New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL13001	A. BUILDING: _____ B. WING _____	C 11/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF EATONTOWN	147 GRANT AVENUE EATONTOWN, NJ 07724

(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	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00180281 CENSUS: 56 SAMPLE SIZE: 3 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.	A 000		
A 401	8:36-4.1(a)(22) Resident Rights (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: 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;	A 401		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/06/25

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A 401	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 0180281 Based on observation, interview and record review, it was determined that the facility failed to ensure a safe environment while providing care and services to residents in the Assisted Living NJ Exec Order 26.4b1 units for 1 of 3 residents reviewed, Resident #1. This deficient practice is evidenced by the following: On 11/29/24, the surveyor investigated a Reportable Event Report (FRE) submitted by the facility's Administrator on NJ Exec Order 26 which occurred on NJ Exec Order 26.4 According to the FRE, "... [Resident] exhibited NJ Exec Order 26.4b1, wanting to NJ Exec Order attempted to NJ Exec Order 26.4b1 , attempting to NJ Exec Order 26.4b1. Called NJ Exec Order 26.4b1 arrived at 8:30 pm. After NJ Exec Order left, resident put a NJ Exec Order 26.4b1 responded." At 10:35 a.m., the surveyor toured the NJ Exec Order 26 neighborhoods of the NJ Exec Order 26.4b1 units and observed toasters plugged in and paper towel holders on the countertops of the kitchenettes. During interview with two Care Partners (CP), both stated that the toasters were used for the residents during meals. At 10:55 a.m., the surveyor reviewed the closed medical record of Resident #1, which indicated that the resident was admitted to the facility on NJ Exec Order with diagnoses of NJ Exec Order 26.4b1 . The "NJ Exec Order 26.4b1 Evaluation" dated NJ Exec Order 26 documented that the resident was NJ Exec O and NJ Exec Order 26.4b1 but NJ Exec Order 26.4b1 and per nursing the resident was NJ Exec Order 26.4 in the	A 401		

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A 401	Continued From page 2 afternoon/evening. The Progress Notes (PN) dated [redacted] at 10:20 p.m., written by a Licensed Practical Nurse (LPN) #1, documented that the resident came to ... unit [redacted] and took a [redacted] and started [redacted] on the [redacted] the [redacted] and a CP was able to get the [redacted] from the resident. The PN dated [redacted] at 10:52 p.m., written by a LPN #2, documented that Resident #1 attempted to [redacted] on the unit with a [redacted]. The LPN documented that at 8:10 p.m., the resident called the [redacted] and at 8:30 p.m., the resident [redacted] in the living room and a [redacted] of unit [redacted] Further, the LPN documented that the resident went to unit [redacted] and [redacted] which [redacted] and also [redacted] the community through another neighborhood. The PN dated [redacted] at 5:28 p.m., written by a LPN #3, documented that the resident was sent to the Emergency Room (ER) for evaluation due to [redacted], [redacted] the facility [redacted] medications, [redacted] CPs and exhibited [redacted] towards other residents. The surveyor interviewed the Executive Director (ED) regarding the above incident and the toasters observed on the countertops of the kitchenettes. The ED stated that the toasters were used for the residents by the staff during meals. On 12/2/24 at 7:50 p.m., the surveyor interviewed LPN #1 who stated that the resident came to the	A 401		

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A 401	Continued From page 3 unit [redacted], [redacted] and [redacted] and the resident was [redacted] back to his/her apartment. The LPN also stated that she received a call a bit later, could not recall the exact time from LPN #2 for assistance with Resident #1. LPN #1 stated that when she got to unit [redacted] the [redacted] and was told that Resident #1 [redacted]. LPN #1 stated that she took the [redacted] outside immediately to [redacted]. LPN #2 was not available for interview, no longer worked at facility. The facility failed to provide safe environment to Resident #1, as well as other residents by leaving toasters on the counter top of the kitchenettes in the [redacted] when not in use which endangered residents' safety. On 11/29/24 at 12:25 p.m., the surveyor informed the ED of the Imminent Danger (ID) and requested a removal plan to ensure the facility took immediate action to ensure facility residents' safety. The removal plan was acceptable which stated that all toasters were unplugged and removed from the countertops and placed in a locked cabinet when not in use to maintain residents safety.	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	A 749		

