

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05C001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/21/2024
NAME OF PROVIDER OR SUPPLIER ALLENDALE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 85 HARRETON ROAD ALLENDALE, NJ 07401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Standard with Complaint Complaint #: NJ00167489, NJ00156306, NJ00153168, NJ00147345 Census: 2/20/24: 91 2/21/24: 90 Sample size: 9 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 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;	A 310		

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

TITLE

(X6) DATE

04/12/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05C001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/21/2024
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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility policies and procedures, it was determined that the facility Administrator failed to implement the following facility policies and procedures titled, "Employee Physicals" to ensure all employees received physical examinations upon hire, for 5 of 5 employees and "Resident Assessments and Service Plans," to ensure an initial resident assessment was completed by a Registered Nurse (RN) for 1 out of 6 Residents reviewed, Resident # 4. These deficient practices were evidenced by the following: On 02/21/24 the surveyor reviewed employee personnel records and observed that 5 of 5 employees did not have physical examinations in their files for a Licensed Practical Nurse (LPN) hired on [NJ ex order 26.4b1], a Home Health Aide (HHA) hired on [NJ ex order 26.4b1], a Housekeeper hired on [NJ ex order 26.4b1], and two Certified Medical Assistants (CMA) hired on [NJ ex order 26.4b1] and [NJ ex order 26.4b1] At 12:22 p.m., the surveyor interviewed the Human Resources Director (HRD) to inquire about the five employees who did not have physical examinations in their file. The HRD stated the facility screened employees for work experience, licensure, qualifications, and background checks but not for physical examinations. In addition, the HRD explained the facility did not pay for physical examinations for the staff and confirmed there were no physical	A 310			

New Jersey Department of Health

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A 310	Continued From page 2 examinations on file. The surveyor reviewed the facility policy titled, "Employee Physicals," which revealed, "Each potential employee, after receiving a conditional offer of employment, and each current employee whose job position necessitates such must undergo physical examinations...Each potential employee who has received a conditional offer of employment will be required to undergo a physical examination and answer any inquiries related to his/her medical status. The cost of such examination will be borne by the facility." Complaint#: NJ00153168 During Surveyor interview on 2/21/24 at 11:30 a.m., the Administrator stated that Resident #4 NJ ex order 26.4b1 The Administrator further stated that NJ ex order 26.4b1 for Resident #4, and there was no assessment by a RN found. On 2/22/24 at 10:20 a.m., the Surveyor reviewed Resident #4's Electronic Medical Record (EMR), which included a document titled, "Admission Record" and observed an admission date of NJ ex order 26.4b1 and diagnoses which NJ ex order 26.4b1 Further review of Resident #4's EMR revealed an initial document titled, NJ ex order 26.4b1 " date of initiation NJ ex order 26.4b1, electronically signed by a Licensed Practice Nurse (LPN). There was no indication of an initial or any other comprehensive assessments conducted by an RN for Resident #4.	A 310		

New Jersey Department of Health

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A 310	Continued From page 3 On 2/22/24, at 10:25 a.m., during surveyor interview, LPN #2 stated that she conducted the initial resident assessments to determine the level of care, and that a resident who enters the facility as a respite, is considered to be more of a visitor, and not a permanent resident, and in that case the LPN can perform the assessment. A review of the facility policy titled, "Resident Assessments and Service Plans", adopted August 2021 revealed the following under Policy Statement: "Residents will receive assessments by a Registered Nurse and service plans as required." Under Admission "1. Upon admission, each resident will receive an initial assessment by a registered nurse to determine the resident's needs..."	A 310		
A 745	8:36-7.2(f) Resident Assessments and Care Plans (f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice. This REQUIREMENT is not met as evidenced by: Complaint Intake # NJ00153168 Based on interview and medical record review, it was determined that the facility failed to ensure that the initial Resident health care assessment was completed and documented by a Registered Nurse (RN) for 1 out of 6 Residents reviewed, Resident # 4. This deficient practice was	A 745		

New Jersey Department of Health

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A 745	Continued From page 4 evidenced by the following: During Surveyor interview on 2/21/24 at 11:45 a.m., with the facility's Administrator, stated that Resident #4 NJ ex order 26.4b1. The Administrator further stated that she provided all the records she had for Resident #4, and there was no RN assessment noted. On 2/22/24, the Surveyor reviewed Resident #4's Electronic Medical Record (EMR), which included a document titled, "Admission Record" and observed an admission date of NJ ex order 26.4b1, and diagnoses which NJ ex order 26.4b1. On 2/22/24, at 10:25 a.m., during surveyor interview with LPN #2, she stated that she conducted the initial resident assessments to determine the level of care, and that a resident who enters the facility as a respite, is considered to be more of a visitor and not a permanent resident, and therefore the LPN can perform the assessment. Further review of Resident #4's EMR revealed an initial document titled, "Personal Care Level of Care Assessment" date of initiation NJ ex order 26.4b1, electronically signed by a Licensed Practice Nurse (LPN). Upon review of the records provided, there was no indication of an initial, or any other comprehensive assessments conducted by a RN for Resident #4.	A 745		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well	A1249		

