STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a003	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACES AT PARKE PLACE	**661 DELSEA DRIVE SEWELL, NJ 08080**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00186269, NJ 00186229 CENSUS: 39 on 5/19 and 5/20/25 SAMPLE SIZE: 5 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) Administrator's Responsibilities (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 07/09/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #s: NJ 00186269, NJ 00186229

Based on observation, interview, and record review, it was determined that the facility Administrator failed to ensure the implementation and enforcement of the facility policies titled, "Accident and Incident Reports: Resident" and "Camera Surveillance: (Video Security Cameras)" for 2 of 5 residents reviewed, Resident #2 and Resident #3. This deficient practice was evidenced by the following:

On 5/9/25, the Department of Health (DOH) received a Facility Reportable Event (FRE), a (document used by facilities to report events to the DOH) regarding the NJ Ex Order 26.4(b)(1) According to the FRE report, two (2) staff members NJ Ex Order 26.4(b)(1) Resident #2 on NJ Ex Order 26.4

1. On 5/19/25 at 12:35 p.m., the surveyor reviewed Resident #2's medical record (MR), which indicated that the resident was admitted in NJ Ex Order 26.4(b)(1) with diagnosis of NJ Ex Order 26.4(b)(1)

Upon review of Resident #2's MR, the surveyor reviewed an "Observation Note" dated NJ Ex Order 26.4 written by a Licensed Practical Nurse (LPN) #1, which revealed, " ... resident has NJ Ex Order 26.4(b)(1) reported Nursing to admin ..."

At 10:11 a.m., the surveyor interviewed LPN #1, regarding her documentation on NJ Ex Order 26, and

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A 310	Continued From page 2 inquired about Resident #2's injury. LPN #1 stated that the Medication Technician (MT) gave her report in the morning of [NJ Ex Order 26] and reported the [NJ Ex Order 26.4(b)(] on Resident #2's [NJ Ex Order 26.4(b)(1)] Additionally, LPN #1 stated that she told the MT that he should have filled out an Incident Report (IR). At 11:44 a.m., the surveyor reviewed the "Investigation Summary and Conclusion for Reportable Event [NJ Ex Order 26]," which revealed that the Administrator interviewed the MT and inquired about the above incident. Further review of the investigative report, the MT reported that he was called to the NJ Ex Order 26.4(b)(1)) at 2:00 a.m. to assist with Resident #2, who was [NJ Ex Order 26] [redacted] at the time. At 1:50 p.m., the surveyor interviewed the Administrator and inquired about the [NJ Ex Order 26] incident. The Administrator stated that the MT was called to the [NJ Ex Orde] after the incident and he observed Resident #2 [NJ Ex Order 26.4(b)(1)] with [NJ Ex Order 26.4(b)(] the resident. The Administrator stated that the MT did not notify the Registered Nurse (RN) or fill out the IR regarding the incident. The surveyor reviewed the facility policy, dated 4/30/21, titled, "Accident and Incident Reports: Resident," which revealed, " ... 1. An incident is ... This includes but is not limited to falls, cuts, bruises, suspected abuse ... 2. The resident is assessed at the time of the accident / incident by the nurse and supervisor. An incident report is to be completed with all pertinent areas documented. The RN Assessment Nurse must be notified immediately ..." 2. On 5/12/25, the DOH received an FRE regarding NJ Ex Order 26.4(b)(1). According to	A 310		

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A 310	Continued From page 3	A 310		

the FRE, Resident #2's family member called the facility and expressed concern that the resident's previously-reported NJ Ex Order 26.4(b)(1) was [redacted] The FRE revealed that the Administrator reviewed the surveillance camera footage and observed that a Certified Nursing Assistant (CNA) [redacted] Resident #2 [redacted] on [redacted]

On 5/19/25 at 11:00 a.m., the surveyor viewed the video camera footage from the incident that occurred on [redacted] The camera footage revealed that on [redacted] at 3:43 a.m., the CNA pulled Resident #2 out of another resident's room and pushed Resident #2 to the ground in the hallway. Additionally, the camera footage revealed the CNA as she walked away from Resident #2 while the resident was NJ Ex Order 26.4(b)(1)

At 12:35 p.m., the surveyor reviewed Resident #2's MR and observed a Progress Note (PN) dated [redacted] at 10:38 a.m., documented by the Director of Wellness (DW), which revealed, "Resident has returned from the hospital after being evaluated for [redacted] ... [Resident #2] was not able to state what happened but knows [he/she] [redacted] ..."

