

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>sipfep</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE ECHELON LAKE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>207 LAUREL ROAD</b> <b>VOORHEES, NJ 08043</b>
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A 000	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Standard with Complaints</p> <p>Complaint #'s: NJ00163780, NJ00163828, NJ00164012, NJ00173995, NJ00177412, NJ00174457, NJ00176831, NJ00176892, NJ00177803, NJ00178092, NJ00179534, NJ00182921, NJ00183049, NJ00183334, NJ00184315, NJ00184365</p> <p>Census: 106</p> <p>Sample Size: 22</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		

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

TITLE

(X6) DATE

05/23/25



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A 000	Continued From page 2  Care Homes, and Assisted Living Programs, based on this Complaint Survey.  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 310	8:36-3.4(a)(1) Administration  (a) The administrator or designee shall be responsible for, but not limited to, the following:  1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;  This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined that the facility's Executive Director (ED) failed to ensure the implementation, and enforcement of the facility's policies and procedures titled, "COVID-19 Playbook" and "COVID-19 Outbreak Plan-NJ 16" when upon	A 310		

New Jersey Department of Health

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A 310	<p>Continued From page 3</p> <p>entry to the facility, staff failed to provide signage on the main entrance/exit doors, failed to notify visitors of [redacted] in the building and failed to provide masks to visitors to ensure infection control was maintained. This deficient practice was evidenced by the following:</p> <p>On 3/12/25 at 9:07 a.m., while conducting a Standard with Complaints survey, upon entry into the facility, there was no signage on the entrance/exit doors to alert visitors that there was [redacted] in the facility. Once inside the facility, the surveyors did not observe any signage posted or masks offered at the reception area. When the surveyor asked if there was [redacted] in the facility, the receptionist was uncertain.</p> <p>At 9:40 a.m., during an interview when the surveyor asked if there was [redacted] in the building, the Assistant Administrator stated that there were 3 [residents] now.</p> <p>At 11:59 a.m., during an interview with the Health and Wellness Coordinator (HWC), she stated that she wore a mask because there were [redacted] cases in the building, the nurse told the residents, called the doctor, called the Executive Director, notified the on-call nurse to inform the Infection Control Nurse, and that masks were available at the front desk.</p> <p>At 3:30 p.m., the surveyor observed no masks were available at the front desk and no signage was posted on the entry/exit doors to the facility to alert staff and visitors of [redacted] in the building.</p> <p>On 3/13/25 at 8:26 a.m., on entry, there was still no signage posted on the front doors alerting staff and visitors about [redacted] in the building and no masks were available at the front desk.</p>	A 310		

New Jersey Department of Health

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A 310	Continued From page 4  Surveyor review of 9/21 facility revised policy titled, "COVID-19 Outbreak Plan NJ-16" revealed under "Policy Detail/Procedures ...1. Facilities shall communicate through multiple means to inform individuals, including non-essential health care personnel, of the visitation restrictions, such as through signage at entrances/exits...."	A 310		
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;  This REQUIREMENT is not met as evidenced by: NJ00177803 and NJ00178092  Based on interview, record review, and facility document and policy review, the facility failed to provide a safe environment for 3 (Residents #1, #2, and #3) of 3 residents reviewed for safety. Specifically, Resident #1 and Resident #2 [redacted] from the [redacted] unit on [redacted] and Resident #3 [redacted] from the [redacted] on [redacted] without staff knowledge.	A 401		

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A 401	<p>Continued From page 5</p> <p>It was determined that the facility's non-compliance with one or more requirements had caused or was likely to cause serious injury, harm, impairment, or death to residents.</p> <p>On 10/11/2024, the New Jersey Department of Health determined the failed practice represented an immediate threat to residents' health and safety. The facility's Executive Director (ED) was provided a copy of an imminent danger template and informed of the immediacy of the situation involving the resident's elopement, and a Removal Plan was requested.</p> <p>Findings included:</p> <p>A facility policy titled, "Missing Resident Policy," revised July 2024, revealed, "A missing resident requires immediate associate attention. If associates discover a resident's [redacted] are [redacted] associates must immediately begin to follow the procedures of this Missing Resident Policy. A visual [redacted] of the [redacted] resident is considered confirmation that the resident has been [redacted]."</p> <p>1. An "Admission Record" revealed the facility admitted Resident #1 on [redacted]. According to the Admission Record, the resident had a medical history that included diagnoses of [redacted].</p> <p>Resident #1's "PSA [Personal Service Assessment] Q&amp;A [Question and Answer]," dated [redacted] indicated that the resident had [redacted]. The record indicated that the resident had [redacted] that required [redacted]. The record indicated that the resident did not attempt to [redacted].</p>	A 401		
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A 401	<p>Continued From page 6</p> <p>the <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #1's "Personal Service Plan [PSP]," dated <b>NJ Exec Order 26.4b1</b>, revealed it did not indicate that the resident <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #1's "Personal Service Plan," dated <b>NJ Exec Order 26.4b1</b>, revealed that, on <b>NJ Exec Order 26.4b1</b>, the resident <b>NJ Exec Order 26.4b1</b> with another resident via an <b>NJ Exec Order 26.4b1</b>. The PSP revealed the resident <b>NJ Exec Order 26.4b1</b> and required <b>NJ Exec Order 26.4b1</b> and indicated that the resident attempted to <b>NJ Exec Order 26.4b1</b> without needed <b>NJ Exec Order 26.4b1</b>. Interventions directed staff to <b>NJ Exec Order 26.4b1</b> the resident away from an <b>NJ Exec Order 26.4b1</b> using a "<b>NJ Exec Order 26.4b1</b>" and to offer <b>NJ Exec Order 26.4b1</b>. Interventions also directed staff to direct the resident to an "<b>NJ Exec Order 26.4b1</b>."</p> <p>An "Admission Record" revealed the facility admitted Resident #2 on <b>NJ Exec Order 26.4b1</b>. According to the Admission Record, the resident had a medical history that included diagnoses of <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b> <b>NJ Exec Order 26.4b1</b>).</p> <p>Resident #2's "PSA Q&amp;A," dated <b>NJ Exec Order 26.4b1</b>, indicated that the resident had <b>NJ Exec Order 26.4b1</b> or <b>NJ Exec Order 26.4b1</b>. The record revealed that the resident had <b>NJ Exec Order 26.4b1</b> requiring <b>NJ Exec Order 26.4b1</b>. The record indicated that the resident did not attempt to <b>NJ Exec Order 26.4b1</b> without <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #2's "Personal Service Plan," dated <b>NJ Exec Order 26.4b1</b>, revealed, "[Resident #2] has <b>NJ Ex</b> <b>NJ Exec Order 26.4b1</b> reported."</p> <p>Resident #2's "Personal Service Plan," dated</p>	A 401		

