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	08A010	A. BUILDING: _____ B. WING _____	12/07/2021

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LANDING OF WASHINGTON SQUARE, THE	120 TOWN CENTER BOULEVARD 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: Census: 69 Sample Size: 5 TYPE OF SURVEY: Standard Survey of 138 residential units 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 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.	A 891		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/02/22

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A 891	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review and facility policy review, the facility failed to comply with the N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. The facility failed to ensure food items were labeled and dated; failed to ensure the cleanliness of the kitchen; failed to ensure kitchen equipment was maintained; failed to ensure facility staff wore hairnets in the kitchen; failed to wash vegetables prior to slicing; failed to ensure food items were stored off the floor; and failed to ensure food temperatures were checked prior to serving. This deficient practice had the potential to affect all residents, the evidence was as follows: 1. Reference: New Jersey Chapter 24, "8:24-4.6 Cleaning of equipment & utensils (c) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." On 12/6/21 from 10:13 a.m. to 11:20 a.m. the surveyor toured the kitchen and observed the following: a. Four large bins were labeled with flour, sugar, breadcrumbs, and rice. All four containers were observed to have food particles on the handles and the tops of the lids, and the containers were not dated. b. On a shelf, over a preparation (prep) table, were three bags of chocolate chip cookies in reusable/re-sealable zipper storage bags. The bags were opened but not dated when opened to	A 891		

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A 891	Continued From page 2 alert the user when they should be discarded. c. A [redacted] (commercial food processor) was on top of a prep table. The table was observed to have food debris and the Robot Coupe was observed to be sticky with food debris on the machine. Next to the [redacted] was a meat slicer that was covered with a plastic bag. The bag had what appeared to be splash marks from food particles. The resting plate of the food slicer had what appeared to be dried food on the plate and near the slicing blade. d. There were two shelves above the food prep area that were to the right of the hand-washing sink. On the left side of the top shelf was an open container of chocolate icing that was not dated when opened. On the same shelf was a bag of vanilla wafers that was not sealed or dated when opened, a bag of brown sugar that was not sealed or dated when opened, and a bag of pancake mix that was not sealed or dated when opened. e. On another prep table was a [redacted] commercial mixer. The machine was observed to have food particles stuck to the machine and the mixing bowl. The mixing blades were in the bottom of the bowl, and the bottom of the bowl was observed with crumb-type food particles. f. On the shelf above the prep table with the [redacted]" commercial mixer was a bag of stuffing mix that was not sealed or labeled when it was opened. There was a box of yellow cake mix that was open and not dated when opened. g. The prep table with the "[redacted] commercial mixer had two drawers side by side. The stainless-steel drawer handles were sticky to	A 891		

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A 891	Continued From page 3	A 891		

the touch and rough from dried-on food particles. The top, front edge of the drawers had brown-colored drip marks and were sticky. Inside both drawers were serving scoops, along with dried food particles/crumbs.

h. Located on the top shelf of the walk-in refrigerator, next to the box of green peppers, was a container that had cooked chicken wings. The container was not labeled, dated, or tightly wrapped.

On 12/06/2021 at 10:35 a.m., three boxes of food, not labeled, were observed on the floor of the walk-in freezer. Additionally, 12 cups of ice cream were observed to be pre-scooped in a monkey dish (a small bowl with a flat bottom). The 12 cups were not covered, labeled, or dated. Three of the cups appeared to have previously melted and were placed back in the freezer. One cup was frozen to the bottom side of the platter the cups were on.

On 12/06/2021 at 10:37 a.m., the fire door to the mop room was observed to be propped open with a mop bucket.

On 12/06/2021 at 10:38 a.m., in the back part of the kitchen was a drink station for the [redacted] neighborhood. The area around the drink dispensing machine was sticky and appeared to have dried sticky substances that had dripped and pooled to a shelf below. The refrigerator in that room was empty. However, the handle and the area around the handle was observed to have a white, powdery-looking substance on the stainless steel of the outside of the refrigerator.

