members who know of or suspect abuse, neglect or exploitation of any resident must immediately notify the Executive Director/designee, to ensure appropriate action is timely taken for the safety of the resident and those potentially impacted ... Definitions: ... Exploitation: taking, misplacement, retention or use of a resident's belongings or services without the resident's consent ..."</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 safely accommodate</p>	A 401		

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A 401	<p>Continued From page 4</p> <p>while providing services and care;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ 00184290</p> <p>Based on interview and record review, it was determined that the facility failed to ensure a safe environment during an investigation of an [redacted] for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>The Department of Health (DOH) received a Facility Reportable Event (FRE) (a document used to report events to the DOH) dated [redacted], regarding an [redacted] that occurred on [redacted]. Resident #2 reported the [redacted] to facility staff members on [redacted] at 9:30 p.m. According to the FRE, Resident #2 told a staff member that the resident was [redacted] on [redacted] by a [redacted] that came in to [redacted] him/her and did not want to be [redacted]. The FRE also indicated that Resident #2 was sent to the hospital for evaluation following the report to staff.</p> <p>On 4/9/25 at 10:04 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed a move in date of [redacted], and diagnoses of [redacted]. The surveyor observed that Resident #2 resided in the facility's [redacted].</p> <p>The surveyor reviewed a "LATE ENTRY" progress note (PN) dated [redacted] at 11:23 a.m., written by the Resident Care Director (RCD), a Registered Nurse, which indicated, "Received a call from [team member] on [redacted] at 9:37</p>	A 401		

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A 401	<p>Continued From page 5</p> <p>p.m., that resident was [redacted] care and [redacted] that he/she was [redacted] "yesterday ..." The PN also indicated that Resident #2 was transferred to the emergency room on [redacted] at approximately 9:45 p.m. due to an [redacted] situation.</p> <p>At 11:54 a.m., the surveyor reviewed the facility's "Summary and Conclusion of Reportable Event" (SCRE) which indicated, "Resident was [redacted] that came in his/her room to [redacted] him/her. [Resident #2's Responsible Party] plans to call the [redacted] APN and request an evaluation to help ... [Resident] with his/her [redacted]. Resident was elevated by [redacted] or [redacted].</p> <p>The surveyor further reviewed the SCRE, but did not observe documented evidence that the resident was [redacted] from the staff member(s) during the investigation of the [redacted].</p> <p>On 4/10/25 at 10:09 a.m., the surveyor interviewed Care Manager (CM) #1 and inquired about Resident #2. CM #1 stated that she was familiar with Resident #2, but that she had never been assigned to provide care to the resident.</p> <p>At 10:13 a.m., the surveyor interviewed CM #2 and inquired about Resident #2. CM #2 stated that she was usually assigned to Resident #2's care and that the lead CM informed her of the [redacted] incident involving Resident #2 on her next shift back to work. CM #2 stated that to she was unaware of any staffing changes made to Resident #2's care following the [redacted] incident.</p> <p>Additionally, CM #2 stated that on her first day back to work, she brought another CM into the</p>	A 401		

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A 401	<p>Continued From page 6</p> <p>resident's room when she provided care to the resident due to the NJ Exec Order 26.4b1. CM #2 stated that she was not instructed to have another CM with her; however, she decided to have another CM with her in Resident #2's room.</p> <p>On 4/9/25 at 1:08 p.m., the surveyor interviewed the Executive Director (ED) and inquired about the NJ Exec Order 26 incident involving Resident #2. The ED stated that she interviewed all the NJ Exec Ord staff members and obtained written statements from them. The ED explained that since all staff members who were interviewed did not report any concerns, no staff member(s) were NJ Exec Order 26.4b1 during the investigation of the NJ Exec Order 26 event.</p> <p>The surveyor reviewed a facility policy, dated 5/08, with a revision date of 2/16/22, titled, "Abuse, Neglect & Exploitation - Prevention, Reporting and Investigation" which indicated, " ... Action Steps: ... 8. The ED/designee: ... b. Removes the individual alleged to be involved in the abuse, neglect or exploitation from the area i. Ensures that any team member alleged to be involved in the abuse, neglect or exploitation is placed on administrative leave, pending the results of the investigation ..."</p>	A 401		
H 000	<p>Initials Comments</p> <p>TYPE OF SURVEY: Complaint</p> <p>COMPLAINT # NJ00184290, NJ00184447</p> <p>CENSUS: (67) 4/9/25, (68) 4/10/25</p> <p>SAMPLE SIZE: 3</p> <p>THE FACILITY IS NOT IN COMPLIANCE WITH</p>	H 000		