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A 401	<p>Continued From page 7</p> <p>NJ Exec Order 26.4b1, revealed that, on NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1 with another resident via an NJ Exec Order 26.4b1. The PSP revealed that the resident NJ Exec Order 26.4b1 and required NJ Exec Order 26.4b1 and indicated that the resident NJ Exec Order 26.4b1 without needed NJ Exec Order 26.4b1 interventions directed staff to the resident away from an NJ Exec Order 26.4b1 using a NJ Exec Order 26.4b1 and to NJ Exec Order 26.4b1. Interventions also directed staff to the resident to an "NJ Exec Order 26.4b1 space."</p> <p>A report to the state survey agency, dated NJ Exec Order 26.4b1, revealed that, on NJ Exec Order 26.4b1 at approximately 1:00 PM, Resident #1 and Resident #2 were NJ Exec Order 26.4b1. The report indicated that the residents were NJ Exec Order 26.4b1 by the receptionist and were assessed by nursing."</p> <p>Untitled, handwritten facility documents, dated NJ Exec Order 26.4b1 and provided as the facility investigation, indicated that, on NJ Exec Order 26.4b1, Resident #1 and Resident #2 NJ Exec Order 26.4b1 via an NJ Exec Order 26.4b1 that they NJ Exec Order 26.4b1 after NJ Exec Order 26.4b1. The documents indicated interventions that were implemented included the following:</p> <ul style="list-style-type: none"> <li>- Staff education was provided to monitor NJ Exec Order 26.4b1 doors.</li> <li>- Remind visitors to watch for residents, so they do not enter the NJ Exec Order 26.4b1 without staff members.</li> <li>- The NJ Exec Order 26.4b1 need to close completely after visitors exit.</li> <li>- The NJ Exec Order 26.4b1 codes were changed.</li> <li>- The staff were reminded to not give out codes to visitors.</li> <li>- The staff are to enter codes for visitors.</li> <li>- The receptionist makes an announcement to the</li> </ul>	A 401		
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A 401	<p>Continued From page 8</p> <p>fourth-floor staff via two-way radio to notify them of visitors coming to the fourth floor so they can greet the visitors and ensure the elevator door shuts. - Visitors are reminded to avoid allowing residents to enter the elevator without a staff member.</p> <p>2. An "Admission Record" revealed the facility admitted Resident #3 into the [redacted] or [redacted]. According to the Admission Record, the resident had a medical history that included diagnoses of [redacted] and [redacted].</p> <p>Resident #3's "PSA [Personal Service Assessment] Q&amp;A [Question and Answer]," dated [redacted], indicated that the resident had [redacted]. The record indicated that the resident had [redacted]. The record indicated that the resident did not [redacted] without [redacted].</p> <p>Resident #3's "Personal Service Plan [PSP]," dated [redacted] revealed, "[The resident] has [redacted] and [redacted] as stated by the [family member]."</p> <p>Resident #3's "Progress Notes" revealed a note, dated [redacted] at 8:19 PM, and documented by Registered Nurse (RN) #5, that revealed the resident was [redacted]. The note indicated that the resident was [redacted] and that [redacted] was called. The note indicated that the resident was returned in the [redacted]. Per the note, the resident was [redacted] and vital signs were checked and were [redacted].</p>	A 401		

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A 401	<p>Continued From page 9</p> <p>Resident #3's "Personal Service Plan," dated [redacted], revealed that the resident [redacted] and [redacted] and indicated that the resident attempted to [redacted]. Interventions directed staff to [redacted] the resident away from an [redacted] using a [redacted]" and to offer [redacted]. Interventions also directed staff to [redacted] the resident to an "[redacted]."</p> <p>A report to the state survey agency, dated [redacted] revealed that, on [redacted] at 1:30 PM, Resident #3 was observed [redacted]. The document indicated that the resident was sent to the [redacted] for an evaluation due to a [redacted].</p> <p>An untitled, handwritten facility document, dated [redacted] and provided as a facility investigation, revealed that Resident #3 got on an [redacted] when a [redacted] entered the [redacted] after [redacted]. The document indicated that the [redacted] thought Resident #3 was a [redacted]. Per the document, the resident got to the [redacted], then the receptionist notified the administrative staff that the resident was [redacted] the [redacted]. The document indicated that administrative staff immediately responded. Per the document, the resident was resistant to [redacted] and [redacted] to [redacted] to the [redacted] and [redacted] was called. The document indicated that the resident was [redacted] to the [redacted] for evaluation due to [redacted] and [redacted] to go [redacted].</p> <p>During an interview on 10/10/2024 at 12:17 PM, the Director of Activity (DA) stated she was the only activity staff member in the [redacted] unit. She stated there were more than 30</p>	A 401		
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A 401	<p>Continued From page 10</p> <p>residents in the [redacted] unit. The DA stated that, on [redacted], she did not recall observing Resident #1 or Resident #2 [redacted]. The DA also stated that, on [redacted] she did not observe Resident #3 [redacted]. She revealed she was notified of Residents #1's, #2's, and #3's [redacted] after they were [redacted] to the [redacted]. She stated that the residents had [redacted] and she did not know how they got on the [redacted].</p> <p>During an interview on 10/10/2024 at 12:50 PM, Certified Medication Aide (CMA) #1 stated she was not scheduled to work on [redacted], so she did not observe Resident #1 and Resident #2 get on the [redacted]. CMA #1 stated that, on [redacted] when she came back from a break, she was told that Resident #3 had [redacted] found in the [redacted] after [redacted]. She stated that Resident #3 had been [redacted] in the activity room before she went on a break.</p> <p>During an interview on 10/10/2024 at 1:04 PM, Certified Nursing Assistant (CNA) #2 stated she was not scheduled to work on [redacted]. She stated she was scheduled to work in the [redacted] unit on [redacted] but did not observe Resident #3 [redacted].</p> <p>During an interview on 10/10/2024 at 1:57 PM, Receptionist #6 stated that she was sitting at the reception desk when she observed Resident #1 and Resident #2 [redacted]. She stated she recognized that the two residents were coming from the [redacted]. She stated that she called the nurse on the [redacted] floor, notifying her of the two unattended residents [redacted]. She stated she</p>	A 401		
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A 401	<p>Continued From page 11</p> <p>(Receptionist #6) took the residents back to the <b>NJ Exec Order 26.4b1</b>. Receptionist #6 further stated that, on <b>NJ Exec Order 26.4b1</b>, she observed Resident #3 in the <b>NJ Exec Order 26.4b1</b>. She stated she notified the nurse on the <b>NJ Exec Order 26.4b1</b> about Resident #3 <b>NJ Exec Order 26.4b1</b> and also notified the Clinical Healthcare Director (CHD) and the ED. She stated that Resident #3 <b>NJ Exec Order 26.4b1</b> was called, and the resident was <b>NJ Exec Order 26.4b1</b> to the hospital <b>NJ Exec Order 26.4b1</b>.</p> <p>During an interview on 10/10/2024 at 2:23 PM, CNA #3 stated that she was scheduled to work on the <b>NJ Exec Order 26.4b1</b> on <b>NJ Exec Order 26.4b1</b>. She stated that she did not observe Resident #1 or Resident #2 <b>NJ Exec Order 26.4b1</b>. She stated that the residents had <b>NJ Exec Order 26.4b1</b>.</p> <p>During an interview on 10/10/2024 at 2:54 PM, CNA #4 stated that she was working in the <b>NJ Exec Order 26.4b1</b> but did not see Resident #1 or Resident #2 <b>NJ Exec Order 26.4b1</b>. She stated that she was taking care of other residents in the unit when Resident #1 and Resident #2 <b>NJ Exec Order 26.4b1</b>.</p> <p>During an interview on 10/11/2024 at 3:20 PM, the Executive Director (ED) stated that, on <b>NJ Exec Order 26.4b1</b>, Resident #1 and Resident #2 <b>NJ Exec Order 26.4b1</b>. The ED stated the investigation revealed that a family member was moving a new resident's items to the <b>NJ Exec Order 26.4b1</b> and did not notice the two residents <b>NJ Exec Order 26.4b1</b>. She also stated that Resident #3 <b>NJ Exec Order 26.4b1</b> when the <b>NJ Ex Order 26.4(b)(1)</b> thought that the resident was a <b>NJ Exec Order 26.4b1</b>. The ED stated</p>	A 401		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>sipfep</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE ECHELON LAKE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>207 LAUREL ROAD VOORHEES, NJ 08043</b>
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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
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A 401	<p>Continued From page 12</p> <p>that, in both incidents, the receptionist was able to observe the residents in the lobby and notify the staff. She stated that Resident #3 [redacted] as called, and the resident was sent to the [redacted] for an evaluation.</p> <p>During an interview on 10/11/2024 at 1:30 PM, the Clinical Healthcare Director (CHD) stated that, on [redacted], Resident #1 and Resident #2 [redacted] from the [redacted] unit after visitors, who were moving items to the [redacted]. She stated that, on [redacted] Resident #3 entered the [redacted] after the hairdresser thought the resident was a [redacted]. The CHD stated that the receptionist saw the residents in the [redacted] and was able to notify the nurse in the [redacted] the residents were in the [redacted]. The CHD stated that Resident #3 was a [redacted] resident [redacted] and, when they were [redacted], the resident [redacted] to go back to the [redacted]. She stated [redacted] was called and Resident #3 was [redacted] to the [redacted] for an evaluation.</p> <p>Complaint #'s: NJ00177803, NJ00178092, NJ00183334</p> <p>Based on observation, interview and review of records, it was determined that the facility failed to ensure the resident right to safety related to the [redacted] of 4 of 22 residents reviewed, Resident#s 1, 2, 3 and 4. This deficient practice was evidenced by the following:</p> <p>1. On [redacted] at 11:01 a.m., the Department of Health (DOH), received a Facility Reportable Event (FRE), (A document utilized by health care</p>	A 401		
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New Jersey Department of Health