On 5/19/25 at 12:06 p.m., the surveyor reviewed the investigative report regarding the [redacted] incident. The investigative report indicated that Resident #2's Responsible Party (RP) discussed the incident that occurred on [redacted], with the Administrator, and brought up a concern that the RP had with a previously reported NJ Ex Order 26.4(b)(1). The investigative report also indicated that Resident #2's RP was concerned that NJ Ex Order 26.4(b)(1) the resident [redacted] instead of the resident [redacted] Additionally, the investigative report revealed that

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A 310	Continued From page 4 the Administrator informed the RP that she would review the camera footage and conduct a full investigation regarding the incident on [redacted]. At 1:50 p.m., the surveyor interviewed the Administrator and inquired about what would warrant a review of the surveillance cameras footage. The Administrator stated that she would review the footage if there was any question regarding an incident. Additionally, the Administrator stated that if there were any incidents/[redacted] that occurred in a common area, then she would also review the camera footage. During the interview, the Administrator confirmed that she did not review the camera footage following the [redacted] incident until after she spoke with Resident #2's RP on [redacted]. On 5/20/25 at 11:16 a.m., the surveyor interviewed the DW and inquired about the facility's process for tracking resident [redacted]. The DW informed the surveyor that the facility tracked incidents on the "Incident Log." The DW explained that the incidents were reviewed and documented on the incident log. At 12:14 p.m., the surveyor reviewed the Incident Log dated [redacted] and observed that Resident #3 had [redacted] on [redacted]. On 5/19/25 at 1:02 p.m., the surveyor reviewed Resident #3's MR, which indicated that the resident was admitted in [redacted] with diagnosis of [redacted]. Further surveyor review of Resident #3's MR, the surveyor observed a progress note dated [redacted] at 10:51 p.m., written by LPN #2, which revealed, "At 9 pm it was noted that the resident had [redacted] the hallway ..."	A 310		

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A 310	Continued From page 5 On 5/20/25 at 12:56 p.m., the surveyor interviewed the Administrator and inquired about Resident #3's NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b), and in addition, the surveyor asked the Administrator if she reviewed the camera footage of Resident #3's NJ Ex[illegible] that occurred in the hallway. The Administrator confirmed that she did not view the camera footage following the resident's NJ Ex O[illegible] in the hallway, on NJ Ex Order 26.4(b)(1) The surveyor reviewed a facility policy, dated 9/15/16, titled, "Camera Surveillance: (Video Security Cameras)" which revealed, " ... 2. The video will be reviewed by the Administrator / Designee following a concern. 3. When an incident ... occurs, the Administrator must get the following information ..."	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall 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:	A 401		