On 12/06/2021 at 10:45 a.m., green, red, and

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A 891	Continued From page 4 blue cutting boards were observed to be worn and gouged to the point that the color was worn off the cutting boards. The white cutting board on the food prep table located on the serving line was worn and gouged. The plate warmer equipment was dirty with drip marks and dried food particles. On 12/07/2021 at 11:08 a.m., in the walk-in freezer, the following was observed: A clear bag of sausage links, a clear bag of sausage patties, a clear bag of breaded chicken wings, a clear bag of chicken tenders, and a clear bag of raviolis were all wide open and sitting on shelves in the freezer. The bags were not labeled with what was in them and were not dated. The ice cream cups from 12/06/2021 had been removed from the freezer. At 11:09 a.m. the surveyor interviewed the Cook who stated the items should have been labeled and dated. He stated that the ice cream cups from the day before should never have been placed back in the freezer uncovered, and that they should have been discarded. 2. Reference: New Jersey Sanitation Code, 8:24-2.4 Hygienic practices, indicated, (c) The following requirements shall apply to hair restraints: 1. Except as provided in (c)2 below, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens; and unwrapped single-service and single-use articles. On 12/06/2021 at 10:25 a.m., the Activities Director (AD) entered the kitchen to put	A 891		

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A 891	Continued From page 5	A 891		

something in the walk-in refrigerator. He was observed walking through the entire kitchen without wearing a hair restraint. At 10:27 a.m., the surveyor interviewed the AD who stated that he thought he was only required to wear a hair restraint if he was working in the kitchen.

On 12/07/2021 at 8:40 a.m., the surveyor observed a Housekeeper walk around the kitchen without a hair restraint. The Housekeeper had her hair in a ponytail that reached the middle of her back. When interviewed by the surveyor regarding if she knew that she was supposed to wear a hair restraint in the kitchen, she stated that she was there because the kitchen requested paper towels and she did not usually enter the kitchen.

During surveyor interview with the Cook, she stated that the Housekeeper needed to put on a hair restraint and the kitchen staff should have told the Housekeeper to do so prior to her entering the kitchen.

On 12/07/2021 at 8:48 a.m., during interview with the GM she stated that no one should ever enter the kitchen without a hair restraint on.

3. Reference: New Jersey Sanitation Code 8:24-3.2 (j) Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants.

On 12/06/2021 at 10:40 a.m., the door to the storage room was propped open with a large can of food. In the dry storage room, there were two boxes of [redacted] coffee stored on the floor. Next to the [redacted] coffee were four boxed containers of frying oil that were stored on the floor. One of

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A 891	Continued From page 6 the boxes had leaked oil, and one side of the box was wet with oil. On a top shelving rack was a box of 500 hinged-lid containers located less than 18 inches from a smoke detector. On another shelf were bags of pasta. Two bags of spaghetti were opened, with no label or date as to when the bag had been opened. On that same shelf was a large bag of penne pasta, which was open with no label or date as to when the bag had been opened. There was a large plastic box labeled [redacted] bread crumbs." The lid of the box appeared to be covered in dust and food particles and was sticky to touch. The box was not dated as to when the box was opened. There was a six-quart container of salt which had a red-colored top that was covered with dust and food particles and was sticky to the touch. 4. On 12/07/2021 at 8:38 a.m., the Cook was observed slicing potatoes. When asked if he had washed the potatoes prior to slicing them, he held out a potato and stated he thought they were clean. This surveyor and the Cook looked at the bag of potatoes together. The bag indicated, "Wash before use." The Cook stated that he would go wash off the pan of potatoes and continued to prepare them. The Cook had sliced approximately ¾ of the bag and had not washed the potatoes. 5. On 12/06/2021 at 10:50 a.m., the Cook during surveyor interview, and document review of the food temperature log, the surveyor asked the Cook to review the temperature logs that were to be completed prior to all meals. The last time temperatures had been documented was on 11/23/2021. The Cook stated that he took temperatures, but never wrote them down. On 12/06/2021 at 10:50 a.m., the Cook stated	A 891		

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that he had been the only Cook for quite some time since the Food Services Director (FSD) had been out. He stated that he had one day off in the last month. He stated that the sanitation of the kitchen was up to him and the full-time Dishwasher, and that he did not have the time to do a lot of cleaning.

Regarding the mop room and the dry storage room being propped open, the Cook stated that he was not aware of the fire prevention regulations and did not know that those doors could not be propped open. The Cook stated the boxes of coffee and frying oil were not supposed to be stored on the floor and that he was not aware of the fire protocol when he stored the box on the top shelf with the hinged lid containers.