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A 401	<p>Continued From page 13</p> <p>facilities to report incidents to the DOH), which revealed that on [redacted] at approximately 1:00 p.m., two facility residents who resided in the [redacted] NJ Exec Order 26.4b1 Resident #3 and Resident #4, were observed by the receptionist [redacted] NJ Exec Order 26.4b1. The FRE further revealed that the residents were immediately [redacted] NJ Exec Order 26.4b1 to the [redacted] NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed Resident #3's medical record (MR) which revealed that Resident #3 moved into the facility in [redacted] NJ Exec Order 26.4b1 and had diagnoses of [redacted] NJ Exec Order 26.4b1 and an [redacted] NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed Resident #4's MR which revealed that Resident #4 moved into the facility in [redacted] NJ Exec Order 26.4b1 and had diagnoses of [redacted] NJ Exec Order 26.4b1 and a [redacted] NJ Exec Order 26.4b1.</p> <p>2. On [redacted] NJ Exec Order 26.4b1 at 12:09 p.m., the NJDOH received a FRE, which revealed that on [redacted] NJ Exec Order 26.4b1 at approximately 1:30 p.m., a facility resident, Resident #1, was observed by the receptionist [redacted] NJ Exec Order 26.4b1. The FRE further revealed that Resident #1 was [redacted] NJ Exec Order 26.4b1 for evaluation for a [redacted] NJ Exec Order 26.4b1 and returned the same evening.</p> <p>The surveyor reviewed Resident #1's MR which revealed Resident #2 moved into the facility in [redacted] NJ Exec Order 26.4b1 and had a diagnosis of [redacted] NJ Exec Order 26.4b1.</p> <p>3. On [redacted] NJ Exec Order 26.4b1 at 10:49 a.m., the DOH received a FRE which revealed that on [redacted] NJ Exec Order 26.4b1 at approximately 3:12 p.m., a facility resident, Resident, Resident #2 was [redacted] NJ Exec Order 26.4b1 in the</p>	A 401		

New Jersey Department of Health

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A 401	<p>Continued From page 14</p> <p><b>NJ Exec Order 26.4b1</b> and that it was unclear how the resident <b>NJ Exec Order 26.4b1</b>.</p> <p>The surveyor reviewed Resident #2's MR which revealed that Resident #2 moved into the facility in <b>NJ Exec Order 26.4b1</b> and had diagnoses of <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b>.</p> <p>On 3/12/24 At 10:32 a.m., the surveyor interviewed a facility Certified Medication Aide (CMA), who stated that although she was not working when Resident #1, Resident #2, Resident #3 or Resident #4 <b>NJ Exec Order 26.4b1</b> she stated that she was aware that the <b>NJ Exec Order 26.4b1</b> occurred. The CMA explained that there was a code which had to be entered on the inside of the <b>NJ Exec Order 26.4b1</b> which was where the <b>NJ Exec Order 26.4b1</b> ) was located; and, that there was another code located on the <b>NJ Exec Order 26.4b1</b>, if a person wanted to <b>NJ Exec Order 26.4b1</b>.</p> <p>The CMA further explained however, if the <b>NJ Exec Order 26.4b1</b> was <b>NJ Exec Order 26.4b1</b>, a person could get into the elevator and leave the <b>NJ Exec Order 26.4b1</b>. During continued surveyor interview, the CMA stated that there used be a sign on the inside and outside of the <b>NJ Exec Order 26.4b1</b> and on the first floor, that cautioned visitors about the <b>NJ Exec Order 26.4b1</b>. The CMA was not sure why the signage was no longer there, but stated that it had been awhile since the signs were there.</p> <p>At 10:45 a.m., the surveyor observed that there were no signs regarding the <b>NJ Exec Order 26.4b1</b> on the <b>NJ Exec Order 26.4b1</b> outside of the <b>NJ Exec Order 26.4b1</b> or on the <b>NJ Exec</b> floor.</p> <p>At 11:22 a.m. the surveyor interviewed a facility Licensed Practical Nurse (LPN #1), who stated</p>	A 401		

New Jersey Department of Health

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A 401	<p>Continued From page 15</p> <p>that she was the Health and Wellness Coordinator (HWC) and oversaw the [redacted] LPN #1 stated that she was aware of the [redacted] and it was determined that the residents must have [redacted] and then took the [redacted] to the [redacted]. LPN #1 stated that there used to be a sign by the [redacted] that instructed visitors not to [redacted] until it was closed, but that the signs were no longer there.</p> <p>On 3/12/25 at 1:12 p.m., the surveyor reviewed the facility investigation, summary and conclusion regarding Resident #3 and Resident #4's [redacted]. The investigation revealed that it was determined that the [redacted] was open because a [redacted] resident was [redacted] into the facility; and, that must have been when Resident #3 and Resident #4 [redacted] and [redacted].</p> <p>On 3/13/24 at 2:45 p.m., the surveyor reviewed the facility investigation summary regarding Resident #2's [redacted] which revealed that Resident #2 was [redacted] in the [redacted] by a care partner as she was [redacted] to start her shift. The investigation further revealed that the receptionist saw Resident #2 [redacted], but did not realize it was a facility resident. It was further determined that at change of shift, an incoming employee may have sent the [redacted] to the [redacted] but got off on a [redacted]; and, the [redacted] continued to the [redacted]. Resident #2 [redacted].</p>	A 401		
A 565	8:36-5.10(a)(3) General Requirements  (a) The facility shall notify the Division of Health	A 565		

New Jersey Department of Health

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A 565	<p>Continued From page 16</p> <p>Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following:</p> <p>3. Any suspected cases of resident abuse or exploitation which have been reported to the State Long-Term Care Ombudsman.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00164012</p> <p>Based on observation, interview, and record review, it was determined that the facility staff failed to report an <b>NJ Exec Order 26.4b1</b> incident of <b>NJ Exec Order 26.4b1</b> immediately to Administration and the Department of Health (DOH) in accordance with state regulated reporting for 1 of 22 residents, Resident #15 as evidenced by the following:</p> <p>On <b>NJ Exec Order 26.4b1</b> through <b>NJ Exec Order 26.4b1</b> the Department of Health (DOH) investigated a Facility Reportable Event dated <b>NJ Exec Order 26.4b1</b> regarding an <b>NJ Exec Order 26.4b1</b> staff to resident <b>NJ Exec Order 26.4b1</b>. According to the FRE, the Administration was not made aware of the <b>NJ Exec Order 26.4b1</b> until <b>NJ Exec Order 26.4b1</b>.</p> <p>On 3/14/25 at 12:00 p.m., the surveyor reviewed Resident #15's closed electronic medical record which revealed that the resident moved into the facility in <b>NJ Exec Order 26.4b1</b> and was discharged in</p>	A 565		
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New Jersey Department of Health

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A 565	<p>Continued From page 17</p> <p>NJ Exec Order 26.4b1, with diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1</p> <p>During MR review, the surveyor observed that a Health and Wellness Director on NJ Exec Order 26.4b1 at 9:37 p.m., documented in the "Progress Notes" that Resident #15 had NJ Exec Order 26.4b1 [was] NJ Exec Order 26.4b1 ...Resident NJ Exec Order 26.4b1 on a staff [member] NJ Exec Order 26.4b1. ..."</p> <p>At 1:00 p.m., the surveyor interviewed the Executive Director regarding the FRE of an NJ Exec Order 26.4b1 incident of NJ Exec Order 26.4b1. The ED stated that she was not employed at the facility during the time of the incident on NJ Exec Order 26.4b1. In addition, the ED stated that the employees involved in the NJ Exec Order 26.4b1 incident no longer worked at the facility. The ED then provided the surveyor with a copy of the facility investigation "Summary and Conclusion" report.</p> <p>At 1:15 p.m., the surveyor reviewed the investigation "Summary and Conclusion" report that revealed "The incident was reported late to administration. [The] incident occurred on NJ Exec Order 26.4b1 [and] Administration was made aware on NJ Exec Order 26.4b1."</p> <p>According to surveyor review of the FRE, the facility reported the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 to the DOH on NJ Exec Order 26.4b1</p> <p>The surveyor reviewed the revised 5/21 facility policy and procedure titled, "Abuse, Neglect &amp; Exploitation Policy-NJ-1" that revealed "...3. Internal Reporting: a. Associate Obligations. Any associate who witnesses or becomes aware of alleged abuse, neglect or exploitation, should report such incident to the Executive Director or</p>	A 565		