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A 401	Continued From page 6 Complaint #: NJ 00186269, NJ 00186229 Based on observation, interview, and record review, it was determined that the facility failed to ensure that the resident right to live in a safe environment was protected for 1 of 5 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On [NJ Ex Order 26], the Department of Health (DOH) received a Facility Reportable Event (FRE) (a document used by facilities to report events to the DOH) regarding NJ Exec Order 26.4b1. According to the FRE, two (2) staff members NJ Ex Order 26.4(b)(1) Resident #2 on [NJ Ex Order 26]. On 5/12/25, the DOH received another FRE regarding NJ Ex Order 26.4(b)(1). According to the FRE, Resident #2's Responsible Party (RP) called the facility and expressed concern that the resident's previously-reported NJ Ex Order 26.4(b)(1) [redacted]. The FRE revealed that the Administrator reviewed the surveillance camera footage and observed a Certified Nursing Assistant (CNA) as she [NJ Ex Order 26.4(] Resident #2 [NJ E] [redacted]. 1. On 5/19/25 at 12:35 p.m., the surveyor reviewed Resident #2's medical record (MR), which indicated that the resident was admitted in NJ Ex Order 26.4(b)(1) with diagnosis of [NJ Ex Order 26.4(b)(1)] Upon review of Resident #2's MR, the surveyor observed an "Observation Note" dated [NJ Ex Order 26], written by a Licensed Practical Nurse (LPN), which revealed, " ... resident has NJ Ex Order 26.4(b)(1) [redacted], reported Nursing to admin ..." Additionally, the surveyor reviewed a Progress Note (PN) dated [NJ Ex Order 26] at 10:38 a.m.,	A 401		

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A 401	Continued From page 7 documented by the Director of Wellness (DW), which revealed, "Resident has returned from the hospital after being evaluated for [NJ Ex Order 26.4(b)] [Resident #2] was not able to state what happened but knows [he/she] [NJ Ex Order 26.4(b)] ..." On 5/19/25 at 11:00 a.m., the surveyor viewed the video camera footage from the incidents that occurred on [NJ Ex Order 26.4(b)] and [NJ Ex Order 26.4(b)]. The observations were as follows: 1. On [NJ Ex Order 26.4(b)] at 3:43 a.m., the camera footage revealed that the CNA pulled Resident #2 out of another resident's room and [NJ Ex Order 26.4(b)] Resident #2 [NJ Ex Order 26.4(b)(1)] in the hallway. 2. On 5/8/25 at 12:43 a.m., the camera footage revealed Home Health Aide (HHA) #1, [NJ Ex Order 26.4(b)] Resident #2 [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] the resident [NJ Ex Order 26.4(b)(1)]. The surveyor observed HHA #2 in the footage watching as HHA #1 was [NJ Ex Order 26.4(b)(1)] Resident #2. 3. On 5/8/25 at 1:05 a.m., the camera footage revealed that HHA #2 [NJ Ex Order 26.4(b)] Resident #2 [NJ Ex Order 26.4(b)] and then [NJ Ex Order 26.4(b)] the resident [NJ Ex Order 26.4(b)(1)] before he [NJ Ex Order 26.4(b)] the resident [NJ Ex Order 26.4(b)(1)]. 4. On 5/8/25 at 2:05 a.m., the camera footage revealed that HHA #1 [NJ Ex Order 26.4(b)] Resident #2 [NJ Ex Order 26.4(b)] and [NJ Ex Order 26.4(b)(1)] the resident. At 11:44 a.m., the surveyor reviewed the investigation report regarding the [NJ Ex Order 26.4(b)] incident. The investigation report indicated that Resident #2 reported to the LPN that [NJ Ex Order 26.4(b)(1)]. The LPN then informed the Administrator of Resident #2's report. The investigation report indicated that the Administrator then reviewed the camera	A 401		