On 12/06/2021 at 11:07 a.m., the surveyor interviewed the General Manager (GM) regarding the concerns in the kitchen, the GM confirmed awareness of the concerns identified by the surveyor and stated that they had been short-staffed. At 11:37 a.m., the GM stated that the FSD had been out since 10/27/2021 and she was not sure when the FSD would return to the facility. The GM identified the need to look into obtaining additional kitchen help through an agency.

The facility policy, titled, "Menu Planning and Modified Diet Policy," dated August 2000 and revised January 2019, indicated, in part, that state specific considerations for New Jersey included, "A current diet manual should be available to staff ...A designated food service coordinator shall be present when meals are prepared."

The facility policy, titled, "Food Handling Policy," dated November 2004 and revised July 2019,

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A 891	Continued From page 8 indicated, in part, "The General Manager, in conjunction with the Chef, will ensure all staff responsible for receiving, handling, preparing, serving and storing food complete training commensurate with their job duties including, but not limited to the following areas: Temperature controls including storage, hot/cold holding, cooling, transferring, and reheating ... Sanitation practices including ware washing, kitchen and restaurant cleaning."	A 891		
A 935	8:36-11.4(b) Pharmaceutical Services (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy it was determined that the facility failed to administer medications in accordance with facility policy, when staff that were not qualified pre-pouring medications for 1 of 5 residents, Resident #5, observed during medication pass and failed to administer medications in accordance with prescriber orders for a medication administered without a physician's order for 1 of 5 residents, Resident	A 935		

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A 935	Continued From page 9 #3, also observed during medication pass. This deficient practice was evidenced by the following: 1. During surveyor observation on 12/06/2021 at 10:15 a.m., Licensed Practical Nurse (LPN) #1 was observed giving Resident #5 a medication cup with [redacted] medications pre-poured. The medication cup was observed to contain [redacted] milligrams (mg), [redacted] mg, [redacted] mg, [redacted], and [redacted] mg. During surveyor interview on 12/06/2021 at 10:24 a.m., with the General Manager, she stated that the facility policy for administering medications was not to pre-pour medications and that the Nurse should not have pre-poured any medications. During surveyor interview on 12/06/2021 at 10:30 a.m., LPN #1 stated that the resident for whom she pre-poured the medications did not come down to the medication room, and the LPN had pre-poured the medications to take to the resident's room. LPN #1 further stated that she had not been instructed to pre-pour the medications and had pre-poured nine other residents' medications and placed them in an opened caddy. Surveyor review of the facility policy titled, "Medication Services Policy (Excluding Insulin)," written in January of 2003 and last revised in August of 2020, revealed in part, "Regardless of credentials, staff of a Leisure Care managed community shall not: Pre-pour-medications (transfer medications from one container to another for transport to the resident or for later assistance)."	A 935		

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A 935	Continued From page 10 2. On 12/06/2021 at 10:50 a.m., the surveyor observed Resident #3 seated in the nurses' station and LPN #1 was observed applying a [redacted]) to Resident #3's [redacted]. The resident stated that their right knee was also hurting and requested the Nurse to apply a [redacted] patch to the resident's [redacted] LPN #1 informed the resident that there was no order for the patch for the [redacted], but was observed placing a [redacted] patch on Resident #3's [redacted]. On 12/07/2021 at 8:35 a.m., LPN #1 stated that she did not get an order for a [redacted] patch that she had applied to Resident #3's [redacted] and she had not notified the Physician to get an order. During surveyor interview on 12/07/2021 at 8:40 a.m., Resident #3 stated that the patch placed on the [redacted] made no difference with [redacted] On 12/07/2021 at 8:39 a.m. the General Manager (GM) stated during surveyor interview that Nurses should always get an order before giving any medication, but the facility had no related policy. The GM further stated that the Physician was always available and the Nurse should have called the Physician to get an order before placing the lidocaine patch on the resident's [redacted].	A 935		
A1035	8:36-14.2(b) Emergency Services and Procedures (b) The emergency plans, including a written evacuation diagram specific to the unit that includes evacuation procedure, location of fire	A1035		