New Jersey Department of Health

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A 565	Continued From page 18 supervisor on duty immediately ...."	A 565		
A 577	<p>8:36-5.11(a)(2) General Requirements</p> <p>(a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public:</p> <p style="padding-left: 40px;">2. A copy of the last annual licensure inspection survey report and the list of deficiencies from any valid complaint investigation during the past 12 months;</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and interview, it was determined that the facility failed to provide annual inspections. This deficient practice was evidenced by the following:</p> <p>1. On 3/5/25 at 1:00 p.m., the surveyor observed, during documentation review, that the facility failed to provide 1 semiannual kitchen suppression inspection.</p> <p>2. On 3/5/25 at 1:00 p.m., the surveyor observed, during documentation review, that the facility failed to provide the annual fire inspection.</p> <p>2. On 3/5/25 at 1:00 p.m., the surveyor observed, during documentation review, that the facility failed to provide the annual electrical inspection.</p> <p>The surveyor interviewed the Administrator who acknowledged the above.</p>	A 577		

New Jersey Department of Health

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A 765	<p>8:36-7.4(c)(1) Resident Assessments and Care Plans</p> <p>(c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following:</p> <p>1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital;</p> <p>This REQUIREMENT is not met as evidenced by: NJ00178092</p> <p>Based on interview, record review, and facility document and policy review, the facility failed to assess residents upon return from the hospital. The deficiency affected 1 (Resident #3) of 3 residents reviewed for safety.</p> <p>It was determined that the facility's non-compliance with one or more requirements had caused or was likely to cause serious injury, harm, impairment, or death to residents.</p> <p>On 10/11/2024, the New Jersey Department of Health determined the failed practice represented an immediate threat to residents' health and safety. The facility's Executive Director (ED) was provided a copy of an imminent danger template and informed of the immediacy of the situation involving the resident's <span style="background-color: black; color: white; font-size: small;">NJ Exec Order 26.4b1</span> and a Removal Plan was requested.</p>	A 765		

New Jersey Department of Health

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A 765	<p>Continued From page 20</p> <p>Findings included:</p> <p>A facility policy titled, "Resident Evaluation Policy," revised April 2015, revealed, "A comprehensive evaluation/assessment will be completed for each prospective resident to determine if his or her service, health and care needs can be adequately met at [the facility]. Once the service needs are determined, specifics of the services and pricing required will be documented in the Service Plan (e.g. [exempli gratia; for example] Personal Service Plan)."</p> <p>An "Admission Record" revealed the facility admitted Resident #3 into the <b>NJ Exec Order 26.4b1</b> unit on <b>NJ Exec Order 26.4b1</b>. According to the Admission Record, the resident had a medical history that included diagnoses of <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #3's "PSA [Personal Service Assessment] Q&amp;A [Question and Answer]," dated <b>NJ Exec Order 26.4b1</b>, indicated that the resident had <b>NJ Exec Order 26.4b1</b>. The record indicated that the resident had <b>NJ Exec Order 26.4b1</b>. The record indicated that the resident did not attempt to <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #3's "Personal Service Plan [PSP]," dated <b>NJ Exec Order 26.4b1</b> revealed, "[The resident] has <b>NJ Exec Order 26.4b1</b> of <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b> as stated by the [family member]."</p> <p>Resident #3's "Progress Notes" revealed a note, dated <b>NJ Exec Order 26.4b1</b> at 8:19 PM, and documented by Registered Nurse (RN) #5, that revealed the resident was seen in the <b>NJ Exec Order 26.4b1</b>, <b>NJ Exec Order 26.4b1</b>. The note indicated that the</p>	A 765		

New Jersey Department of Health

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A 765	<p>Continued From page 21</p> <p>resident was [redacted] and that [redacted] was called. The note indicated that the resident was [redacted] in the <b>NJ Exec Order 26.4b1</b> [redacted]. Per the note, the resident was [redacted] and vital signs were checked and were <b>NJ Exec Order 26.4b1</b>.</p> <p>A report to the state survey agency, dated [redacted], revealed that, on [redacted] at 1:30 PM, Resident #3 was observed [redacted]. The document indicated that the resident was sent to the [redacted] for an evaluation due to a <b>NJ Exec Order 26.4b1</b>.</p> <p>An untitled, handwritten facility document, dated [redacted] and provided as a facility investigation, revealed that Resident #3 [redacted] when a [redacted] entered the [redacted] after <b>NJ Exec Order 26.4b1</b>. The document indicated that the [redacted] thought Resident #3 was a [redacted]. Per the document, the resident got to the [redacted] then the receptionist notified the administrative staff that the resident was [redacted] the [redacted]. The document indicated that administrative staff immediately responded. Per the document, the resident was [redacted] to [redacted] and [redacted] to [redacted] to the [redacted] floor, and [redacted] was called. The document indicated that the resident was transported to the [redacted] for evaluation due to [redacted] and [redacted] to go <b>NJ Exec Order 26.4b1</b>.</p> <p>During an interview on 10/11/2024 at 3:20 PM, the ED stated that Resident #3 got on the [redacted] when the [redacted] thought the resident was a [redacted]. She stated that the receptionist observed the resident [redacted] and notified staff. She stated that Resident #3 <b>NJ Exec Order 26.4b1</b></p>	A 765		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>sipfep</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE ECHELON LAKE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>207 LAUREL ROAD</b> <b>VOORHEES, NJ 08043</b>
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A 765	Continued From page 22  was called and the resident was sent to the hospital for an evaluation. She stated that she did not find a completed readmission assessment after the resident <b>NJ Exec Order 26.4b1</b> . The ED stated that she expected the nurse to complete a readmission assessment after a resident was readmitted back to the facility.	A 765		
A 779	8:36-7.5(c) Resident Assessments and Care Plans  (c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care.  This REQUIREMENT is not met as evidenced by: Complaint #'s: NJ00173995, NJ00176892, NJ00177412, NJ00179534, NJ00183049  Based on observation, interview, and record review, it was determined that the facility failed to ensure that the Registered Nurse (RN) was notified of a resident <b>NJ Exec Order 26.4b1</b> , to determine the need for assessment and further nursing care interventions for 5 of 22 residents, Resident #'s 5, 6, 7, 8, and 9. This deficient practice was evidenced by the following:  1. On 3/13/25 at 2:00 p.m., the surveyor reviewed the medical Record (MR) of Resident #8 which	A 779		

New Jersey Department of Health

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A 779	<p>Continued From page 23</p> <p>revealed the resident moved into the facility in NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1</p> <p>During MR review, the surveyor observed that a Licensed Practical Nurse (LPN) on NJ Ex Order 26.4b1 at 16:06 p.m., documented in the "Progress Notes" that Resident #7 "NJ Exec Order 26.4b1 [did other resident NJ Exec and NJ Exec Order 26.4b1 Resident #8]. Resident #8 has a NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 d. [Resident #8's] NJ Exec and doctor [were] notified."</p> <p>On 3/14/25 at 11:45 a.m., the surveyor reviewed Resident #7's medical record (MR) which revealed that Resident #7 moved into the facility in NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1</p> <p>During MR review, the surveyor observed that a Licensed Practical Nurse (LPN) on NJ Exec Order 26.4b1 at 1:49 p.m., documented in the "Progress Notes" that Resident #7 was NJ Exec Order 26.4b1 by a resident, that required staff intervention and assistance to NJ Exec Order 26.4b1. In addition, the LPN documented that Resident #7 "was noted with NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1]. The LPN documented that the resident's Power of Attorney and Physician was notified.</p> <p>The surveyor did not observe documentation in Resident #7's or 8's MR that reflected a Registered Nurse was notified to determine the need for assessment and treatment.</p> <p>At 1:00 p.m., the surveyor interviewed LPN #1 regarding the incident that occurred on NJ Exec Order 26.4b1</p>	A 779		