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A 401	Continued From page 8 footage and confirmed that there was [NJ Ex Order 26.4] [redacted] Resident #2. At 12:06 p.m., the surveyor reviewed the investigation report regarding the [NJ Ex Order 26] incident. The investigation report indicated that on [NJ Ex Order 26.4] the Administrator reviewed the camera footage from [NJ Ex Order 26], which revealed that the CNA [NJ Ex Order 26.4(b)(1)] Resident #2 [NJ Ex Order 26.4(b)(1)] At 1:16 p.m., the surveyor interviewed the DW and inquired about the incidents on [NJ Ex Order 26.4] and [NJ Ex Order 26.4] The DW stated that Resident #2 was transferred to the hospital after [NJ Exec Order] on [NJ Ex Order 26] and confirmed that at the time of the resident's transfer to the hospital, it was believed that Resident #2 was NJ Ex Order 26.4(b)(1) The DW stated that she was out of the facility when the LPN informed her of the [NJ Ex Order 26] incident. The DW stated that she returned to the facility and performed an assessment on Resident #2, then the resident was transferred to the hospital for further evaluation. At 1:50 p.m., the surveyor interviewed the Administrator and inquired about the investigations for the [NJ Ex Order 26.4] and [NJ Ex Order 26.4] incidents. The Administrator stated that she contacted Resident #2's family member to report the investigation finding regarding the [NJ Ex Order 26.4] incident. The Administrator stated that the resident's RP expressed her suspicion that Resident #2's [NJ Exec] on [NJ Ex Order 26] may have been NJ Ex Order 26.4(b)(1). The Administrator stated that on [NJ Ex Order 26.4] she investigated the resident's [NJ Ex O] which occurred on [NJ Ex Order 26.4] and confirmed that it was [NJ Ex Order 26.4(b)] [redacted]	A 401		

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2. On 5/19/25 at 11:00 a.m., the surveyor viewed the video camera footage from the incident that occurred on [NJ Ex Order 26.4] The camera footage revealed that on [NJ Ex Order 26] at 3:43 a.m., the CNA pulled Resident #2 out of another resident's room and [NJ Ex Order 26.4(] Resident #2 [NJ Ex Order 26.4(b)(1)] in the hallway. Additionally, the surveyor observed that the camera footage which revealed the CNA as she walked away from Resident #2 while the resident was [NJ Ex Order 26.4(b)(1)].

At 12:06 p.m., the surveyor reviewed the investigation report regarding the [NJ Ex Order 26] incident, which revealed that the CNA's description of Resident #2's [NJ Ex] did not match the camera footage and the CNA was suspended pending the investigation.

At 1:50 p.m., the surveyor interviewed the Administrator and inquired about the investigation for the [NJ Ex Order 26] incident. The Administrator stated that Resident #2's RP expressed her suspicion that the resident's [NJ Exe] on [NJ Ex Order 26] may have been resident [NJ Exec Order 2] The Administrator stated that she obtained the CNA's statement regarding the [NJ Ex Order 26] incident on [NJ Ex Order 26.4(] after speaking with Resident #2's RP.

On 5/20/25 at 9:10 a.m., the surveyor reviewed the "[Facility Name] DAILY ASSIGNMENT SHEET" from [NJ Ex Order 26.4] to [NJ Ex Order 26.4(b)(] The findings were as follows:

On [NJ Ex Order 26], CNA was assigned to the [NJ Ex Order 26.4( ] from 11 p.m.-7 a.m.
On [NJ Ex Order 26], CNA was assigned to the [NJ Ex Orde] from 3 p.m.-7 a.m.
On 5/9/25, CNA was scheduled to work on the First Floor A Wing from 3 p.m.-7 a.m.; however, the surveyor observed a line across the CNA's

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A 401	Continued From page 10 name on the schedule. The surveyor observed that the CNA continued to work on the [NJ Ex Order 2] where Resident #2 resided in the facility, following the resident's [NJ Ex Order 26.4(b)(1)] that occurred on [NJ Ex Order 26.4] The surveyor reviewed a facility policy, dated 4/20/17, titled, "Abuse and Neglect: Identifying and Reporting" which indicated, " ... 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment ... Residents/patients with needs and behaviors which might lead to conflict or neglect ... Staff are required to report concerns, incidents, and grievances ... Review resident/patient Concern Reports and Accident and Incident Reports routinely to monitor for indicators leading to suspected abuse and/or neglect ..." Additionally, the surveyor reviewed the facility policy, dated 3/21/13, titled, "Resident Rights, Protecting and Ensuring" which indicated, "PURPOSE: To make certain all residents are made aware of resident rights and to prohibit deprivation of resident rights ... 3. The facility staff will be advocates for resident rights to ensure that residents are not deprived of their rights ..."	A 401		
H 000	Initials Comments TYPE OF SURVEY: Complaint COMPLAINT # NJ 00186269, NJ 00186229 CENSUS: 39 on 5/19 and 5/20/25 SAMPLE SIZE: 5	H 000		