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A 749	Continued From page 4 physical or cognitive status. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 0180281 Based on interview and record review it was determined that the facility failed to revise and update the Service Plan (SP) with interventions to address the resident's NJ Exec Order 26.4b1 needs for 1 of 3 residents reviewed for SP, Resident #1. The deficient practice was evidenced by the following: On 11/29/24 at 10:55 a.m., the surveyor reviewed the closed medical record of Resident #1, which indicated that the resident was admitted to the facility on NJ Exec Order 26 with diagnoses of NJ Exec Order 26.4b1 [redacted]. The "NJ Exec Order 26.4b1 Evaluation" dated NJ Exec Order 26 documented that the resident was NJ Exec Order 26.4b1 but NJ Exec Order 26.4b1 and per nursing the resident was NJ Exec Order 26.4 in the afternoon/evening. The Progress Notes (PN) dated NJ Exec Order 26 at 9:15 a.m., written by a Licensed Practical Nurse (LPN) documented that the resident was found NJ Exec Order 26.4 [redacted]. The LPN documented that the resident stated that someone NJ Exec Order 26.4b1 him/her and NJ Exec Order 26.4b was noted. The PN dated NJ Exec Order 26.4b at 11:37 p.m., written by a LPN documented that the resident NJ Exec Order 26.4b1 [redacted] on his/her NJ Exec Ord with NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1.	A 749		

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A 749	Continued From page 5 The PN dated [redacted] at 9:54 p.m., written by a LPN documented that at 6:15 p.m., the resident had a witnessed [redacted] while [redacted] to the Convention Hall hallway and no [redacted] The PN dated [redacted] at 10:20 p.m., written by a LPN documented that at 4:20 p.m., the resident was observed [redacted] in the community center. The LPN documented that a [redacted] and [redacted] on [redacted] and the resident was sent to the ER for evaluation. The PN dated [redacted] at 2:36 p.m., written by a LPN documented that at 12:17 p.m., the resident was [redacted] in the dining room and [redacted] was noted. At 2:40 p.m., a LPN documented that the resident [redacted] wheelchair while [redacted], [redacted] and was sent to the ER for evaluation. The PN dated [redacted] at 4:33 p.m., written by the Director of Health and Wellness (DOHW) documented that she was aware of the resident's [redacted] yesterday on [redacted] in the community center. The DOHW documented that the resident [redacted] and was sent to the ER for evaluation. Further, the DOHW documented that the resident returned this morning, resident [redacted] and was sent back out to the ER for evaluation. The PN dated [redacted] at 10:39 a.m., written by the ED documented that Resident #1 [redacted] coming out from his/her room, [redacted] and [redacted] The ED documented that the resident was sent back to the ER for [redacted].	A 749		

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A 749	Continued From page 6 The PN dated [redacted] at 11:07 a.m., written by the DOHW documented that she was of resident [redacted] yesterday on [redacted] NJ Exec Order 26.4b1 [redacted], sent to the ER, returned with [redacted] of his/her [redacted] and [redacted]. The PN dated [redacted] at 12:41 p.m., a LPN documented that the resident was [redacted] NJ Exec Order 26.4b1 [redacted] of his/her [redacted] and stated that he/she [redacted] NJ Exec Order 26.4b1 [redacted]. The LPN documented that the resident was sent to the hospital for admission as per the physician. Additionally, the PN dated from [redacted] NJ Exec Order 26.4b1 [redacted] by the Licensed staff documented [redacted] NJ Exec Order 26.4b1 [redacted], [redacted] NJ Exec Order 26.4b1 [redacted] with [redacted] and [redacted] NJ Exec Order 26.4b1 [redacted] since admission on [redacted]. However, the SP was not developed and updated with interventions to address the resident's [redacted] NJ Exec Order 26.4b1 [redacted] and [redacted] NJ Exec Order 26.4b1 [redacted]. Refer to 8:36-4.1(a)(22)	A 749		