New Jersey Department of Health

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A 779	<p>Continued From page 24</p> <p>where Resident #7 was <b>NJ Exec Order 26.4b1</b>. The LPN stated that she did not recall the details of the incident.</p> <p>At 1:55 p.m., the surveyor interviewed LPN #2 regarding the documented incident that occurred on <b>NJ Exec Order 26.4b1</b> where Resident #8 was <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b> by another resident. The LPN stated that the LPN's handled resident incidents and that she could not recall if the RN was notified. In addition, the LPN stated that the Corporate RN was usually notified if there was no RN in the building.</p> <p>At 2:00 p.m., the surveyor interviewed the Regional RN regarding notification of <b>NJ Exec Order 26.4b1</b> in resident's <b>NJ Exec Order 26.4b1</b>. The RN stated that he was only made aware of a <b>NJ Exec Order 26.4b1</b> in a resident's <b>NJ Exec Order 26.4b1</b>.</p> <p>2. On 3/13/25 at 12:00 p.m., the surveyor reviewed Resident #5's medical record (MR) which revealed that Resident #5 moved into the facility in <b>NJ Exec Order 26.4b1</b> and had diagnoses of <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b>.</p> <p>The surveyor reviewed a progress note (PN) dated <b>NJ Exec Order 26.4b1</b> at 2:06 p.m., written by a Licensed Practical Nurse (LPN) who was also the Health and Wellness Coordinator (LPN #1), which revealed that Resident #5 had a <b>NJ Exec Order 26.4b1</b> on the <b>NJ Exec Order 26.4b1</b> and that the doctor was notified. The surveyor reviewed a PN dated <b>NJ Exec Order 26.4b1</b> at 11:59 a.m., written by LPN #1, which revealed that a physician's order was received for Resident #5's <b>NJ Exec Order 26.4b1</b> for <b>NJ Exec Order 26.4b1</b> to <b>NJ Exec Order 26.4b1</b> and also the <b>NJ Exec Order 26.4b1</b>.</p> <p>The surveyor observed an additional PN dated 1/30/25 at 2:25 p.m., written by a LPN/ Infection</p>	A 779		

New Jersey Department of Health

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A 779	<p>Continued From page 25</p> <p>Preventionist ((LPN #2) which revealed that LPN #2 was notified that Resident #5 had a [redacted] NJ Exec Order 26.4b1. The PN additionally revealed that LPN #2 and a home care nurse completed a [redacted] NJ Exec Order 26.4b1 on Resident #5 which revealed the following: NJ Exec Order 26.4b1 [redacted]</p> <p>The PN further revealed that Resident #5 was sent to the hospital for a [redacted] NJ Exec Order 26.4b1 and was then admitted to the hospital with [redacted] NJ Exec Order 26.4b1. The surveyor reviewed the MR which revealed no documentation to reflect that the Registered Nurse (RN) was initially notified of a [redacted] NJ Exec Order 26.4b1 in [redacted] NJ Exec Order 26.4b1 to determine the need for assessment and changes to the plan of care, regarding Resident #5's [redacted] NJ Exec Order 26.4b1.</p> <p>On 3/13/25 at 1:00 p.m., the surveyor reviewed Resident #6's MR which revealed that Resident #6 moved into the facility in [redacted] NJ Exec Order 26.4b1 with diagnoses of [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed the MR which revealed that Resident #6 had a [redacted] NJ Exec Order 26.4b1 on the dates of [redacted] NJ Exec Order 26.4b1. The surveyor observed no documentation to reflect that the RN was notified of the [redacted] NJ Exec Order 26.4b1 for assessment and follow up.</p> <p>The surveyor observed a PN dated [redacted] NJ Exec Order 26.4b1 at 10:25 p.m., by a facility LPN (LPN #3), which revealed that Resident #6 was accompanied to the [redacted] NJ Exec Order 26.4b1 by his/her [redacted] NJ Exec Order 26.4b1 because he/she complained of [redacted] NJ Exec Order 26.4b1. The PN further indicated that Resident #6 returned to the facility</p>	A 779		

New Jersey Department of Health

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A 779	<p>Continued From page 26</p> <p>with a <b>NJ Exec Order 26.4b1</b> and a diagnosis of a <b>NJ Exec Order 26.4b1</b>. The surveyor observed no documentation to reflect that the RN was notified to determine the need for assessment and changes to plan of care.</p> <p>An additional PN dated <b>NJ Exec Order 26.4b1</b> at 10:44 p.m. written by LPN #3 revealed that Resident #6 returned from the ER and had <b>NJ Exec Order 26.4b1</b>.</p> <p><b>NJ Exec Order 26.4b1</b> The surveyor observed no documentation to reflect why the resident was sent to the hospital or that the RN was notified to determine the need for assessment and changes to the plan of care for Resident #6.</p> <p>3. The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE) (A form utilized by health care facilities to report events), dated <b>NJ Exec Order 26.4b1</b>, with a "Date of Event" of <b>NJ Exec Order 26.4b1</b>, and a "Time of Event" of 7:00 p.m. The FRE revealed that a facility resident, Resident #9, was <b>NJ Exec Order 26.4b1</b>.</p> <p><b>NJ Exec Order 26.4b1</b> of her/his <b>NJ Exec Order 26.4b1</b>. No <b>NJ Exec Order 26.4b1</b> or <b>NJ Exec Order 26.4b1</b> was <b>NJ Exec Order 26.4b1</b> by the facility staff.</p> <p>On 3/13/25 at 12:30 p.m., the surveyor interviewed a facility LPN/Infection Preventionist (IP) and the Regional Clinical Support RN, who stated that residents should be assessed when there was a <b>NJ Exec Order 26.4b1</b>, but the assessment was not always performed by an RN. The LPN and Support RN also stated that residents were not always assessed by an RN when they return from the hospital.</p> <p>On 3/14/25 at 11:30 a.m., the surveyor reviewed the MR for Resident #9, who was admitted in <b>NJ Exec Order 26.4b1</b>.</p>	A 779		
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New Jersey Department of Health

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A 779	<p>Continued From page 27</p> <p><b>NJ Exec Order 26.4b1</b> with diagnoses that included <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b></p> <p>Continued surveyor review of Resident #9's nurses notes (NN) revealed that on <b>NJ Exec Order 26.4b1</b> resident #9 was observed by care staff <b>NJ Exec Order 26.4b1</b> in the <b>NJ Exec Order 26.4b1</b> and coming from <b>NJ Exec Order 26.4b1</b>. The <b>NJ Exec Order 26.4b1</b> was <b>NJ Exec Order 26.4b1</b>. The Nurse Practitioner (NP) was notified and instructed staff to call <b>NJ Exec Order 26.4b1</b> and send Resident #9 to local hospital emergency room (ER).</p> <p>Further review of Resident #9's NN dated <b>NJ Exec Order 26.4b1</b> at 12:21 returned from the <b>NJ Exec Order 26.4b1</b> at approximately 2:30 a.m. with a diagnosis of <b>NJ Exec Order 26.4b1</b>. <b>NJ Exec Order 26.4b1</b> The care staff reported to the LPN on duty that Resident #9 was <b>NJ Exec Order 26.4b1</b> and had <b>NJ Exec Order 26.4b1</b>. The NP was made aware of Resident #9's symptoms and instructed the LPN to send Resident #9 back to the area hospital <b>NJ Exec Order 26.4b1</b>. The facility failed to provide documented evidence that the RN was notified of the resident's <b>NJ Exec Order 26.4b1</b>.</p> <p>On 3/14/25 at 1:00 p.m., the surveyor reviewed 5/2000 facility policy titled, "Documentation Policy - DOC-1" which revealed the following: "Policy Overview ...Documentation is completed on a documentation by exeption basis. Documentation of exceptions in care and services provided may include events such as ...resident change in condition, unexpected clinical outcomes... Policy detail... Health and Wellness Director (HWD), nurse or designee should document in the resident record those events and changes of condition that require physician/healthcare provider notification, additional monitoring, or specific interventions....a. Associates should notify the nurse/designee of a resident change of condition and b. The nurse/designee should</p>	A 779		