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H 000	Continued From page 11 THE FACILITY IS NOT IN COMPLIANCE WITH THE STANDARDS FOR LICENSURE OF RESIDENTIAL FACILITIES CHAPTER N.J.A.C. 8:43E GENERAL LICENSURE PROCEDURES AND STANDARDS APPLICABLE TO ALL LICENSED FACILITIES	H 000		
H5730	8:43E-13.4(a) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall use the Universal Transfer Form, HFEL-7, provided as N.J.A.C. 8:43E-13 Appendix, incorporated herein by reference, and available on the Department's website at http://web.doh.state.nj.us/apps2/forms/, in either paper or electronic version, whenever a patient is transferred to another licensed healthcare facility or program. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00186269 Based on interview and record review, it was determined that the facility failed to utilize the Universal Transfer Form (a form that communicates pertinent patient care information at the time of a transfer between health care facilities/programs), when a resident was transferred to the Emergency Room (ER) for evaluation for 1 of 5 residents, Resident #2. This deficient practice was evidenced by the following: On 5/12/25, the Department of Health (DOH) received a Facility Reportable Event (FRE)	H5730		

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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
H5730	Continued From page 12	H5730		

regarding staff to resident physical abuse. According to the FRE, a Certified Nursing Assistant (CNA) NJ Ex Order 26.4(Resident #2 NJ Ex Order 2 [redacted] on NJ Ex Order 26.4

On 5/19/25 at 12:35 p.m., the surveyor reviewed Resident #2's medical record (MR), which indicated that the resident was admitted in NJ Ex Order 26.4(b)(1) with diagnoses that included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)

Upon review of Resident #2's MR, the surveyor observed a Progress Note (PN) dated NJ Ex Order 26 at 10:38 a.m., written by the Director of Wellness (DW), which indicated, "[Resident #2] has returned from the hospital ..."

On 5/19/25 at 12:19 p.m., the surveyor interviewed the Regional Nurse (RN) and requested a copy of the Universal Transfer Form (UTF) from Resident #2's transfer to the hospital on NJ Ex Order 26.4

At 12:31 p.m., the RN informed the surveyor that she could not locate the UTF from NJ Ex Order 26.

At 1:48 p.m., the surveyor interviewed the DW and RN and inquired about the UTF from NJ Ex Order 26.4(b The DW stated that there was no UTF from Resident #2's transfer to the hospital on NJ Ex Order 26.4(b

The surveyor reviewed a facility policy, dated 5/16/13, titled, "Emergency Medical Care and Documents" which revealed, " ... 1. Emergency packs will be put together for every resident in the event of a 911 emergency or hospital evaluation. 2. Emergency packs contain the following: ... F. Universal transfer form ... 3. Emergency packs will be placed in a binder on each unit ... should be sent with the emergency crew with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a003	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACES AT PARKE PLACE	**661 DELSEA DRIVE SEWELL, NJ 08080**

(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
H5730	Continued From page 13 completed transfer form ..."	H5730		

POC#3 received 7/22/25
Accepted 7/22/25

Terraces at Parke Place

Assisted Living

DePaul Healthcare

Plan of Correction for 5/20/2025 Complaint Visit

A310 Completion Date: July 14, 2025

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

   The Administrator and the RN Assessment Nurse reviewed the "Accident and Incident Reports: Resident" and the "Camera Surveillance; (Video Security Cameras) policy as specified.

   Resident #2 and Resident #3 continue to reside in the community.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

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

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

   Accident and Incident Reports will be reviewed by the Administrator and the RN Assessment Nurse/ Designee. The Administrator and the RN Assessment Nurse conducted in-services on "Abuse and Neglect: Identifying and Reporting" for all employees on 5/14/25. The Administrator and RN Assessment Nurse conducted the in-service on Employee Response to a Combative Resident on 5/15/25. The Lead LPN conducted the in-service for all nursing staff on "Accident and Incident Report: Resident" on 7/3/25.

