New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A012	A. BUILDING: ___ B. WING ___	C 07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHINGTON	339 GREENTREE ROAD 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 #: NJ00155623 CENSUS: 104 SAMPLE SIZE: 3 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

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint # NJ00155623 Based on interview and record review, the facility failed to develop and implement a policy and procedure to safeguard cognitive impaired residents during facility sponsored field trips for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 7/20/22 at 11:40 a.m., the surveyor reviewed the medical record (MR) of Resident #2 which revealed that Resident #2 moved into the facility on [redacted] with diagnoses which included EX Order 26 § 4b1 According to the nursing assessment dated 4/1/22, Resident #2 [redacted] and was alert and occasionally needed EX Order 26 § 4b1 to person, place, and time. On 7/20/22 at 11:50 a.m., the surveyor interviewed the Memory Care Director (MCD) who informed the surveyor that on 6/6/22 Resident #2 EX Order 26 § 4b1 of the resident van line up after head count was taken and went back into the store unbeknownst to staff. While on return to the facility, the van was alerted by phone call that Resident #2 was left behind at the store. The MCD explained the procedure for resident trips that she carried a list of the residents who were on the trip and performed head counts on the way to the trip destination and on return to the facility. The MCD stated that she was not aware if there was a written protocol to follow when taking	A 310		

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A 310	Continued From page 2 residents out of the facility on field trips. On 7/20/22 at 12:20 a.m., the surveyor interviewed the Health and Wellness Director (HWD) regarding the procedure for resident trips who explained that the Resident Care Aides and the Activity staff accompanied residents on trips. Also, the HWD stated that there were no reports given upon return from trips unless there was an issue or concern with a resident. On 7/20/22 at 1:00 p.m., the surveyor interviewed the new Executive Director who was only at the facility for nine days regarding the policy and procedure for resident field trips. The ED explained that the facility did not have a trip policy and procedure in place in order to ensure resident safety when their cognitively impaired residents partook in facility sponsored field trips. The facility failed to develop and implement a policy and procedure outlining protocols in order for staff to maintain accountability of their [redacted] [redacted] residents, including Resident #2, who was left behind on a facility sponsored filed trip and did not return to the facility with the other staff and residents on 6/6/22. Reference: 8:36-4.1(a)(16)	A 310		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:	A 389		

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A 389	Continued From page 3 16. The right to be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced by: Complaint # NJ00155623 Based on observation, interview and record review, it was determined that the facility neglected to maintain accountability of a EX Order 26 § 4b1 resident who was left behind on a facility sponsored field trip which placed the resident at risk for injury for 1 of 3 residents reviewed, Resident #2. This deficient practice was evident by the following: On 7/20/22 at 9:50 a.m., during the entrance conference, the surveyor interviewed the Executive Director (ED) who informed the surveyor that she, the ED, had only been working at the facility for nine days. On 7/20/22 at 10:20 a.m., the surveyor toured the Memory Care (MC) unit and observed residents engaged in activities. The surveyor observed that Resident #2 was clean and neatly dressed wandering around the common areas. The surveyor greeted Resident #2 and observed that there was no response reciprocated. On 7/20/22 at 10:25 a.m., the surveyor interviewed the Resident Care Aide (RCA) regarding resident activities. The RCA stated that the facility provided a variety of activities for the residents which included trips outside the facility. In addition, the RCA explained that the staff	A 389		

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A 389	Continued From page 4	A 389		

accompanied residents on trips and that the trips were planned by the Memory Care Director (MCD).

On 7/20/22 at 11:30 a.m., the surveyor interviewed the MCD regarding the trip activity procedure. The MCD explained that a list of the residents' names and information sheets were carried on the trips and head counts of the residents were conducted on the way to the trip destination and upon leaving to return to the facility. The surveyor than requested a list of the residents who attended trips. The MCD continued to explain that there were only two trips one on 5/9/22 and one on 6/6/22. The MCD informed the surveyor that she attended both trips. The surveyor than asked the MCD if there were any resident issue on the trips. The MCD explained to the surveyor that on the 6/6/22 trip, Resident #2 walked out of the resident line up to get back on the van to return to the facility after head count and returned into the store unbeknownst to staff. Also, the MCD explained that while the van was en route to the facility, which was approximately ten minutes away from trip destination, the store staff called the facility to notify them that Resident #2 had been left behind. The MCD stated that the van returned to pick up Resident #2 and that she had notified the Executive Director (ED) and the nursing staff.