New Jersey Department of Health

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A 779	Continued From page 28  document follow up observations at a minimum of every shift for at least 72 hours or unless further indicated. 3. Documentation should include exceptions to care-specific details with the resident's response to care provided which may include care provided by third party providers...."	A 779		
A 891	8:36-10.5(a) Dining Services  (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and in accordance with the New Jersey Administrative Code (N.J.A.C.) 8:24 "Sanitation in Retail Food Establishments, Food and Beverage Vending Machines and Cottage Food Operations," it was determined that the dietary staff failed to monitor and record refrigerator temperatures on the facility memory care unit (MCU) to ensure the prevention of food borne illnesses. In addition, the facility failed to ensure that the equipment used to scoop ice was maintained in a drainable holder to prevent condensation as evidenced by the following:	A 891		

New Jersey Department of Health

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A 891	<p>Continued From page 29</p> <p>1. On 3/12/25 at 11:38 a.m., during tour of the facility main kitchen with Cook #1, the surveyor observed that the ice scoop holder mounted on the wall next to the ice machine did not contain a draining system to prevent condensation.</p> <p>The surveyor interviewed Cook #1 regarding the ice holder. Cook #1 stated that he was newly employed at the facility and would notify the Dining Service Manager (DSM) that the ice holder required a draining system.</p> <p>The DSM was not available for interview on 3/12/25.</p> <p>Reference: N.J.A.C. 8:24-4.2(r) "Equipment compartments that are subject to accumulation of moisture due to conditions such as condensation ...from melting ice shall be sloped to an outlet that allows complete draining. ..."</p> <p>2. On 3/13/25 at 12:00 p.m., the surveyor toured and inspected the MCU kitchen. The surveyor observed that the refrigerator contained juice beverages, yogurt, salad dressings, ketchup, and other condiments. In addition, the surveyor observed that there was no thermometer in the refrigerator to monitor temperature controls, and there was no visual documentation of temperature recording.</p> <p>At 12:05 p.m., the surveyor interviewed Cook #2 who served the MCU kitchen meals, regarding refrigerator temperature monitoring documentation and thermometers. Cook #2 stated that she was not aware that the refrigerator did not have a thermometer and did not know if there was documented temperature recordings.</p>	A 891		

New Jersey Department of Health

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A 891	<p>Continued From page 30</p> <p>At 12:30 p.m., the surveyor interviewed the DSM regarding the MCU refrigerator thermometer and temperature recording documentation. The DSM stated that he had been employed at the facility for <small>NJ Exec Order 28,481</small> and was not aware that the MCU refrigerator was missing a thermometer and documentation for temperature recording.</p> <p>In addition the surveyor interviewed the DSM regarding the ice holder that did not have a drainable system to prevent condensation. The DSM stated that he was not aware that the bottom of the ice scoop holder was not drainable and would address the issue.</p> <p>Reference: N.J.A.C. 8:24-3.2(f)(1) ..."Refrigerated, potentially hazardous food shall be at a temperature of 41 degrees Fahrenheit ..."</p>	A 891		
A 935	<p>8:36-11.4(b) Pharmaceutical Services</p> <p>(b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of records, it was determined the facility failed to</p>	A 935		

New Jersey Department of Health

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A 935	<p>Continued From page 31</p> <p>ensure that medications were given in accordance with prescriber orders for 2 of 22 residents reviewed, Resident #s 13 &amp; 22. This deficient practice was evidenced by the following:</p> <p>1. On 3/12/25 at 1:35 p.m., the surveyor reviewed the medical record (MR) of Resident #13, the "Admission Record" revealed an admission date of [redacted] with diagnoses that included [redacted] to [redacted] with [redacted] and [redacted].</p> <p>Surveyor review of the Treatment Administration Record (TAR) dated [redacted] for Resident #13, revealed the following prescriber's orders:</p> <p>*weekly [redacted] check every day shift every Wed [Wednesday] for monitoring revealed the staff initials and the code [redacted] documented on the following dates: [redacted].</p> <p>*[redacted] Apply to [redacted] every day and evening shift for [redacted] revealed the staff initials and the code [redacted] documented on the following dates: [redacted].</p> <p>Further surveyor review of the TAR for the "Chart Codes" did not indicate a number [redacted] listed.</p> <p>On 3/14/25 at 10:48 a.m., when the surveyor asked the Licensed Practice Nurse (LPN) what the code [redacted] meant, she replied that there was no code [redacted] and she looked into the computer system, and there was never a code [redacted] was all she could say.</p>	A 935		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>sipfep</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE ECHELON LAKE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>207 LAUREL ROAD VOORHEES, NJ 08043</b>
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A 935	<p>Continued From page 32</p> <p>On 3/14/25 at 9:52 a.m., the surveyor interviewed the Certified Medication Aide (CMA) who documented the code <b>NJ EXM</b> on all the dates listed above, when the surveyor asked her what does the code mean, she stated that she did not know. She continued to say that when she signed for the medications, she saw them in the computer, the code <b>NJ EX</b> was not on the TAR now.</p> <p>2. On 3/14/25 at 12:00 p.m., the surveyor reviewed Resident #22's medical record (MR) which revealed that resident #22 moved into the facility in <b>NJ Exec Order 26.4b1</b>, with a diagnosis of <b>NJ Exec Ord</b> [REDACTED]</p> <p>On 3/14/25 at 12:30 p.m., the surveyor observed a facility Certified Medication Aide (CMA#2), while she administered the medication <b>NJ Exec Order 26.4b1</b> [REDACTED] 1 tablet by mouth to a facility resident, Resident # 22. The surveyor observed that CMA #2 ensured the right medication, the right dose, the right time, the right route and the right resident, then she poured the medication, and administered the medication to Resident #22.</p> <p>The surveyor reviewed the Electronic Medication Record (EMR) which revealed that the medication <b>NJ Exec Order 26.4b1</b> had a prescriber order which included <b>NJ Exec Order 26.4b1</b> to <b>NJ Exec Order 26.4b1</b> for a <b>NJ Exec Order 26</b> [REDACTED]</p> <p>The surveyor asked CMA #2 about the parameters for Resident #22 's <b>NJ Exec Order 26.4b1</b> and she stated that a <b>NJ Exec Order 26.4b1</b> for Resident #22 was not required.</p> <p>At 1:20 p.m., the surveyor reviewed Resident # 22's MR which revealed an order for <b>NJ Exec Order 26.4b1</b></p>	A 935		

New Jersey Department of Health

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A 935	<p>Continued From page 33</p> <p><b>NJ Exec Order 26.4b1</b> give 1 tablet by mouth three times a day for <b>NJ Exec Order 26.4b1</b>), <b>NJ Exec Order 26.4b1</b>. The surveyor observed a document titled, "Order Summary Report" which revealed that the <b>NJ Exec Order 26.4b1</b> was ordered on <b>NJ Exec Order 26.4b1</b> and started on <b>NJ Exec Order 26.4b1</b>.</p> <p>The surveyor reviewed Resident #22's EMR records dated <b>NJ Exec Order 26.4b1</b> which revealed that <b>NJ Exec Order 26.4b1</b> were recorded for the prescribed <b>NJ Exec Order 26.4b1</b> for the <b>NJ Exec Order 26.4b1</b>.</p> <p>At 1:28 p.m., the surveyor interviewed the Support Registered Nurse (SRN) and inquired about the location of the <b>NJ Exec Order 26.4b1</b> and he stated that the <b>NJ Exec Order 26.4b1</b> vitals should be recorded and found within the resident EMR. The RN reviewed Resident #22's MAR with the surveyor and acknowledged that the <b>NJ Exec Order 26.4b1</b> were not recorded.</p> <p>On 3/14/25 during the survey exit conference, the SRN stated that he looked into the <b>NJ Exec Order 26.4b1</b> order for Resident #22 and discovered that when the order was transcribed, although the parameters were entered into the EMR, the prompt for the <b>NJ Exec Order 26.4b1</b> to be taken before administration was not included.</p>	A 935		
A1057	<p>8:36-15.4 Resident Records</p> <p>All records shall be maintained for a period of 10 years after the discharge of a resident from the assisted living residence, comprehensive personal care home or assisted living program.</p>	A1057		