   The regional team reviewed the camera surveillance policy with Administrator/RN Assessment Nurse on 7/8/25.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

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At the morning clinical meetings, which are held Monday-Friday, the RN Assessment Nurse/Designee will review any accidents or incidents with the Administrator to ensure the policies have been followed. When the RN Assessment Nurse/Administrator is not in the facility, the RN Assessment Nurse will be notified of any clinical incidents. The RN Assessment Nurse will notify the Administrator of the clinical incidents, and the Administrator will notify the DOH of any reportable events as per regulation. The Administrator and the RN Assessment Nurse will review the incident reports at the next clinical meeting. Further in-services will be determined at that time by the Administrator/RN Assessment Nurse. [redacted] approved 7/22/25

A 401 Completion Date: July 14, 2025

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

   Resident #2 is entitled to have all resident rights protected.

   Resident #2 continues to reside in the facility.

   HHA#1 and HHA#2 were [redacted] from their positions at the facility on [redacted] CNA was [redacted] from the position on [redacted]

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

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

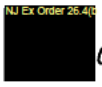
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

   All staff were re-in serviced on Resident Rights by the Administrator and Lead LPN on 7/3/25. The Administrator and RN reviewed on the policy "Camera Surveillance (Video Security Cameras)" by the regional team on 7/8/25. The Administrator and the RN Assessment Nurse conducted in-

services on "Abuse and Neglect: Identifying and Reporting" for employees on 5/14/25.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

The Administrator/Designee will provide Resident Rights training upon hire and a yearly in-service of Resident Rights to each employee. Resident Rights are reviewed at each monthly Resident Council Meeting. The minutes of these meetings are forwarded to the Administrator for review. The Administrator will review any violation of resident rights and respond appropriately. The Administrator/RN Assessment Nurse will review any violation of Resident's Rights at the clinical meetings that are held Monday-Friday. When the RN Assessment Nurse/Administrator are not in the facility, the RN will be notified of any clinical incidents and will review the incident report at the next clinical meeting. The RN will notify the Administrator of the clinical incidents, and the Administrator will notify the DOH of any reportable events per regulation. The Administrator and the RN will review the incident report at the next clinical meeting.



approved 7/22/25

H5730 Completion Date: July 14, 2025

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

The Universal Transfer form will be completed for Resident #2 should the resident need to be transferred to the hospital. Resident #2 continues to reside in the facility.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

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

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

Terraces at Parke Place

Assisted Living

DePaul Healthcare

Nursing staff received an in-service titled "Emergency Medical Care and Documents" by the RN Assessment Nurse on 7/7/25. Emergency packs have been put together for every resident in the event of a 911 emergency or hospital evaluation. The emergency packs were updated on 7/9/25.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

The RN or Designee will be responsible for compiling and updating the Emergency Pack and then place the binder on each unit. The emergency pack will be updated by the RN Assessment Nurse/Designee immediately when changes to the Residents' information occur. The RN Assessment Nurse/Designee will audit the information monthly for accuracy. The RN Assessment Nurse or designee will do a chart audit of 4 residents who went out to the hospital each month to ensure that the Universal Transfer form has been utilized. The results of this audit will be reviewed at the Clinical Nursing meeting at the beginning of each month for the next 6 months. The RN Assessment Nurse will determine the need for further action. [redacted] approved 7/22/25

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
35a003	A. Building B. Wing	7/22/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACES AT PARKE PLACE	661 DELSEA DRIVE SEWELL, NJ 08080

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 07/14/2025	ID Prefix A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 07/14/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/20/2025	☐ 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 Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
35a003	A. Building B. Wing	7/22/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACES AT PARKE PLACE	661 DELSEA DRIVE SEWELL, NJ 08080

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 H5730 Reg. # 8:43E-13.4(a) LSC	Correction Completed 07/14/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 5/20/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			