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A1035	Continued From page 11 exits, alarm boxes, and fire extinguishers, and all emergency procedures shall be conspicuously posted throughout the facility. All employees shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and resident evacuation as part of their initial orientation and at least annually thereafter. All residents shall be instructed in emergency evacuation procedures. This REQUIREMENT is not met as evidenced by: Based on facility policy review, employee file review, and interview the facility failed to provide documentation of fire drill staff participation for 2 of 5 employee files reviewed, Employees #1 and Employee #5. This deficient practice was evidenced by the following: 1. Surveyor review of the employee file for Employee #1, a Certified Medication Aide, revealed the facility had no documentation that the employee attended a fire drill for the past 12 months. 2. Surveyor review of the employee file for Employee #5, a Licensed Practical Nurse, revealed the facility had no documentation that the employee had attended a fire drill for the past 12 months. During surveyor interview with the General Manager on 12/07/2021 at 12:00 p.m., she stated that she could not find the "Fire Drill Reports" for Employee #1 and Employee #5 and did not have documentation that the employees attended a fire drill.	A1035		

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A1035	Continued From page 12 Surveyor review of the facility fire drill policy titled, "Emergency Procedures Policy," written 03/19/1985 and revised in December of 2018, read in part, "The General Manager shall ensure the following ...Each shift must participate in a fire drill every quarter ...The drill will be documented using the Fire Drill Report."	A1035		
A1047	8:36-14.3(d) Emergency Services and Procedures (d) Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable NFPA requirements and N.J.A.C. 5:70. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined that the facility failed to perform monthly visual inspections of fire extinguishers in November of 2021, and failed to perform an annual service, including inspection, recharging, and maintenance of the facility fire extinguishers by an approved vendor in October of 2021. This deficient practice had the potential to affect all residents, at the time of the survey the census was [redacted]. This deficient practice was evidenced by the following:	A1047		