New Jersey Department of Health

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A1057	<p>Continued From page 34</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00173995, NJ00176831</p> <p>Based on interview and record review it was determined that the facility failed to maintain resident record availability following discharge for 2 of 22 residents, Resident #s 9 and 10 as evidenced by the following:</p> <p>On 3/12/25, 3/13/25, and 3/14/25 the Department of Health (DOH) conducted a standard inspection at the facility. During the standard inspection, the DOH investigated a Facility Reported Event (FRE) dated [redacted] regarding a <b>NJ Exec Order 26.4b1</b>.</p> <p>On 3/12/25 at 9:39 a.m., the surveyor interviewed the Assistant Executive Director (AED) regarding access to resident medical records (MR). The AED stated that the facility used electronic and paper MR. In addition, the AED stated that the resident service plans, progress notes, and medications were documented electronically, while resident assessments were in the paper MR.</p> <p>On 3/13/25 at 10:10 a.m., the surveyor requested Resident #9's MR from the Clinical Support Licensed Practical Nurse (LPN). The LPN stated that the resident was discharged, and that the resident's electronic records were available. However, the LPN stated that she was not sure if the paper MR was still on the facility premises. In addition, the LPN stated that closed paper MR were stored at an offsite location.</p> <p>At 1:35 p.m., the LPN provided the surveyor with</p>	A1057		

New Jersey Department of Health

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A1057	<p>Continued From page 35</p> <p>copies of Resident #9's electronic progress notes, service plans, and paper behavior plans, and stated that she was unable to locate the resident's closed paper MR.</p> <p>On 3/14/25 1:15 p.m., the surveyor requested the MR of Resident #10 from the Clinical Support LPN for review regarding a FRE submitted to the DOH on <b>NJ Exec Order 26</b> concerning <b>NJ Exec Order 26.4b1</b>. The LPN stated that the resident was discharged and the paper MR was closed out and sent to storage.</p> <p>On 3/14/25 at 1:20 p.m., the surveyor interviewed the Executive Director regarding resident MR. The ED also stated that facility records including paper MR that were not located at the facility were stored at an off-site location.</p>	A1057		
A1073	<p>8:36-15.6(b) Resident Records</p> <p>(b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that documentation of a resident's <b>NJ Exec Order 26.4b1</b> notes were maintained in the record for 1 of 22 residents</p>	A1073		

New Jersey Department of Health

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A1073	<p>Continued From page 36</p> <p>reviewed, Resident #13, The deficient practice was evidenced by the following:</p> <p>On 3/12/25 at 1:35 p.m., the surveyor reviewed the medical record (MR) of Resident #13, the "Admission Record" revealed an admission date of <b>NJ Exec Order 26.4b1</b> with diagnoses that included <b>NJ Exec Order 26.4b1</b> with <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b>.</p> <p>On 3/13/25 at 3:35 p.m., the surveyor requested paperwork not yet received from the Administrator for Resident #13 to include the <b>NJ Exec Order 26.4</b> notes from <b>NJ Exec Order 26.4b1</b>.</p> <p>On 3/14/25 at 9:40 a.m., when the surveyor asked the Licensed Practice Nurse (LPN) regarding the <b>NJ Exec Order 26.4</b> notes not observed in the MR of Resident #13, she stated that she was awaiting a return call from the <b>NJ Exec Order 26.4b1</b>.</p> <p>The facility failed to provide the surveyor documented evidence to show that the <b>NJ Exec Order 26.4</b> notes were available for review and included in the Resident #13's MR.</p>	A1073		
A1097	<p>8:36-16.6 Physical Plant</p> <p>All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23.</p>	A1097		

New Jersey Department of Health

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A1097	Continued From page 37  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a fire supression system on the 4th floor. This deficient practice was evidenced by the following:  On 3/13/25 at 9:49 a.m., in the presence of the facility Administrator, the surveyor observed a storage room on the 4th floor did not have a sprinkler.  The surveyor interviewed the Administrator who acknowledged the above.	A1097		
A1217	8:36-17.3(b)(4) Housekeeping-Sanitation-Safety-Maintenance  (b) The following safety conditions shall be met:  4. All household and cleaning products used by facility staff shall be identified, labeled, and secured. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room. The telephone number of the poison control center shall be conspicuously posted in the facility;  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain a	A1217		

New Jersey Department of Health

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A1217	Continued From page 38  safe environment. this deficient practice was evidenced by:  On 3/13/25 at approximately 11 a.m., in the presence of the facility Administrator and Maintenance Director (MD), on the fourth floor the surveyor observed cleaning supplies in an unlocked room. The surveyor observed 10 (20 oz) bottles. The warning labels had a caution label stating, "Causes skin and eye irritation" and "if Mixed with acid or ammonia can cause chlorine gas."  The surveyor interviewed the MD, who stated he would make sure the room stays locked.	A1217		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance  The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a safe environment. This deficient practice was	A1249		

New Jersey Department of Health

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A1249	<p>Continued From page 39</p> <p>evidenced by the following:</p> <ol style="list-style-type: none"> <li>On 3/13/25 at 9:49 a.m., in the presence of the facility Administrator, the surveyor observed that the facility failed to maintain battery backup illuminated exit signs, sign # 41, 38, 30, 56, which did not illuminate.</li> <li>On 3/13/25 at 9:49 a.m., in the presence of the facility Administrator, the surveyor observed that exit signs #36 and #43 were backwards.</li> <li>On 3/13/25 at 10:00 a.m., in the presence of the facility Administrator, the surveyor observed that the second floor was missing an illuminated emergency exit sign by room 209.</li> <li>On 3/13/25 at 10:15 a.m., in the presence of the facility Administrator, the surveyor observed elevator #2 had an emergency phone that did not work.</li> <li>On 3/13/25, at 11:10 a.m., in the presence of the facility Administrator, the surveyor observed that the facility failed to have a generator annunciator panel installed.</li> </ol> <p>The surveyor interviewed the Administrator who acknowledged the above.</p>	A1249		



**Brookdale Echelon Lake  
207 Laurel Road  
Voorhees, NJ 08043**

**Survey Date- March 14, 2025**

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

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**  
Residents #1 through Resident #22:  
No residents found to be affected by the deficient practice
- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**  
All residents have the potential to be affected by this deficient practice.
- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**  
In-service nurses (LPN, RN) on: NJ Outbreak Plan NJ16, Infection Control and Prevention Signage, Brookdale and NJDOH guidance on notification process during "Outbreak", Availability and proper usage of PPE during Outbreak to residents, staff, 3<sup>rd</sup> party providers, and visitors.  
In-services completed on May 21, 2025.
- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**  
Executive Director and Health and Wellness Director or designee to monitor training, PEE and NJ Outbreak Plan compliance 1x monthly and as needed.

**COMPLETION DATE: 05/21/2025**

**A401 8:36-4.1(a)(22) Residents Rights**

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**  
Residents 1,2,3, and 4: All staff inserviced on 5/21/2025 regarding the NJ Exec Order 26.4b1 policy. Also implemented walkie talkies so staff is aware when visitors are going onto the NJ Exec Order 26.4b1. Also when new residents move onto the unit, Families will be educated on the process of making sure the NJ Exec Order 26.4b1 close when they are on the unit to prevent residents that do not look like residents from NJ Exec Order 26.4b1. Signs have also been placed at the entrances of the NJ Exec Order 26.4b1 inside the NJ Exec Order 26.4b1 and on the unit explaining that doors should be closed before proceeding to their destinations. Contracted vendors also educated on process.
- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**  
All residents have the potential to be affected by this deficient practice. The documentation policy has been reviewed. The ED, HWD or designee will review elopement practices monthly with all staff to ensure that there are no future elopements.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

All staff and contracted vendors were in-serviced on missing resident policy which will include all new hires including vendors. AL residents will also be aware of processes. Families will also be notified of the process via monthly newsletter.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

The ED, HWD or designee will audit and monitor elopement prevention twice a month with all staff to ensure that there are no future elopements, then monthly.