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H 000	Continued From page 7 THE STANDARDS FOR LICENSURE OF RESIDENTIAL FACILITIES CHAPTER N.J.A.C. 8:43E GENERAL LICENSURE PROCEDURES AND STANDARDS APPLICABLE TO ALL LICENSED FACILITIES	H 000		
H5730	<p>8:43E-13.4(a) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM</p> <p>A licensed healthcare facility or program shall use the Universal Transfer Form, HFEL-7, provided as N.J.A.C. 8:43E-13 Appendix, incorporated herein by reference, and available on the Department's website at http://web.doh.state.nj.us/apps2/forms/, in either paper or electronic version, whenever a patient is transferred to another licensed healthcare facility or program.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ 00184290</p> <p>Based on interview and record review, it was determined that the facility failed to retain the Universal Transfer Form (a form that communicates pertinent, accurate clinical patient care information at the time of a transfer between health care facilities/programs) when a resident was transferred to the Emergency Room (ER) for evaluation for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 4/9/25 at 10:04 a.m., the surveyor reviewed Resident #2's medical record (MR) which</p>	H5730		

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H5730	<p>Continued From page 8</p> <p>revealed a move-in date of [NJ Exec Order 26.4b1], and diagnoses of [NJ Exec Order 26.4b1].</p> <p>The surveyor reviewed a "LATE ENTRY" progress note (PN) dated [NJ Exec Order 26.4b1] at 11:23 a.m., which revealed that Resident #2 was transferred to the emergency room on [NJ Exec Order 26.4b1] at approximately 9:45 p.m., due to an [NJ Exec Order 26.4b1] situation.</p> <p>Surveyor further review of Resident #2's MR, revealed another PN dated [NJ Exec Order 26.4b1] at 2:01 p.m., written by the Wellness Nurse, a Registered Nurse (RN), which indicated that Resident #2, was admitted to the hospital for [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1].</p> <p>On 4/10/25 at 11:26 a.m., the surveyor requested the Executive Director (ED) to provide the Universal Transfer Form (UTF) for when Resident #2 was transferred to the hospital on [NJ Exec Order 26.4b1] for review.</p> <p>At 12:31 p.m., the ED informed the surveyor that the UTF was sent out with Resident #2 on [NJ Exec Order 26.4b1]; however, the facility did not keep a copy of the form. The ED reported that she confirmed with the Resident Care Director, a RN, and a copy of the [NJ Exec Order 26.4b1] UTF could not be located.</p> <p>Additionally, the ED explained that since there was a more recent transfer to the hospital for Resident #2, the [NJ Exec Order 26.4b1] UTF was replaced by the [NJ Exec Order 26.4b1] UTF in the facility's electronic MR system. The surveyor then requested a copy of the UTF dated [NJ Exec Order 26.4b1].</p> <p>At 1:43 p.m., the ED provided the surveyor with a copy of the [NJ Exec Order 26.4b1] UTF for Resident #2. The</p>	H5730		

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H5730	<p>Continued From page 9</p> <p>surveyor reviewed the UTF and observed that the form was incomplete.</p> <p>The facility failed to provide the surveyor with copy of the UTF for Resident #2 transfer to the hospital on [REDACTED].</p> <p>The surveyor reviewed the facility policy, dated 6/29/05 and revised on 8/17/16, titled, "Responding To Medical Emergencies" which indicated, " ... 7. The Licensed Nurse/Team Member will provide the following documents to the emergency medical personnel: a. Emergency Information Sheet b. Medication list c. Copy of any Advance Directive d. MOLST/POLST form (as applicable) e. Copies of health insurance card(s), if available ..."</p>	H5730		

POC #3 received 6/16/25
Accepted 6/17/25



Sunrise Senior Living Plan of Correction

Name of Facility: Sunrise of Morris Plains

Address of Facility: 209 Littleton Road, Morris Plains, NJ 07950.