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A1047	Continued From page 13 1. On 12/06/2021, at 10:13 a.m. the surveyor toured the kitchen and observed one fire extinguisher in the kitchen. The tag on the fire extinguisher indicated that it was last serviced in October of 2020 and last inspected by the facility in October of 2021. As of the time of the survey, the annual servicing and monthly inspections of the fire extinguishers were out of compliance. On 12/06/2021, beginning at 12:08 p.m. the surveyor started the tour of the building on the [redacted] floor of the facility and observed (7) seven fire extinguishers and the tag on each fire extinguisher indicated they were last serviced in October of 2020, and last inspected by the facility in October of 2021. As of the time of the survey, the annual servicing and monthly inspections of the fire extinguishers were out of compliance. On 12/06/2021, at 12:43 p.m. the surveyor started the tour of the [redacted] floor and observed (4) four fire extinguishers. The tag on each fire extinguisher indicated that they were last serviced in October of 2020 and last inspected by the facility in October of 2021. As of the time of the survey, the annual servicing and monthly inspections of the fire extinguishers were out of compliance. On 12/06/2021, at 1:20 p.m. the surveyor toured the [redacted] floor of the facility and observed (4) four fire extinguishers. The tag on each fire extinguisher indicated they were last serviced in October of 2020 and last inspected by the facility in October of 2021. As of the time of the survey, the annual servicing and monthly inspections of the fire extinguishers were out of compliance. On 12/07/2021 at 9:30 a.m., the surveyor	A1047		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A010	A. BUILDING: _____ B. WING _____	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDING OF WASHINGTON SQUARE, THE	120 TOWN CENTER BOULEVARD 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
A1047	Continued From page 14 interviewed the Maintenance Director (MD) regarding required annual inspections, one of which was the annual fire extinguisher inspection. The MD stated that he was taking over for the former MD, who had recently been relieved of his position. The MD stated that he planned to review existing records to see if the inspection had been completed. On 12/07/2021 at 12:35 p.m., the MD stated that he was unable to find any evidence that the annual fire extinguisher inspection had been completed. Based on the tag on each fire extinguisher, he was able to establish that the last inspection occurred in October of 2020. On 12/07/2021 at 2:00 p.m., the MD stated that the fire extinguisher inspection had not been completed for the year 2021 and the last visual inspection occurred in October of 2021. He stated that he was aware that the findings put the facility out of compliance. On 12/07/2021 at 2:45 p.m., the surveyor interviewed the General Manager (GM) who stated that the MD informed her that the November 2021 visual inspection had not occurred and the annual servicing had not been completed. She stated that that was the reason why the previous MD was no longer employed at the facility. Review of the facility policy titled, "Emergency System Policy," dated 03/15/1985 and revised 06/2018, revealed, in part, "Fire extinguishers will be serviced every 12 months or as recommended by the manufacturer and will be tagged specifying the date of recharging and the name of the approved vendor performing the work. If monthly inspections are required, community staff will document inspections on each extinguisher's	A1047		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A010	A. BUILDING: _____ B. WING _____	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDING OF WASHINGTON SQUARE, THE	120 TOWN CENTER BOULEVARD 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
A1047	Continued From page 15 inspection tag."	A1047		
A1225	8:36-17.3(b)(8)(i-ii) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition; i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved; and ii. The written statement shall be available for review by the Department during survey. This REQUIREMENT is not met as evidenced by: Based on interview and facility policy review, the facility failed to have a licensed Electrician perform an annual inspection of the facility electrical circuits and wiring, this deficient practice had the potential to affect all residents and was evidenced by the following:	A1225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A010	A. BUILDING: _____ B. WING _____	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDING OF WASHINGTON SQUARE, THE	120 TOWN CENTER BOULEVARD 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
A1225	Continued From page 16 1. On 12/07/2021 at 9:30 AM, the surveyor interviewed the Maintenance Director (MD) regarding required annual inspections, one of which was the annual inspection of the electrical system by a licensed Electrician. The MD stated he was taking over for the former MD who had recently been relieved of his position. The MD stated that he needed to review the records that remained from the prior MD to see if the inspection was completed. On 12/07/2021 at 12:35 PM, the MD stated that he was unable to find any evidence that the annual inspection by an Electrician had been completed, noting that he called the vendor to see if the vendor had any type of record of the inspection being completed. At that time, the MD was unable to find an electrician inspection from the prior year. On 12/07/2021 at 2:00 PM, the MD stated that an inspection of the electrical system had not been completed for the year 2021. He stated that he was aware that it put the facility out of compliance. On 12/07/2021 at 2:45 PM, the surveyor interviewed the General Manager (GM) who stated that the MD informed her that the electrical system inspection had not been completed. She identified this as the reason why the previous MD was no longer employed by the facility. The facility policy titled, "Equipment Maintenance Policy," dated March 1985 with a revision date of November 2017, revealed in part, "On an annual basis, a licensed electrician shall inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory	A1225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A010	A. BUILDING: _____ B. WING _____	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDING OF WASHINGTON SQUARE, THE	120 TOWN CENTER BOULEVARD 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
A1225	Continued From page 17 and in safe condition, that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved."	A1225		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
08A010 Y1	A. Building B. Wing Y2	6/2/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDING OF WASHINGTON SQUARE, THE	120 TOWN CENTER BOULEVARD 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 A0891	Correction	ID Prefix A0935	Correction	ID Prefix A1035	Correction
Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-11.4(b)	Completed	Reg. # 8:36-14.2(b)	Completed
LSC	02/01/2022	LSC	02/01/2022	LSC	02/01/2022
ID Prefix A1047	Correction	ID Prefix A1225	Correction	ID Prefix	Correction
Reg. # 8:36-14.3(d)	Completed	Reg. # 8:36-17.3(b)(8)(i-ii)	Completed	Reg. #	Completed
LSC	02/01/2022	LSC	02/01/2022	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	
12/7/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

December 22, 2021

Ms. Rita Rivera-Worley, Administrator
Landing Of Washington Square, The
120 Town Center Boulevard
Sewell, NJ 08080

Dear Ms. Rivera-Worley:

Thank you for your courtesy and cooperation extended during our Standard Survey visit to your facility, which was conducted on December 7, 2021.

Your Statement of Deficiencies (SOD) will be emailed to you. Please reply to each deficiency on an item-by-item basis in your Plan of Correction (POC) and include the date you expect the correction to be completed. All responses should be numbered to correspond with the numbers on your deficiency statement. Then email the POC back to **HFEL.POCAL@doh.nj.gov** within ten (10) business days from receipt of this letter. **Please do not mail the POC.**

The POC should be a narrative and must include:

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

2. How the facility will identify other residents having 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.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

Sign and date the first page of the Statement of Deficiencies, and return via email as instructed in paragraph three of this letter within ten (10) business days from receipt of this letter.