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A1249	Continued From page 5 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 observations, interviews, and facility document review, the facility failed to ensure the facility was kept free from fire hazards. Specifically, the facility failed to document the required annual fire door inspection as required by the standards set forth by National Fire Protection Association (NFPA) 80, Standard for Fire Doors and Other Opening Protectives, and failed to ensure the annunciator panel for the emergency standby generator was in a constantly attended area as required by the standards set forth NFPA 110, Standard for Emergency and Standby Power Systems. These deficiencies affected 27 of 27 smoke compartments in the facility. Findings included: A review of facility inspection and testing of all Life Safety Code systems in the facility revealed that there was no record of an annual fire door testing as required by the standards set forth by NFPA 80. During an interview on 02/20/2024 at 10:30 AM, the Director of Maintenance (DOM) stated that the inspections were conducted	A1249		

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A1249	Continued From page 6 annually but the facility did not document the results of the inspections. He stated that the facility did not have a policy to ensure that the annual fire door inspections were conducted as required by the Life Safety Code. During an interview on 02/20/2024 at 10:45 AM, the Executive Director (ED) stated at that she was not aware that the fire door inspections had not been documented. An observation on 02/20/2024 at 1:25 PM revealed the remote annunciator panel for the emergency standby generator was not located in a constantly attended location, as required by the applicable Life Safety Code standard. The panel was located in the former facility security office. During an interview at the time of the observation, the Director of Maintenance (DOM) stated that there was no staff stationed in the location of the annunciator panel and the former security office was locked at night. The DOM stated that the annunciator panel had been in that location for at least 30 years. During an interview on 02/20/2024 at 1:50 PM the Executive Director (ED) stated she was unaware that the current location of the panel was not in compliance with the applicable Life Safety Code standard.	A1249		
A1413	8:36-21.2(b) Quality Improvement (b) The use of any restraining device shall be based on an assessment and shall require a physician, advanced practice nurse or physician assistant order.	A1413		

If continuation sheet 8 of 9

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A1417	Continued From page 8 This REQUIREMENT is not met as evidenced by: Complaint #: NJ00147345 Based on interview and record review, it was determined that the facility failed to ensure a specific plan of care was developed and implemented for the [NJ Exec Order 26.4b1] and use/need for the use of [NJ Exec Order 26.4b1] for 1 of 6 residents, Resident #8. This was evidenced by the following: On 2/21/2024 at 10:00 a.m., the surveyor reviewed Resident #8's closed medical record which revealed Resident #5 was admitted on [NJ ex order 26.4b1] 1 with diagnoses which included [NJ ex order 26.4b1]. The surveyor reviewed a communication note dated [NJ ex order 26.4b1] which reads [NJ ex order 26.4b1] At 12:45 p.m., the Executive Director stated that there was no service plan in place for Resident #8 [NJ ex order 26.4b1]. There was no plan of care in place for Resident #8 in regards to the use of [NJ ex order 26.4b1] for patient safety.	A1417			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALLENDALE SENIOR LIVING

85 HARRETON ROAD
ALLENDALE, NJ 07401

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A 000	Initial Comments Initial Comments: Type of Survey: Standard with Complaint Complaint #: NJ00167489, NJ00156306, NJ00153168, NJ00147345 Census: 2/20/24: 91 2/21/24: 90 Sample size: 9 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 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;	A 310		

NJ Exec Order 26.4b1

LABORATORY DIRECTOR'S

TITLE

(X6) DATE

EXECUTIVE DIRECTOR

4/12/24



ALLENDALE

SENIOR LIVING

Standard plus complaint

Survey Visit: February 21, 2024

A310 Administration – Resident Assessments

1. Resident #4 was discharged from the community on [REDACTED] NJ Exec Order 26.4b1. Audited current resident charts no resident was identified needing an RN assessment.
2. All residents have the potential to be affected by this deficient practice.
3. Current residents were reviewed for the last 3 months by the Wellness Director/designee to ensure that they received an RN assessment. Regional Director of Operations/designee has educated the Executive Director and Wellness Director on "Resident Assessment and Service Plan" policy. The Executive Director/designee will audit new admissions weekly x4 to ensure they receive an RN assessment.
4. The Executive Director or designee will report the findings of the audits to the Quality Assurance and committee for any additional monitoring or modifications of this plan monthly for 4 months, then quarterly.