**COMPLETION DATE: 05/21/2025**

**A565 8:36-5.10(a)(3) General Requirements**

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

No residents found to be affected by the deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**

All residents have the potential to be affected by the deficient practice

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

In-service associates on Brookdale Abuse, Neglect and Exploitation policies and procedures, and Brookdale Reportable Events Grid reporting procedures. Above in-services completed on May 22, 2025.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

ED or designee to ensure compliance of the above mandatory in-services monthly and thereafter.

**COMPLETION DATE: 05/22/2025**

**A577 8:36-5.11(a)(2) General Requirements**

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

No residents found to be affected by the deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**

All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

In-serviced Maintenance associates on: Required contracts guidelines and tracker which includes the contract type, frequency, and description such as but not limited to Fire Sprinkler, Fire Alarm, Kitchen Fire Suppression system, and Annual Electrical inspection.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

ED or designee to monitor compliance monthly for 6 months, then annually, and as needed.

**COMPLETION DATE: 05/21/2025**

#### **A779 8:36-7.5(c) Resident Assessments and Care Plans**

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**  
Residents 5,6,7,8 and 9: Reviewed and updated Health Service Plans and Personal Service Plans. Residents plan of care included on monthly Collaborative Care Review. Primary care physician informed of current plan of care.
- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**  
All residents have the potential to be affected by the deficient practice.
- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**  
In-serviced RNs, LPNs, and CMAs on: Brookdale Incident Notification policies, Brookdale Change in medical condition guidance, and Brookdale policies on nursing documentation/ alert charting. In-services completed on 5/21/2025.
- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**  
Health and Wellness Director to monitor clinical reporting, documentation and follow up compliance weekly and as needed. Executive Director to verify compliance adherence monthly for 6 months, and as needed thereafter.

**COMPLETION DATE: 05/21/2025**

#### **A891 8:36-10.5(a) Dining Services**

1. **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**  
No residents found to be affected by the deficient practice.
- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**  
All residents have the potential to be affected by the deficient practice.
- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**  
POC: ice scooper holder changed to a drainable holder on 3/14/2025. Temperature Log sheet with protective sleeve posted on all commercial and common area Refrigerators on 3/14/2025. Placed brand new thermometer on all Kitchen and common area refrigerators on 3/17/2025. Dining associates in-serviced on Brookdale Temperature log policy which includes Temperature log sheet, monitoring guidelines, reporting procedures for any changes in temperature readings of food holding equipment. In-service completed on 5/21/2025.
- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**  
Dining Service Manager to ensure that all temp logs are utilize and completed daily, and food holding equipment have working thermometers at all times. Executive director or designee to monitor compliance of the above POC on a monthly basis for 3 months and as needed thereafter.

**COMPLETION DATE: 05/21/2025**

#### **A935 8:36-11.4(b) Pharmaceutical Services**

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

RN audit completed on Point Click Care Treatment Administration Records of residents requiring skin checks. Point Click Care E-MAR audit of residents with vital signs parameter checks before and after medication administration. Basing on this audits no other residents found to be affected.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**

All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

In-serviced on: Weekly Point Click Care E-MAR audit on vital signs/ parameter readings and follow-up, skin checks, treatments, medication administration, initials, med administration codes, and documentation compliance by RNs, LPNs and CMAs. In-services completed on 5/22/2025.

Med Pass Observations by RN on CMAs and LPNs ongoing. Completion date June 5<sup>th</sup> 2025.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

Health and Wellness Director or RN designee to monitor med administration and documentation compliance on weekly basis and as needed. Executive Director to meet with Health and Wellness Director or designee to ensure plan of action compliance on a monthly basis and as needed.

**COMPLETION DATE: 06/05/2025**

#### **A1057 8:36-15.4 Resident Records**

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

Residents that have been discharged will have charts stay onsite for 6 months before sent to storage.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**

All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

Electronic access has been set up with Iron Mountain on 5/20/2025, so if a resident's chart is requested before 1pm, the chart will be at the community by 5pm that same day.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

Charts will be requested weekly for the next month to ensure that system access is accurate with returning files, then as needed.

**COMPLETION DATE: 05/20/2025**

#### **A1073 8:36-15.6(b) Resident Records**

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

No residents found to be affected by the deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**

All residents have the potential to be affected by the deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**

Informed podiatry provider office to provide MD notes/report no more than 7 days after visits/services rendered to residents. Podiatry provider granted access to Point Click Care for resident visits documentation. Completion date: June 1<sup>st</sup> 2025.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**

Health and Wellness Director or designee to ensure compliance monthly and as needed.

**COMPLETION DATE: 05/21/2025**

#### **A1097 8:36-16.6 Physical Plant**

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

No residents have been affected by the deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**

All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

Sprinkler system inspected on 4/7/2025. Will contact Cintas to ensure Sprinkler was installed in storage room on the 4<sup>th</sup> floor.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

Cintas will be contacted to ensure sprinkler has been installed, which will be overseen by maintenance manager. Inspection to then be completed annually.

**COMPLETION DATE: 06/30/2025**

#### **A1217 8:36-17.3(b)(4) Housekeeping-Sanitation-Safety-Maintenance**

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

No residents have been affected by the deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**

All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

Log will be implemented to ensure that rooms are locked for safety daily.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

Maintenance Manager or designee will conduct audit weekly for 30 days to ensure rooms are locked for safety, then as needed.

**COMPLETION DATE: 6/20/2025**

**A1249 8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance**

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

No residents have been affected by the deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**

All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

ABM electric has replaced all of the emergency exit signs in the community the week of March 17, 2025.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

Maintenance Manager or designee will ensure that emergency exits signs are checked monthly, then will document results in Direct Supply NJ Exec Order 2

**COMPLETION DATE: 05/21/2025**

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER sipfep <span style="float: right;">Y1</span>	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/26/2025 <span style="float: right;">Y3</span>
NAME OF FACILITY BROOKDALE ECHELON LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 207 LAUREL ROAD VOORHEES, NJ 08043

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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 05/21/2025	ID Prefix A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 05/21/2025	ID Prefix A0577 Reg. # 8:36-5.11(a)(2) LSC	Correction Completed 05/21/2025
ID Prefix A0779 Reg. # 8:36-7.5(c) LSC	Correction Completed 05/21/2025	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 05/21/2025	ID Prefix A0935 Reg. # 8:36-11.4(b) LSC	Correction Completed 06/20/2025
ID Prefix A1073 Reg. # 8:36-15.6(b) LSC	Correction Completed 05/21/2025	ID Prefix A1097 Reg. # 8:36-16.6 LSC	Correction Completed 06/30/2025	ID Prefix A1217 Reg. # 8:36-17.3(b)(4) LSC	Correction Completed 06/20/2025
ID Prefix A1249 Reg. # 8:36-17.7 LSC	Correction Completed 05/21/2025	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

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 3/14/2025
  CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
  YES  NO

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER sipfep <span style="float: right;">Y1</span>	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/26/2025 <span style="float: right;">Y3</span>
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0401	Correction	ID Prefix A0565	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-5.10(a)(3)	Completed
LSC	05/21/2025	LSC	05/21/2025	LSC	05/22/2025
ID Prefix A0779	Correction	ID Prefix A0935	Correction	ID Prefix A1057	Correction
Reg. # 8:36-7.5(c)	Completed	Reg. # 8:36-11.4(b)	Completed	Reg. # 8:36-15.4	Completed
LSC	05/21/2025	LSC	06/20/2025	LSC	05/20/2025
ID Prefix A1073	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-15.6(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/21/2025	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 3/14/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		