1/28/22

N.J.A.C. 8:43E-2.3 provides facilities the option to challenge factual survey findings by requesting Informal Dispute Resolution (IDR) with Department representatives. Facilities wishing to challenge only the assessment of penalties are not entitled to IDR review, but may request a formal hearing at the Office of Administrative Law. IDR requests must be made in writing within ten (10) business days from receipt of this letter and must state whether the facility opts for an in-person conference at the Department, a telephone conference or review of facility documentation only. The request must include an original and ten (10) copies of the following:

1. A specific listing of the deficiencies for which informal review is requested; and,
2. Documentation supporting any contention that a survey finding was in error.

Any supporting documentation or other papers submitted later than 10 business days prior to the scheduled IDR may not be considered at the discretion of the IDR panel.

Send the above referenced IDR INFORMATION ONLY to:
Program Compliance & Health Care Financing
New Jersey Department of Health
P.O. Box 358
Trenton, New Jersey 08625-0358

It is important to return the completed forms promptly. Please do not hesitate to contact me if you have any questions regarding the deficiencies. I can be reached at (609) 633-8990.

Sincerely,

[redacted]
Supervisor of Inspections
Health Facility Survey & Field Operations

Enc.

COMPLETION DATE DETAIL:

TAG# A891 8:36-10.5 (a)
An In-service was completed on January 12th, 2022. This in-service has also recently been added to our New Employee Orientation Sessions, which take place every other Wednesday.

TAG# A935
A Full In-service was done on 2/1/2021 to all Health and Wellness Team in regard to administering medication. In addition, Leisure Care policy is trained on every new employee orientation and full in-services are now presented monthly.

TAG #A1035
As of 1/19/2022, regular fire drills have been performed. In our New Employee orientations every other Wednesday, all employees are getting fire life and safety training. In addition, on January 19th, 2022, our emergency procedure manual was updated and placed in three areas of the community, included our front desk. All employees are directed to this manual on a tour of our building at New Employee Orientation, occurring every 2nd Wednesday.

TAG #A1047 8:36-14.3 (d)
They are all instructed on proper use of fire extinguishers. On 1/19/2022, every fire extinguisher was inspected and will routinely be maintained going forward. Monthly inspections will continue to take place. The first one was completed and logged on 1/19/2022.

TAG # A1225 8:36-17.3 (b)(8)(i-ii)
On January 13th, 2022, we had a licensed electrician perform a safety inspection. These Inspections are now routinely scheduled for at least once every 12 months. The next inspection is scheduled for December 2022.

The Landing of Washington Square

Plan of Corrections for Survey conducted on 12.7.2021

License # 08A010

On 12/07/2021 the NJ Department of Health conducted a Standard Survey Visit at The Landing of Washington Square and found the following deficiencies. Please see below for plan of corrections.

Tag# A891 8:36-10.5 (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 NJ Sanitary code.

1.How the corrective action will be accomplished for those resident's found to have been affected by the deficient practice:

During the investigation it was determined that the deficient practice had the potential to affect all residents. **8:24-4.6 (Cleaning of utensils and equipment), 8:24-2.4 (Hygienic practices), 8P:24-3.2 (Sanitation Code)** referenced the items below and these deficient practices will be corrected by:

- Maintaining all kitchen equipment free of dust, dirt, food residue and other debris.
- Dating all open packages and containers twice (date it was received and date it was opened)
- All equipment will be cleaned and put back into proper placement after drying.
- All surfaces will be properly cleaned after food service.
- Any ice cream that has been left to defrost will be discarded if not used during the mealtime and not placed back in the freezer.
- Hair restraints shall be worn by all personnel when entering the kitchen.
- Door to the dry storage unit shall always remain closed
- All produce, unless labeled as "prewashed" shall be rinsed prior to cutting or peeling such items
- All temperature logs shall remain up to date with daily food temperatures
- All items on top shelf shall be placed 18' or lower from smoke detector
- New cutting boards will be ordered and the ones in circulation will be discarded
- All items in freezer will be sealed and dated with open date

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

During the investigation it was determined that the deficient practice had the potential to affect all residents and by identifying the deficiencies and putting measures in place we will have the opportunity to positively affect all our residents.