On 7/20/22 at 11:40 a.m., the surveyor reviewed the medical record (MR) of Resident #2 which revealed that Resident #2 moved into the facility on [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted] According to the nursing assessment dated 4/1/22, Resident #2 [redacted] and was alert and occasionally needed EX Order 26 § 4b1

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A 389	Continued From page 5 EX Order 26 § 4b1 to person, place, and time. On 7/20/22 at 12:35 p.m., the surveyor re-interviewed the RCA regarding Resident #2 being left behind on the 6/6/22 trip. The RCA explained that the staff performed a head count of all the Residents in line prior to entering the van and every resident had been accounted for but somehow Resident #2 left the line after head count and returned into the store. On 7/20/22 at 12:38 p.m., the surveyor interviewed the Utility staff member who also attended the trip on 6/6/22 who explained that the van arrived at the facility and during resident head count it was noticed that Resident #2 was missing. In addition, the store staff called the facility to notify them that Resident #2 was left behind. On 7/20/22 at 12:55 p.m., the surveyor interviewed the Health and Wellness Director (HWD) who explained that she was not at the facility on 6/6/22 but was made aware of Resident #2 being left behind on the field trip on 6/6/22. The HWD informed the surveyor that Resident #2 was not injured and was in the sight of store staff until the van returned to pick up resident (Resident #2). On 7/20/22 at 1:00 p.m., the surveyor interviewed the Activity Aide (AA) who was also the van driver on 6/6/22 regarding Resident #2 being left behind on the field trip. The AA explained that she counted the residents as they got back on the van and realized that Resident #2 was missing. She continued to tell the surveyor that she informed the other staff on board the van that a resident was missing but was informed that the head count was correct and to return to the facility.	A 389		

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A 389	Continued From page 6 Also, the AA informed the surveyor that the van returned to the facility and the MCD received a call from the front desk that Resident #2 was still at the store. The facility neglected to safely monitor Resident #2 who was EX Order 26 § 4b1 and EX Order 26 § 4b1 during a field trip. Also, in spite of the resident head count being incorrect, the van left the site of the field trip to return to the facility without Resident #2 being on board the van.	A 389		
A 563	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, elopements, and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages; This REQUIREMENT is not met as evidenced	A 563		

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A 563	Continued From page 7 by: Complaint # NJ00155623 Based on interview and record review, it was determined that the facility failed to report to the Department of Health (DOH) that a [redacted] resident was left behind from facility staff while on a facility run field trip for 1 of 3 residents reviewed, Resident #2. This deficient practice was evident by the following: On 7/20/22 at 11:40 a.m., the surveyor reviewed the medical record (MR) of Resident #2 which showed that Resident #2 moved into the facility on [redacted] with diagnoses which included EX Order 26 § 4b1 According to the nursing assessment dated 4/1/22, Resident #2 [redacted] and was alert and occasionally EX Order 26 § 4b1 to person, place, and time. On 7/20/22 at 11:50 a.m., the surveyor interviewed the Memory Care Director who informed the surveyor that on 6/6/22, Resident #2 EX Order 26 § 4b1 out of the resident van line up after a head count had been taken and went back into the store unbeknownst to staff. Upon return to the facility, the van was alerted by phone call that Resident #2 was left behind at the store. On 7/20/22 at 1:25 p.m., the surveyor interviewed the new Executive Director (ED) who had only been working at the facility for nine days inquiring if a report had been sent to the DOH regarding Resident #2 being left behind on the facility run field trip. The ED explained that after interviewing staff and looking through facility records, the prior ED did not submit a reportable event form to the DOH nor was an internal investigation initiated..	A 563		