Accepted

Completion date 5/15/24

A310 Administration – Employee Physicals

1. Current employees were reviewed by the Human Resources/designee to ensure each employee has a physical per the Employee Physical policy.
2. No residents would have been affected by this deficient practice.
3. Regional Director of Operations/designee has educated the Executive Director and Wellness Director on "Employee Physicals" policy. Human Resources Director was educated on Employee Physicals.
4. The Executive Director/designee will audit new employee files prior to the employee's employment start date. Human Resource will audit employee files quarterly, report the findings to the Executive Director.

Accepted

Completion date 5/15/24

Received 4/18/24



ALLENDALE

SENIOR LIVING

A745 RN provides Resident Assessments and Care Plans

1. Resident #4 was discharged from the community on NJ Exec Order 20.4b1
2. All residents have the potential to be affected by this deficient practice.
3. Current residents were reviewed for the last 3 months by the Wellness Director/designee to ensure RN prepares the assessment and Care plans. Regional Director of Operations/designee has educated and in-service the Executive Director and Wellness Director on "Resident Assessment and Service Plan" policy. *Accepted*
4. The Executive Director/designee will audit new admissions and current resident carts weekly x4, then monthly to ensure they receive an RN assessment and Care Plan.

Completion date 5/15/24

A1249 Housekeeping -- Sanitation-Safety-Maintenance

1. The generator annunciator panel location will be moved to a constantly attended area by 5/15/24. The fire door testing was completed 3/1/24 and documented this will continue monthly
2. All residents have the potential to be affected by this deficient practice. *Accepted*
3. The Executive Director educated the Maintenance Director on National Fire Protection Association (NFPA) 80, Standard for Fire Doors and Other Opening Protectives. The Maintenance Director educated the maintenance staff on National Fire Protection Association (NFPA) 80; Standard for Fire Doors and Other Opening Protectives.
4. The Executive Director has ensured documentation is completed for fire door testing. The maintenance director will perform monthly rounds and report findings to the executive director during the monthly safety meeting. *Accepted 4/18/24*

Completion date 5/15/24



ALLENDALE

SENIOR LIVING

A1413 (b) Quality Improvement

1. Resident #8 no longer resides in the community.
2. All residents have the potential to be affected by this deficient practice.
3. Current residents with restrictive devices have been audited to ensure there is a physician order for the device to be utilized.
4. The Wellness Director has educated all staff on the "Bed Rails, Enablers, and Other Assistive Devices" policy. The Wellness Director/designee will complete weekly x 4 to ensure residents with restrictive devices have orders from the physician to be utilized. The maintenance director will perform monthly rounds and report findings to the executive director during the monthly safety meeting.

Accepted

Completion date 5/15/24

A1417 (d) Quality Improvement

1. Resident #8 no longer resides in the community.
2. All residents have the potential to be affected by this deficient practice.
3. Current residents with restrictive devices have been audited to ensure the plan of care is developed and implemented for the use and need of the device. The Wellness Director has educated all staff on the "Bed Rails, Enablers, and Other Assistive Devices" policy.
4. The Wellness Director/designee will complete weekly x 4 then monthly to ensure any new residents with restrictive devices have a plan of care in place. The maintenance director will perform monthly rounds and report findings to the executive director during the monthly safety meeting and then quarterly.

Accepted

Completion date 5/15/24

NJ Exec Order 26.4b1

NJ Exec Order 26.4b1 Executive Director

NJ Exec Order 26.4b1

NJ Exec Order 26.4b1 Wellness Director

Received 4/10/24

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 05C001	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/19/2024
NAME OF FACILITY ALLENDALE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 85 HARRETON ROAD ALLENDALE, NJ 07401	

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 A0745	Correction	ID Prefix A1249	Correction	ID Prefix A1413	Correction
Reg. # 8:36-7.2(f)	Completed	Reg. # 8:36-17.7	Completed	Reg. # 8:36-21.2(b)	Completed
LSC	05/15/2024	LSC	05/15/2024	LSC	05/15/2024
ID Prefix A1417	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-21.2(d)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/15/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 2/21/2024		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A1249	Correction	ID Prefix	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-17.7	Completed	Reg. #	Completed
LSC	05/15/2024	LSC	05/15/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 2/21/2024		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			