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

The General Manager will oversee that the Sanitation Inspection form has been developed to monitor cleanliness of the kitchen and equipment, verify temperature monitoring is conducted, conducted by a different team member during kitchen operating hours on a monthly basis and given to Chef, retain for 30 days and ensure other operational aspects of the food service establishment are satisfactory.

Chef will be the primary Food Service Coordinator, however in their absence the team will follow a posted schedule with a designated food service coordinator for each shift.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

- The General Manager and Chef will follow company policy ensure that a current diet manual is available to staff.
- The General Manager and Chef, will follow company policy and ensure there is a food service coordinator present when meals are prepared
- The General Manager and Chef will ensure to conduct training to all staff involved in receiving, handling, preparing, storing, and serving food at the community to receive additional training in the above mentioned.
- The monitoring will occur during the GM/Chef weekly 1:1 business meeting; The 1:1 meeting will also be used to monitor monthly sanitation forms.
- GM and Chef can use the F&B section of the company's Operations Audit to periodically review compliance; Operations Leader will conduct formal Operations Audit annually

Tag# A935

The facility and personnel shall comply with the provisions 8:36-11.4 (b) Pharmaceutical Services.

1. How the corrective action will be accomplished for those resident's found to have been affected by the deficient practice:

During the investigation it was determined that the deficient practice had the potential to affect all residents.

All medications shall be administered by qualified personnel in accordance with prescribers' orders, facility, or program policy manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations.

As per Leisure Care policy, only staff properly credentialed and trained in accordance with state law will be permitted to provide medication services. No staff member shall provide medication services outside of their approved scope of training.

#1 – As per stated in the statement of deficiency it was noted that the LPN failed to follow proper LC procedure which clearly states that regardless of credentials, staff of Leisure Care managed community **shall not**: (for purpose of form only noting relevant policy)

- Pre-pour-medications (transfer medications from one container to another for transport to the resident or for later assistance)

The LPN and additional staff certified to administer medication (LPN's and Med Tech's) where re-educated on the Leisure Care policy. The community also began training for the transition to comply with company policy of providing residents privacy by administering medication to them in their apartments where medications will already be stored. This change which will be in full effect by 2/1/2022.

#2 – Surveyor observed LPN administer medication without a physician's order.

- As per Leisure Care Policy under Medication Orders it states, each resident will have monthly medication administration record with exact physician's orders for each prescribed medication. MARS shall be maintained electronically in Eldermark. The community will provide the medications to a resident in the form they are prescribed.

The LPN and additional staff certified to administer medication (LPN's and Med Tech's) where retrained including educating about documenting variances to service plans, medication errors and completion of incident reports. The Health and Wellness Director, along with the General Manager will keep documentation for attendance.

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

During the investigation it was determined that the deficient practice had the potential to affect all residents and by identifying the deficiencies and putting measures in place we will have the opportunity to positively affect all our residents.

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

The community's electronic recordkeeping system has been set to send the GM and HWD notifications upon the completion of incident reports. The GM and HWD will review incident reports within 24 hours. The electronic platform "Dashboards" that are monitored by the GM and HWD have been set to identify variances to planned service provision and assures an investigation is underway for unresolved incidents.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

- The LPN and nursing staff where re-educated on the Leisure Care policy. The community also began training for the transition to comply with company policy of providing residents privacy by administering medication to them in their apartments where medications will already be stored. This change which will be in full effect by 2/1/2022 and will effectively eliminate the need to travel to any location to assist a resident with medication.
- This process will be overseen by the health and wellness director and general manager.

All nursing staff will ensure to follow Leisure Care policy stating that when staff are providing medication services, the following practices shall be observed:

- HWD/designee is to monitor dashboards daily and the GM will monitor them as part of the ongoing quality management processes.
- All medication assistance shall occur in a private area unless the resident is in a designated Opal program.
- The EMAR must be present and read aloud prior to assisting with medications.
- Each medication must be given to the resident directly from a unit dose bubble pack or container.
- Each resident must be observed taking the medication. Medication will not be left unattended by an employee unless the order prescribes the medication to be left for the resident.
- Prior to medication assistance, the six "rights" will be reviewed twice.
    1. The Right Resident
    2. The Right Medication
    3. The Right Dose
    4. The Right Route
    5. The Right Time
    6. The Right Documentation
- This staff training will be headed by the HWD overseen by the GM

TAG #A1035

8:36-14.2 (b) Emergency Services and Procedures

(b) The emergency plans, including a written evacuation diagram specific to the unit that includes evacuation procedure, location of fire exits, alarm boxes, and fire extinguishers, and all emergency procedures shall be conspicuously posted throughout the facility. All employees shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and resident evacuation as part of their initial orientation and at least annually thereafter. All residents shall be instructed in emergency evacuation procedures.