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A 563	Continued From page 8 On 7/20/22 at 1:30 p.m., the surveyor reviewed the facility policy and procedure titled "Reportable Events" and listed under "Policy: The community will report all reportable events as required by law and regulations." The facility failed to report to the DOH that on 6/6/22, Resident #2, who was [redacted] [redacted] was left behind at a community store and was discovered by store staff while on a facility sponsored filed trip. The staff at the store notified the facility of Resident #2's whereabouts as the van had already left the field trip site and was on its way back to the facility without Resident #2 being on the van. Reference: 8:36-4:1(a)(16)	A 563		
A 753	8:36-7.3(c) Resident Assessments and Care Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. This REQUIREMENT is not met as evidenced by: Complaint # NJ00155623 Based on interview and record review, it was determined that the facility failed to revise, develop and implement interventions on a service plan for a resident who had been assessed as a	A 753		

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A 753	Continued From page 9 wanderer who was left behind on a facility run field trip for 1 of 3 residents, Resident #2. This deficient practice was evidenced by the following: On 7/20/22 at 11:40 a.m., the surveyor reviewed the medical record of Resident #2 which revealed that Resident #2 moved into the facility on [redacted] with diagnoses which included EX Order 26 § 4b1 [redacted] On 7/20/22 at 11:45 a.m., the surveyor reviewed the activity calendar and observed that on 6/6/22 one of the activities was a field trip. The surveyor then reviewed the list of attendees and Resident #2 was observed on the list as having gone on the field trip. On 7/20/22 at 11:50 a.m., the surveyor interviewed the Memory Care Director who informed the surveyor that on 6/6/22 Resident #2 [redacted] of the resident van line up after the head count was taken and went back into the store unbeknownst to staff. While on return to the facility, staff in the van were alerted by phone call that Resident #2 had been left behind at the store. On 7/20/22 at 12:00 a.m., the surveyor reviewed the facility document titled "Assessment" dated for 4/1/22 and observed listed under "EX Order 26 § 4b1 [redacted]" that Resident #2 " 3 ...B. Occasionally needs EX Order 26 § 4b1 [redacted] to person, place, and [or] time ... 7 ...A [redacted]: does not require redirection ...." In addition, according to the "Assessment" dated 4/1/22, it was indicated that Resident #2 did not require a wandering or exit seeking evaluation	A 753		

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A 753	Continued From page 10 plan. On 7/20/22 at 12:50 p.m., the surveyor reviewed Resident #2's CP with the start date of 7/10/20 and a review date of 1/6/21. The surveyor identified that the CP was updated on 7/20/22 with an effective date of 7/20/22, the day the surveyor was in the facility. However, there was no documented evidence that the CP was updated to include interventions for [redacted] behavior that occurred during an activity field trip on 6/6/22 when the resident became unaccounted for and left behind on a facility field trip. On 7/20/22 at 12:55 p.m., the surveyor interviewed the Health and Wellness Director (HWD) who explained that because Resident #2 "was in the sight of store staff" [not facility staff] and sustained no injury" that there was no need to update the resident's CP status post 6/6/22 Resident #2 EX Order 26 § 4b1 EX Ord during a facility sponsored activity field trip. The facility failed to update and revise Resident #2's CP to include interventions for safety during field trips related to Resident #2's EX Order 26 § 4b1 [redacted] behavior that occurred on 6/6/22. Also, the surveyor observed that the facility failed to review and update Resident #2's CP until the date of the survey 7/20/22 at 12:00 p.m. [12:00 AM], according to the effective date and time on the CP. Reference: 8:36-3.1(a)(16)	A 753		

August 16 2022

POC FOR ALL AMERICAN AT WASHINGTON

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

1. Executive Director developed a plan and will continue to monitor the plan to ensure safety for all resident in the community Communities ED/RN will monitor plan to ensure all residents are free from neglect or abuse.