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LABORATORY DIRE [redacted] TITLE (X6) DATE

NJ Exec Order 26.4b1

2/6/25

STATE FORM 6899 YKZO11 If continuation sheet 1 of 7

New Jersey Department of Health

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New Jersey Department of Health

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A401	Continued From page 3 unit [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] and the resident was [NJ Exec Order 26.4b] back to his/her apartment. The LPN also stated that she received a call a bit later, could not recall the exact time from LPN #2 for assistance with Resident #1. LPN #1 stated that when she got to unit [NJ Exec] the [NJ Exec Order 26.4b1] and was told that Resident #1 inserted paper in the toaster. LPN #1 stated that she took the [NJ Exec Orde] outside immediately to [NJ Exec Order 26.4] LPN #2 was not available for interview, no longer worked at facility. The facility failed to provide safe environment to Resident #1, as well as other residents by leaving toasters on the counter top of the kitchenettes in the [NJ Exec Order 26.4b1] when not in use which endangered residents' safety. On 11/29/24 at 12:25 p.m., the surveyor informed the ED of the Imminent Danger (ID) and requested a removal plan to ensure the facility took immediate action to ensure facility residents' safety. The removal plan was acceptable which stated that all toasters were unplugged and removed from the countertops and placed in a locked cabinet when not in use to maintain residents safety.	A401		
A749	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	A749	Resident #1 no longer lives int facility All residents have the potential to be affected by the deficient practice of not updating and revising the general service plan based upon the resident's response to care provided or any changes in a residents physical or cognitive status.	

Received 2/6/25

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A 749	Continued From page 4 physical or cognitive status. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 0180281 Based on interview and record review it was determined that the facility failed to revise and update the Service Plan (SP) with interventions to address the resident's NJ Exec Order 26.4b1 needs for 1 of 3 residents reviewed for SP, Resident #1. The deficient practice was evidenced by the following: On 11/29/24 at 10:55 a.m., the surveyor reviewed the closed medical record of Resident #1, which indicated that the resident was admitted to the facility on NJ Exec Order with diagnoses of NJ Exec Order 26.4b1 [redacted]. The NJ Exec Order 26.4b1 Evaluation" dated NJ Exec Order 26 documented that the resident was NJ Exec Order 26.4b1 but NJ Exec Order 26.4 and per nursing the resident was NJ Exec Order 2 in the afternoon/evening. The Progress Notes (PN) dated NJ Exec Order at 9:15 a.m., written by a Licensed Practical Nurse (LPN) documented that the resident was found NJ Exec Order 26 [redacted]. The LPN documented that the resident stated that someone NJ Exec Order 26.4b1 him/her and NJ Exec Order 26. was noted. The PN NJ Exec Order 26.4b1 at 11:37 p.m., written by a LPN documented that the resident NJ Exec Order 26.4b1 [redacted] on his/her NJ Exec O with little NJ Exec Order 26. to the NJ Exec Order 26.4b1	A 749	The facility has put into place a corrective action plan that will began on 11/30/2024 and is used daily to ensure the deficient practice will not reoccur. All incident reports as well as service plan books are now brought daily to morning meeting to be discussed with all department heads. New Interventions are discussed and written at this time by the Director of Health and Wellness . Also, the corporate management team has required an "At Risk" report to be submitted to the Regional RN each month by day 15. All "at risk" residents and residents that have had a status change or multiple incidents are then discussed by the Regional RN, the Executive Director and the Director of Health and Wellness to determine if any further interventions are needed to safely care for the resident. The Service Plan shall be modified at this time monthly. Received 2/6/25 Accepted 2/14/25	11/30/24

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL13001 Y1	A. Building B. Wing Y2	2/19/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF EATONTOWN	147 GRANT AVENUE EATONTOWN, NJ 07724

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 A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 11/30/2024	ID Prefix A0749 Reg. # 8:36-7.3(a) LSC	Correction Completed 11/30/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			