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

During the investigation it was determined that the deficient practice had the potential to affect all residents.

The facility will remain in compliance with Leisure Care policy

Staff Education/Training

Community staff will be oriented to the contents of the EPM as part of New Employee Orientation and will receive refresher training at least annually. Documentation of training will

be placed in team members' files and may be include in a central training binder. Communities may use the Emergency and Safety Training Attendance

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

During the investigation it was determined that the deficient practice had the potential to affect all residents.

Fire Drills

The language used to describe fire drills in some jurisdictions co-mingles fire drill and evacuation drill references. Leisure Care managed communities consider these to be separate scenarios. Residents should not self-evacuate unless they are in imminent danger. When the building alarm sounds, staff will move quickly through the building to locate the source of the alarm and will initiate evacuation responses if required.

Unannounced fire drills will be initiated by the actuation of the building's alarm system, unless otherwise specified by law.

Residents who remain where they are when the building alarm is activated are considered to have successfully participated in the drill. Residents who attempt to evacuate or open fire doors should be re-oriented to the community's plan.

The General Manager shall ensure the following:

- The community must conduct at least one fire drill each month.
- Each shift must participate in a fire drill every quarter.
- Drills will not be conducted back-to-back to eliminate the need for drills the remainder of the year.
- The same actuation device will not be used to initiate the drill each month.
- The drill will be documented using the fire drill report.

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

Fire drills are scheduled in TELS which sends notices to Plant Ops Sup and GM.

All oversight on fire drills will be the responsibility of the plant operations director in coordination and oversight of the general manager. The assistant plant operations manager will participate and initiate drill when available with the same oversight.

3. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Ie what program will be put in place to monitor the continued effectiveness of the systemic changes.

Plant Operations will conduct monitoring of TELS and Operations Audits conducted by the Operations leader or designee.

By following the Leisure Care policy on fire drills, we will remain in compliance. The drills will take place monthly on rotating shifts to ensure full participation. 1st drill for 2022 took place on 1/19/22 during 1st shift.

Tag A1047

8:36-14.3 (d) Emergency Services and Procedures

(d) Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers and applicable NFPA requirements and N.J.A.C. 5:70. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance.

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

During the investigation it was determined that the deficient practice had the potential to affect all residents.

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

During the investigation it was determined that the deficient practice had the potential to affect all residents. Fire extinguishers inspections will be monitored by the plant ops director with oversight from the GM.\

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

Now that position has been filed and vendor established, we are set on an inspection schedule to stay in compliance.

All tasks will be scheduled in TELS; Plant Operations will ensure completion while General Manager will get notices regardless of vacancies in plant operations department for compliance.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Ie what program will be put in place to monitor the continued effectiveness of the systemic changes.

Fire Extinguishers
Fire extinguishers will be serviced every 12 months or as recommended by the manufacturer and will be tagged specifying the date of recharging and the name of the approved vendor performing the work.
- If monthly inspections are required, community staff will document inspections on each extinguisher's inspection tag.

Monitoring will fall on GM and Plant ops manager.

Tag A1225

8:36-17.3 (b)(8)(i-ii) Housekeeping-Sanitation-Safety-Maintenance
(b) The following safety conditions shall be met:

As per Leisure Care policy, an electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition;

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

During the investigation it was determined that the deficient practice had the potential to affect all residents.

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

During the investigation it was determined that the deficient practice had the potential to affect all residents. Electrical inspections will be monitored by the plant ops director with oversight from the GM. Yearly inspections scheduled and documented as per Leisure Care policy

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

Now that position has been filed and vendor established, we are set on an inspection schedule to stay in compliance.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. i.e., what program will be put in place to monitor the continued effectiveness of the systemic changes.

Electrical Inspections
Electrical Inspections will take place every 12 months or as recommended by the manufacturer and will be logged in TELS for follow up and compliance.

Monitoring will fall on GM and Plant ops manager.