License number: 90117

Inspection date(s): April 9 -10, 2025

Name and Title of Legal Entity Representative Signing the Plan of Correction:
 Andrea Martinez, Executive Director **NJ Exec Order 26.4b1**

Signature of Sunrise Representative: [Redacted]

Date of Submission: 6/16/2025

A310 - 8:36-3.4(a)(1) - Administration:

Target Completion Date: 5/27/2025.

Resident # 1 and Resident #3 continue to reside in the facility.

All residents in the facility have the potential to be affected. Upon receiving the survey on 4/10/2025, the Executive Director provided re-training for all team members in the facility on policies 'Abuse, Neglect and Exploitation Prevention, Reporting and Investigation' and policy on 'Resident Rights'

The Executive Director provided re-training on 4/12/25, 4/17/25 and 4/24/25 for all team members in the facility on policy 'Abuse, Neglect and Exploitation Prevention, Reporting and Investigation' and policy on 'Resident Rights'.

This Plan of Correction to ensure compliance of resident's 'Resident Rights' and 'Abuse, Neglect and Exploitation' will be discussed and evaluated quarterly for two quarters by the ED or designee and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violations does not occur again. QAPI meeting initiated on 4/10/2025 by the ED with the coordinators.

NJ Exec Order approved 6/17/25



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

Target Completion Date: 5/27/2025.

Resident #2 [redacted] [redacted]

The Executive Director completed re-training on policies 'Abuse, Neglect & Exploitation – Prevention, Reporting and Investigation', and 'Resident Rights' on [redacted] to all community Team Members. The Executive Director and RN have been re-educated on policies 'Staffing' and 'Assessing and Evaluating Residents', to ensure capabilities regarding care and services.

On 5/27/2025 the Regional Director of Resident Care, RN, provided re-education to the Executive Director and Registered Nurse on the policies titled 'Staffing' and 'Assessing and Evaluating Residents'.

This Plan of Correction to ensure the compliance of residents' Resident Rights, Abuse, Neglect and Exploitation', 'Staffing' and 'Assessing and Evaluating Residents' will be discussed and evaluated quarterly for two quarters by the ED or designee and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify that the violations do not occur again. QAPI meeting initiated on 4/10/2025 by the ED with the coordinators.

[redacted] approved 6/17/25

H5730 - 8:43e-13.4(a) - Universal Transfer Form: Mandatory Use of Form:

Target Completion Date: 6/25/2025.

Resident #2 [redacted]

All residents in the facility that transfer between healthcare facilities have the potential to be affected. Upon receiving the survey on 4/10/2025, the Executive Director and RN were re-trained on the policy 'Responding to Medical Emergencies' with NJ addendum to 8:43E-13.4. The RN completed re-training on the Policy and the Universal Transfer form with all team members (RNs, LPNs, CMAs, CNAs, HHAs, Department Coordinators) on 4/10/2025 and re-educated the process of obtaining a copy of the resident's Universal Transfer form to the Medical Record.

RN or designee will ensure training on this policy with new team members upon hire. RN or designee will ensure re-education is provided as necessary, particularly in response to policy updates.

The Resident Care Director (RCD) or their designee will conduct weekly audits during Interdisciplinary Team (IDT) meetings for a period of three weeks starting on 6/4/2025. These audits will focus on all residents who have been transferred to a medical setting, ensuring that the Universal Transfer Form (UTF) is properly utilized during each transfer. Following this period, overall compliance with UTF utilization will be reviewed and evaluated during quarterly Quality Assurance and Performance Improvement (QAPI) meetings. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violations does not occur again. QAPI meeting initiated on 4/10/2025 by the ED with the coordinators.

[redacted] approved 6/17/25