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
	D35016	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL MEMORY CARE LIVING MAHWAH	699 WYCKOFF AVENUE MAHWAH, NJ 07430

(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
R 000	Initial Comments Complaint #: NJ00155997 Census: 5 Sample: 4 The facility is not in compliance with all of the standards in the New Jersey Administrative Code N.J.A.C. 8:37 Standards for Licensure of Dementia Care Homes.	R 000		
R 365	8:37-3.1(a)(12) Resident Rights Every resident of a dementia care home shall have the right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident. This STANDARD is not met as evidenced by: Complaint #: NJ00155997 Based on interview and record review, it was determined that the facility failed to provide a safe environment for 1 of 4 residents reviewed for abuse, Resident #2, and in addition, failed to follow its "Staff to Resident Abuse" policy by not reporting an [redacted] as evidenced by the following: On 3/27/24 at 11:15 a.m., the surveyor reviewed the Reportable Event Report (RER) provided by the facility which revealed, "On [redacted], it was reported by Caregiver, ... [#1] that on [redacted], ... [Caregiver #2] [redacted] a resident in his/her apartment and NJ Exec Order 26.4b1 . The resident NJ Exec Order 26.4b1 and	R 365		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/21/24

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R 365	Continued From page 1 NJ Exec Order 26.4b1 his/her apartment NJ Exec Order 26.4b1. At no point did ... [Caregiver #1 and #2] NJ Exec Order the door or report the incident to the ED [Executive Director]." At 12:25 p.m., the surveyor interviewed the Regional Executive Director (RED) who stated that on NJ Exec Order, she was informed by a staff member that Caregiver #1 told her that Caregiver #2 NJ Exec Order Resident #2 in his/her apartment during "Overnight shift" [11-7 shift]. The RED stated that she placed a telephone call to both Caregivers and there was no answer. The RED added that Caregiver #2 called out for the overnight shift on NJ Exec Order During continued interview, the RED explained that on NJ Exec Order she met with Caregiver #1 and Caregiver #1 stated that Caregiver #2 NJ Exec Order Resident #2 in the apartment because Caregiver #2 NJ Exec Order 26.4b1 that night due to the resident's NJ Exec Order 26.4b1 The RED stated she informed Caregiver #1 that she was equally responsible for the NJ Exec Order for not reporting the NJ Exec Order immediately. The RED stated Caregiver #1 was NJ Exec Order 26.4b1 pending investigation and Caregiver #1 later resigned on NJ Exec Order from her employment with the company. In addition, the RED stated that she removed Caregiver #2 from the schedule immediately on NJ Exec Order pending investigation and met with Caregiver #2 the following day, on NJ Exec Order The RED stated Caregiver #2 denied the NJ Exec Order 26.4b1 of NJ Exec Order and refused to give a written statement. The RED stated Caregiver #2 was NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1 pending investigation, however, Caregiver #2 handed in her resignation following the NJ Ex Order 26.4(b)(1)	R 365		

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R 365	Continued From page 2 Further surveyor review of the "Resident Rights" policy provided by the facility, indicated, "... 12). A safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident." The "Staff to Resident Abuse policy W402" provided by the facility indicated, "We do not want in our community who abuses those we serve or condones the abuse of those they serve. Being silent is condoning." The facility failed to provide a NJ Exec Order 26.4b1 for Resident #2 while residing at the community, and Caregiver #1 failed to report a NJ Exec Order 26 [redacted] immediately to management.	R 365		
R 456	8:37-4.1(d) Admission & Retention-Health Care Monitoring Absent an emergency, physical or chemical restraints that are being used for the purpose of restricting a person's mobility within the facility are not permitted. Whenever a physical or chemical restraint is being considered for use in a facility, it must be approved in writing by the resident's attending physician with an accompanying rationale for use of same. This STANDARD is not met as evidenced by: Complaint #: NJ00155997 Based on interview and record review, it was determined that the facility failed to prevent two staff members from NJ Exec Order 26.4b1 a resident with NJ Exec Order 26.4b1 [redacted] the resident's apartment for 1 of 4 residents, Resident #2. This deficient practice was	R 456		

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R 456	Continued From page 3 evidenced by the following. On 3/27/24, surveyor review of Resident 2's "Service Plan" revealed the resident had diagnoses of [redacted] without [redacted] and [redacted]. There was no documented evidence that the physician approved or ordered the use of any restraining methods. The facility's "Admission/Discharge Report" indicated the resident, who no longer resided at the facility, move-in date was on [redacted]. According to the Regional Executive Director (RCD), the resident was discharged from the community on [redacted]. At 12:25 p.m., the surveyor interviewed the Regional Executive Director regarding the [redacted] that occurred on [redacted] where Resident #2 was [redacted] in his/her apartment by Caregiver #2 during "Overnight shift" [11-7 shift]. The RED stated that the incident was reported to her on [redacted] and was confirmed by Caregiver #1 who worked with Caregiver #2 on [redacted] during the overnight shift. The RED explained that the two Caregivers no longer were employed by the company. Refer to 8:37-3.1(a)(12)	R 456		
R2000	8:37-8.3 Resident Records-Retention Records shall be retained and preserved in accordance with N.J.S.A. 26:8-5 et seq. This STANDARD is not met as evidenced by: Complaint #: NJ00155997	R2000		

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R2000	Continued From page 4 Based on interview and incomplete closed medical record review, it was determined that the facility failed to retain a complete medical record for resident that was discharged from the facility for 1 of 4 residents reviewed, Resident #2, This deficient practice was evidenced by the following: On 3/27/24 at 10:30 a.m., the surveyor requested the closed medical record of Resident #2, for review. At 11:05 a.m., the Regional Clinical Specialist (RCS) and the Clinical Regional Director (CRD) informed the surveyor that they were not able to locate Resident #2's closed medical record. At 11:40 a.m., the RCS provided the surveyor with print out of the resident's "Service Plan" from the electronic system for review. The RCS stated that was all she could provide the surveyor. Surveyor review of the "Service Plan" revealed the resident had diagnoses of NJ Exec Order 26.4b1 without NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 The facility's "Admission/Discharge Report" indicated the resident, who no longer resided at the facility move-in date was on NJ Exec Order 26 and according to the RCD, the resident was discharged from the community on NJ Exec Order 26.4b1. At 12:55 p.m., the surveyor informed the RCS that the surveyor was unable to complete the investigation due to incomplete closed medical record.	R2000		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
D35016 Y1	A. Building B. Wing Y2	4/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL MEMORY CARE LIVING MAHWAH	699 WYCKOFF AVENUE MAHWAH, NJ 07430

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 R0365 Reg. # 8:37-3.1(a)(12) LSC	Correction Completed 04/30/2024	ID Prefix R0456 Reg. # 8:37-4.1(d) LSC	Correction Completed 04/30/2024	ID Prefix R2000 Reg. # 8:37-8.3 LSC	Correction Completed 04/30/2024
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	
3/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: QGXJ12