2. A resident was found affected by this deficiency Resident #2

3. All residents can be affected by this deficiency

1. The facility has developed a plan for trip outings going forward. All staff in activities and transportation were in serviced regarding our procedure for trips, including but not limited to sign up sheets with name date time they left the facility, time they returned to the facility. The head count will be completed on the bus at beginning of the trip at the facility. A head count will happen at the event location. Another head count will happen when residents are in the bus before the return to the facility. Another head count when they return in the facility. Face sheet binder will be brought with the staff for emergencies.
4. The plan will include measures to ensure all residents are safe from neglect or abuse.
5. The staff will be in serviced by RN/ED by **July 31 2022** and ongoing on a quarterly basis. Completion date July 31 2022

A389 8:36 – 4.1 (a) (Resident Rights)

1. Resident rights are posted in the community and will be followed to ensure we are caring from the residents as per the residents rights. ED or designee will ensure all residents are free from abuse or neglect.

2. A resident was affected by this deficiency. Resident #2

accepted 9/9/22

3. All residents can be affected by this deficiency

4. The staff responsible for transportation and the care of the resident will ensure they follow above procedure to ensure residents are free from physical and mental abuse and /or neglect Procedure will be communicated to all staff who participate in transportation on trips. In servicing will be completed by RN/ED. All staff in activities and transportation were in serviced regarding our procedure for trips, including but not limited to sign up sheets with name date time they left the facility, time they returned to the facility. The head count will be completed on the bus at beginning of the trip at the facility. A head count will happen at the event location. Another head count will happen when residents are in the bus before the return to the facility. Another head count when they return in the facility. Face sheet binder will be brought with the staff for emergencies.

5. In servicing completed by **July 31 2022** RN/ED will be responsible quarterly to complete above in servicing to ensure all resident are safe from neglect and abuse going forward. Completion date July 31 2022 .

A563 8:36 – 5.10 (a) (2) General Requirements

1. The executive director or designee will contact the DOH within 72 hours for any state reportable

2. A resident was affected by this deficiency Resident #2
3. All residents can be affected by this deficiency
4. The administrator or designee will ensure they notify the DOH of any of the above to ensure the well being of the residents and appropriate reporting as per the regulations within the required DOH time period. Effective immediately the ED or designee will report timely manner
5. This will be ongoing before and after **July 31 2022** Completion date July 31 2022

A 753 8:36 – 7.3 (c) Resident Assessments and Care Plans

1. RN or designee will complete a care plan and assessment for any affected resident by this deficiency.
2. A resident was affected by this deficiency Resident #2

accepted 9/9/22 RR

3. All residents can be affected by this deficiency

4. Resident #2 was assessed and a care plan was completed July 22 2022 physician was notified along with POA. Care plan was updated to reflect new interventions and resident will be monitored during activities including trips and transportation. RN will monitor Resident #2 and all residents for compliance to our policy and procedure to ensure no resident will be affected on all activities including trips or transportation going forward RN or designee will monitor for compliance and oversee care plans to ensure appropriate care is given to resident affected by this deficiency. RN will update any safety measures timely and work closely to ensure all residents are not affected going forward for any deficiencies. RN will ensure that care plans are completed for any incidents or ill effect.

5. This procedure will be in place ongoing before and after **July 31 2022** Completion date July 31 2022

Respectfully,

Debra Petrone
Regional Director of Operations
Interim ED for All American at Washington
08A012

accepted 9/9/22

New Jersey Department of Health

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{A 310}	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by:	{A 310}		
{A 389}	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 16. The right to be free from physical and mental abuse and/or neglect;	{A 389}		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/16/22

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A012	A. BUILDING: ______ B. WING ______	R-C 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
ALL AMERICAN ASSISTED LIVING AT WASHINGTON	**339 GREENTREE ROAD SEWELL, NJ 08080**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 389}	Continued From page 1 This REQUIREMENT is not met as evidenced by:	{A 389}		
{A 563}	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, elopements, and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages; This REQUIREMENT is not met as evidenced by:	{A 563}		

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{A 753}	Continued From page 2	{A 753}		
{A 753}	8:36-7.3(c) Resident Assessments and Care Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. This REQUIREMENT is not met as evidenced by:	{A 753}		